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THE TAX-EXEMPT HOSPITAL SECTOR

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

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THE TAX-EXEMPT HOSPITAL SECTOR

THURSDAY, MAY 26, 2005

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to notice, at 10:18 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Committee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
May 19, 2005
FC–10

CONTACT: 202–225–1721

Thomas Announces Hearing on the Tax-Exempt Hospital Sector

Congressman Bill Thomas (R–CA), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing titled, "A Review of the Tax-Exempt Hospital Sector." The hearing will take place on Thursday, May 26, 2005, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Invited witnesses will include the Honorable David Walker of the U.S. Government Accountability Office, the Honorable Mark McClellan of the Centers for Medicare and Medicaid Services, the Honorable Mark Everson of the Internal Revenue Service (IRS), academic experts and other interested parties. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The Committee on Ways and Means held a hearing on April 20, 2005, to examine the history of the tax-exempt sector, the legal rationale for tax-exemption, and its economic impact. The Committee is continuing its series of hearings to review the tax-exempt sector. These hearings will examine particular components of the tax-exempt sector, such as charitable institutions, cooperatives, and other exempt organizations, to learn more about what they do, how they have evolved over time, if the organizations have become increasingly commercial in their operations, and the current rationale for their tax-exempt status.

According to the Joint Committee on Taxation, health-related organizations make up the largest percentage of § 501(c)(3) non-profit organizations, accounting for almost 60 percent of total revenues of § 501(c)(3)s. Of the health-related organizations, hospitals constitute almost three-quarters of total revenues.

In 1956, the IRS first announced a formal position on what is required for a hospital to be recognized as exempt under section § 501(c)(3), since the law is silent as to "health" as a criteria for exemption. The ruling had a number of criteria, including that the facility must be operated to the extent of its financial ability for those not able to pay, and not exclusively for those able and expected to pay. In 1969, the IRS eliminated the requirement that hospitals provide charity care as a condition to receive tax-exempt status. Because this action was taken through an administrative revenue ruling, it was made without public comment. The IRS believed that this change was warranted, in part, by the enactment of the Medicaid and Medicare programs. Moreover, the view was that taxable and tax-exempt hospitals were dissimilar organizations, since taxable hospitals were commonly organized as small physician-owned facilities. Since 1969, hospital tax-exemption has been governed by the "community-benefit" standard. Under this standard, an entity engaged in the promotion of health for the benefit of the community is pursuing a charitable purpose, even though not all members of the community, such as the indigent, directly benefit from the services.

The hearing will examine the following issues:

- How the standards for hospital tax-exemption evolved over time;

• What criteria are used to assess if hospitals meet the tax-exempt standard;

• If tax-exempt hospitals operate principally as businesses selling their services in a competitive market.

In announcing the hearing, Chairman Thomas stated, "This continues the series of hearings examining the tax-exempt sector. Congress needs a better understanding of the subsidy for tax-exempt hospitals. Tax-exemption is an important benefit and the Congress has a responsibility to assure the American taxpayer that the tax-exempt hospital sector is living up to its community responsibilities."

FOCUS OF THE HEARING:

The hearing will examine the legal history of the tax-exemption for hospitals; IRS oversight of tax-exempt hospitals; the need for congressional oversight of the standards for hospital tax-exemption; and Federal policies that subsidize treatment of the indigent by hospitals.

FURTHER EXAMINATION:

The Committee will be continuing this series of hearings throughout the year, looking both at broad categories of exempt organizations and at specific abusive practices involving tax-exempt organizations, ranging from support of terrorism by tax-exempt organizations to practices that misuse valuable taxpayer dollars. These hearings will assess the impact of such abuses, whether current laws are adequate to address them, and if not, what should be done to curtail them.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov,* select "*109th Congress*" from the menu entitled, "*Hearing Archives*" (*http://waysandmeans.house.gov/Hearings.asp?congress=17*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record.*" Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Thursday, June 9, 2005. **Finally,** please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. Can we ask our guests to find seats, please? Today the Committee is continuing a series of hearings on the tax-exempt sector. Our last hearing provided a broad overview of the history, law, and economics of the sector. We plan to continue this series throughout the 109th Congress, examining both the broad categories of tax exemption and specific activities. The Committee will focus today on the tax exemption standard for hospitals. Health-related organizations account for almost 60 percent of the revenues of all charitable organizations. I know some Members have said, Why are we picking on hospitals? I think it is obvious if we begin an examination in this area; the old Willy Sutton motto of why do you rob banks? He said, That is where the money is. If we are going to examine this area in terms of the not-for-profit activities, it seems almost axiomatic that you look at the area that accounts for almost 60 percent of the revenue in that particular category. Of these, in terms of all charitable organizations, hospitals account for three-quarters of the revenue, making them by far the largest single type of charitable organization.

In light of these statistics, the question that we started with and that I believe is the responsibility of Congress and its oversight function is to ask periodically, and the Chair believes every 25 years is a reasonable timeframe for periodicity, to say what is the taxpayer getting in return for the tens of billions of dollars per year in tax subsidy. History shows us that over time, less and less has been required for hospitals to maintain tax-exempt status. In 1969, the IRS eliminated the requirement that not-for-profit hospitals provide charity care in order to maintain exempt status. In 1983, the IRS dropped the requirement that nonprofit hospitals operate an emergency room. Ironically, as less was required, hospitals have received more help through Federal policies in terms of health coverage both for the old under Medicare and the poor under Medicaid. For example, Federal subsidies were added for treating low-income patients, training physicians, and for locating in rural areas. I think an appropriate question to ask is what does the current standard require of hospitals? Is there adequate oversight of the so-called community benefit standard?

The Committee will hear testimony from a local taxation official today from Illinois suggesting that at least in terms of certain purviews, there are significant oversight duties that fall into local tax officials and that what they have discovered is of primary impor-

tance to this Committee. For example, our nonprofit hospitals, primarily commercial enterprises, that do not differ substantially from for-profits. Data from the American Hospital Association showed in 2002, the average percentage of uncompensated care was 4.4 percent for nonprofit hospitals and 4.5 percent for for-profit hospitals. If blindfolded and taken to a hospital, would a patient know whether he or she was in a for-profit or not-for-profit? The standards for tax exemption are not just an academic debate. My hometown newspaper recently ran an article on how hospital charges just don't make sense. All of us have examples and we have read about them in terms of what kind of a nonsensical pattern of who gets charged, how much, when, and how. Similarly, the level of executive compensation and collection practices of some nonprofit hospitals has been the subject of increasing scrutiny. Given the size of the Federal benefit and the competitive advantages given to tax-exempt entities—and we may attempt to place a ballpark dollar figure on those—I believe it is incumbent upon these Committees to ensure that the taxpayers are given at least some commensurate relationship of benefit for the tax exemption amounts. Fourteen years ago, this Committee held a hearing on this same topic, and yet today we still face many of the same questions because Congress has failed to act. My hope is that through these series of hearings, we will get sufficient information to be able to act. With that, the Chair would recognize the gentleman from New York, Mr. Rangel, for any statement he may wish to make.

Mr. RANGEL. My question is why are you picking on hospitals, which I understand you said that many people ask you; but there is no answer here, because if we were to get involved with why do we give tax exemptions in the first place, I think I could better understand it. We have the President saying he wants to change the Tax Code altogether. I think these are legitimate questions. But when the Chair starts picking certain people out just because they are the beneficiary of tax exemption, I would want to know do they deserve the exemption, what is the policy for the exemption and where do we go from here? Do we go to the universities as opposed to those for-profits, churches, our synagogues, our mosques, our YMCAs? We have so many institutions that don't pay taxes that I just don't know why you won't give us a list or give us reasons other than this is where the money is. This may be where the service is, this may be where the health benefits are, this may be the best thing. Maybe we should give them more money to do good. It seems, Mr. Chairman, that you have had three hearings now on this tax exemption, hospitals, credit unions, and now the full Committee is revisiting this and we might as well get on with tax reform and get the reasons for the policy rather than frighten the heck out of people that clearly there has been no evidence—and maybe we will get it from the panels—of wrongdoing. All of us want to rout out wrongdoing wherever it is. I would like to recognize Mr. McNulty for the purposes of introducing a statement for the record, and then the balance of the time I would like to turn over to Mr. Stark, the senior Member of the Subcommittee on Health.

Chairman THOMAS. Without objection. Any Member who wishes to submit a statement for the record, without objection.

Mr. STARK. Mr. Chairman, if I could continue, it shouldn't surprise you that I am on oversight of the entire hospital sector, but I am a little curious as to where this is leading us and whether, indeed, we have done our homework. No one has provided us with a concrete example of what might happen if this exemption was eliminated. Now I was able to get data on one State, and they have asked to remain anonymous and I would be glad to show the Members the letter I have; but basically what would happen to that State if suddenly—all but one of the hospitals is not for profit—if you suddenly changed and made them all for profit, we would pick up—well, 242 million of revenue would be picked up, 117 to the Feds, sales tax of 35, real estate taxes are 90. They have 525 million of uncompensated care, but that comes out of their margins, and that would be about 90 percent of their margin. Then on top of that, they have 4.3 billion of tax-exempt bonds which would come due the minute you made them for-profit, and they questioned whether they could refinance that in today's market and it would certainly be at a higher rate.

I just suggest that to say within 2 days I have been able to get that information, and for us to be going at this in the blind—and none of us have exact numbers as to what is out there—it would be easy for Joint Tax to do it and then we could regroup and look at what we ought to know, rather than this kind of smearing around here, getting a bunch of opinions as to what is happening. The other question that will come up, gee whiz, won't for-profit hospitals do a better job? The fact is in—and while this is not a peer-review journal, the only thing that is available to me that I can understand is U.S. News and World Reports, and out of that, there is 675 individual rankings in U.S. News and World Reports. Only 17 of those went to for-profit hospitals; in other words, two for-profit hospitals, U.S.C. and St. Louis, were formally not for profit and they converted. So, you don't find a first-quality hospital in the United States that is for profit. So, the idea that converting it to for-profit would improve medical care I think we could debunk rather quickly.

I am suggesting we go back and get data that is reliable on every hospital that is available to us and figure out what to do. The other thing to remember is that if we get Federal tax revenue, my colleagues, it doesn't go to health care. It goes into the general revenues to Iraq, to pay hospitals or whatever we want to do with it, and therefore, I think we ought to proceed with some kind of good data and determine where we think we ought to be. The biggest problem—and I will quit, Mr. Chairman—is how we define charitable care. That has been before us for 30 years that I am aware of, and it is elusive. Every hospital will tell you, we give to the public good. Well, this giving to the public good, running an ad that says you might have a heart attack, or is it going out and grabbing people off the street and saying let us give you a blood test? It is in the eye of the beholder; and is it charitable care at sticker price or what they actually collect from insurance companies? Those things we are unsure of, and that might be another topic of how we define it. But it is our job to do it and I hope we proceed with more data than we have before us today. I thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman. I guess I should have realized that in reading previous hearings and doing historical analysis that I came across a quote from the gentleman from California as a statement for the hearing in front of this Committee some years ago in which the gentleman from California began his statement by saying, "Mr. Chairman, exemption from taxes is a privilege for which communities have a right to expect a measurable definable benefit. Given the value of the exemption and the cost of it to every level of government, it makes sense that we scrutinize the extent to which communities are receiving a return on their investment in not-for-profit hospitals." Apparently the gentleman was able to make that statement without that significant research necessary to reach the conclusion which I think, as the gentleman said on its face is obvious, that periodically we have every right to ask the question. What I am hearing primarily from my colleagues is the concern about the conclusion. The Chair has no conclusion, but believes that beginning the process of examining might lead us to discuss options, as was apparent in the first hearing, where people were beginning to give us some definitions that might be useful. This is an attempt to flesh that process out. We continue to try to gather information, which I think is at the heart or should be at the heart of the legislative process. I welcome the gentleman's offer of bringing additional data from different structures in front of the Committee, which will allow us to make an even more informed decision than would otherwise be the case. I agree completely with the gentleman's statement that he made at a previous hearing.

Mr. STARK. Would the gentleman yield? If he had been at that hearing, he would have heard further testimony that suggested that we ought to look at kickbacks to doctors and a whole host of things that subsequently losing the gavel, I can't claim any problems since '94. But that data should have been established and I stand by the statement. I thank the Chairman.

Chairman THOMAS. The Chair completely agrees with the gentleman that we should not limit our pursuit of a reasonable return on the taxpayers' dollar to not-for-profit, for-profit, or any other particular definition of where the taxpayers' dollars goes. With that, I want to welcome the panel. This seems to be an especially useful panel which will allow us to continue to focus on where we have been, how we got to where we are, and to some extent, if they are bold and willing, where we ought to be going. We have the honorable Mark Everson, Commissioner of the Internal Revenue Service, certainly a principal player in where we are today; the honorable David M. Walker, Comptroller General, U.S. government Accountability Office. Welcome back. Dr. Mark McClellan, the Administrator for the Centers of Medicare and Medicaid Services, who in his previous life had some involvement in academia looking at this very question through slightly different spectacles. If we will, I will start with Mr. Everson. Your written testimony will be made part of the record and you can address us in the time you have in any way you see fit.

STATEMENT OF THE HONORABLE MARK EVERSON, COMMISSIONER, INTERNAL REVENUE SERVICE

Mr. EVERSON. Mr. Chairman, Mr. Rangel, distinguished Members of the Committee, thank you for the opportunity to discuss the tax-exempt hospital sector. I commend you for your interest in this area and in the subject of charities more generally. To start, I would like to put IRS oversight of the tax-exempt sector into a broader context. Last year, we issued the IRS Strategic Plan for 2005 through 2009. In that plan we set three goals: to improve taxpayer service, to enhance enforcement of the tax laws, and to modernize the IRS. As GAO noted in a report issued just last week, over the past several years, the IRS has made progress in each of these areas. As the Comptroller General noted in his recent update to GAO's governmentwide High Risk Report, the IRS still has important work to do, particularly with respect to enforcement of the tax law. Within the enforcement arena, we have four key objectives. These include attacking abusive activity by corporations, high-income individual taxpayers, and other contributors to the tax gap; ensuring attorneys, accountants, and other tax practitioners adhere to professional standards and follow the law; and augmenting our investigations of tax and financial crimes. Our fourth enforcement objective, which hits squarely the issues you are addressing in your series of hearings on the charitable sector, is to deter abuse within tax-exempt and governmental entities and misuse of such entities by third parties for tax avoidance or other unintended purposes.

While most charities, including hospitals, are good solid citizens, we have made the tax-exempt sector a service-wide important priority because we are seeing increasing problems. Specific examples include problems with particular components of the tax-exempt sector like credit counseling and supporting organizations, as well as issues such as excessive compensation across a larger portion of the sector. If we do not act now, we will be faced with two results: first, an alarming erosion of the tax base as individuals and for-profit entities masquerade as charities in order to escape taxation and regulation; second, erosion of the American public's trust in charities if people conclude that charities no longer operate for the public good. If that happens, one of our Nation's great strengths will waste away. Over time, Americans will stop giving and those in need will suffer. The extent of our concern is such that we are dedicating increased resources to tax-exempt organizations, reversing a multiyear trend. Although the total IRS budget for fiscal year 2005 increased by only one-half percent, we have boosted our budget for exempt organization examinations by over 20 percent. I would note that the President's 2006 request asks for another $14½ million to further step-up our activities in the tax-exempt sector.

Turning now to tax-exempt hospitals, since 1969 the basic standard for tax exemption has been the community benefit standard. The community benefit standard includes considerations such as existence of a community-controlled board and open medical staff, a full-time emergency room opened to all without regard to ability to pay, acceptance of Medicare and Medicaid, and appropriate use of earnings. While our standard for assessing an organization's eligibility for tax exemption has remained essentially unchanged over

36 years, the hospital industry has not. What we have seen since 1969 has been a convergence of practices between the for-profit and nonprofit hospital sectors, rendering it increasingly difficult to differentiate for-profit from not-for-profit health care providers. In our review of tax-exempt hospitals, some of the issues we are finding include complex joint ventures with profit-making companies, excessive executive compensation, operating for the benefit of private interest rather than the public good, unrelated business income and employment taxes. Let me state clearly that, as with other parts of the tax-exempt sector and enforcement generally, we have not been able to do enough with respect to tax-exempt hospitals. Our audit rates are too low. We welcome your support as we strive to do more.

As you consider possible changes to the law, let me reiterate three points I have made before and I hope you consider as a part of your review. First, is the question of whether the IRS has sufficiently flexible enforcement tools. There are times when revocation of exempt status is not workable either because it imposes a disproportionate hardship on those who need help or is otherwise not in the public interest. We need intermediate sanctions that are of sufficient impact and focused on the right parties. Second, enhanced transparency is a vital component of a healthy tax-exempt sector. Key to achieving this goal is the ability to require sufficient numbers of organizations to electronically file their form 990. Third, is whether the IRS can leverage its activities through improved information sharing with fellow State regulators. Increasing the capacity to share information with State regulators would improve the Nation's ability to combat abuses in the exempt community. In addition to these areas of possible statutory revisions to boost oversight of the tax-exempt sector, I also urge the Committee to support the administration's 2006 budget request. The budget increases enforcement by 8 percent generally, and would help expand our coverage with respect to hospitals and other key areas of the tax exempt sector. Thank you.

Chairman THOMAS. Thank you for that commercial message in terms of the desire to have more money. Somehow I knew you would work that into the testimony, but the other stuff is really good and I appreciate that.

[The prepared statement of Mr. Everson follows:]

Statement of The Honorable Mark Everson, Commissioner, Internal Revenue Service

Mr. Chairman, Congressman Rangel, distinguished members of the Committee: Thank you for the opportunity to discuss tax-exempt hospitals and health care organizations, and the IRS administration of this area.

Tax-exempt hospitals and health care organizations are an important and highly visible element of the tax-exempt community. According to Statistics of Income (SOI) data for 2001, the most recent available, this sector consists of approximately 7,000 entities. It includes hospitals, clinics, other health care providers, cooperative health service organizations, and medical research organizations. Over half these organizations are traditional hospitals. That year, this sector controlled approximately $490 billion in assets and received over $500 billion in gross receipts. In terms of assets, it is the largest element within the universe of tax-exempt entities.

The country rightfully takes pride in its system of tax-exempt hospitals and health care organizations. This sector employs the talents of millions of dedicated professionals, staff and volunteers who conscientiously, and with great dedication and skill, provide life-saving medical and rehabilitative care, train medical profes-

sionals, educate the public about health and medical issues, and conduct groundbreaking research. Their contributions and importance to the country cannot be overstated.

My remarks will focus on the law applicable to tax-exempt hospitals and health care organizations, and on the Internal Revenue Service's coverage of this area.

As I outline the law and our work in this area, what should become clear is that we at the IRS are now faced with a health care industry in which it is increasingly difficult to differentiate for-profit from non-profit health care providers. Our agents at work in this industry encounter dauntingly complex corporate tax issues. These derive from the use of multiple inter-related entities and a complex web of service and other contractual relationships. We regularly find ourselves engulfed in paper as we attempt to discern whether those in control of a particular non-profit health care provider are acting more as investors for their own account or as stewards of charitable assets.

General Discussion of the Internal Revenue Service's Regulation of the Non-Profit Sector

Before beginning a specific discussion of the health care sector, I would like briefly to place health care within the context of our overall regulation of tax-exempt organizations. I believe that the overwhelming majority of charitable organizations do their utmost to comply fully with the letter and spirit of the tax law. But we are now at an important juncture. Simply stated, there are increasing indications that the twin cancers of technical manipulation and outright abuse that we saw develop in the profit-making segments of the economy are now spreading to pockets of the non-profit sector.

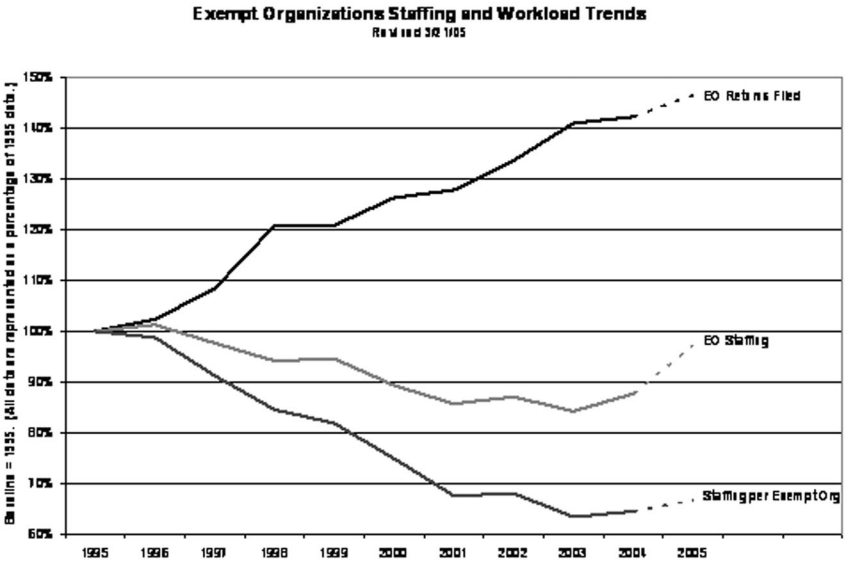
We can see that abuse is increasingly present in the tax-exempt sector, and we must work to address it. We will act vigorously, for to do otherwise is to risk the loss of the faith and support that the public has always given to the charitable community. And if that is lost, the bountiful vitality of the American charitable sector will wither.

That is why the IRS Strategic Plan for 2005–2009 recognizes the significance of the tax-exempt sector as a whole for tax administration. The IRS Strategic Plan sets out four key objectives designed to enhance tax law enforcement over the next five years. One of them directly addresses the charitable sector:

Deter abuse within tax-exempt and governmental entities and misuse of such entities by third parties for tax avoidance and other unintended purposes.

Despite the importance of the tax-exempt sector, and its unique set of challenges, our enforcement budget did not keep up with the sector's growth. From 1995 through 2003, the number of exempt organization returns filed increased 40 percent, yet IRS staffing of the exempt organizations function steadily declined.

The chart below shows that we have begun to turn this around. Using 1995 as a benchmark, the chart shows the percentage increase in exempt organization returns filed, together with the percentage changes in staffing and staffing per exempt organization, on a year-by-year basis. Although our staffing devoted to exempt organizations has declined, we are reversing this trend.



This reversal reflects the priority we have given to the charitable sector. Although the IRS budget as a whole increased only one-half percent in FY 2005, the Exempt Organizations budget increased 13.8 percent, and the Exempt Organizations examination budget increased 21 percent.

In FY 04, we added 70 new agents to conduct exempt organizations examinations, as well as additional employees to begin implementing our plans for a more flexible approach to enforcement. This year's budget supports additional staffing to continue our plans. We established two new offices to enhance our ability to identify and resolve compliance issues. The first, our new EO Compliance Unit, will help us interact with a larger number of exempt organizations by reviewing Forms 990, corresponding with organizations to resolve inconsistencies and errors, and conducting correspondence audits. The second new office, the Financial Investigations Unit, will focus on in-depth analysis of our most complex and significant cases to identify civil tax issues as well as potential fraud and terrorist-financing referrals, and will serve as a strike force when we need to move quickly.

These units will be aided by two new groups and additional staffing. The first group is the Data Analysis Unit, established in 2004, which uses combinations of data to better select cases for examination. A second newly-funded group will identify and follow up with selected Form 990 filers in the first years of their operations, bridging the gap between what an applicant organization tells us when it applies for exemption and how it actually operates. In addition, I have reallocated resources to our Exempt Organizations function to enable it to hire 69 additional compliance employees.

The Law Governing Tax Exemption for Hospitals and Health Care Organizations

Overview: Current Exemption Requirements—the Current Community Benefit Standard.

The current standard for exemption of a hospital, known as the "community benefit standard," was first set forth in 1969 in Revenue Ruling 69–545, 1969–2 C.B. 117. The factors considered in Rev. Rul. 69–545 to determine whether a hospital met the community benefit standard were the following:

(a) The governing body of the hospital is composed of members of the community (as opposed to financially interested individuals);

(b) Medical staff privileges in the hospital are available to all qualified physicians in the area, consistent with the size and nature of the facilities;

(c) The hospital operates a full-time emergency room open to all regardless of ability to pay;

(d) The hospital otherwise admits as patients those able to pay for care, either themselves or through third-party payers such as private health insurance or government programs such as Medicare and Medicaid; and

(e) The hospital's excess funds are generally applied to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care, and medical training, education, and research.

In addition to meeting the community benefit standard, hospitals must meet the general requirements for exemption under section 501(c)(3), including the prohibitions on inurement and substantial private benefit.

History and Discussion of Tax Exemption for Hospitals.

Despite the significance of hospitals and health care organizations in the tax-exempt sector, neither the Code nor the underlying regulations explicitly provides for the exemption from federal income tax of non-profit hospitals.

Nevertheless, we have long recognized that non-profit hospitals can qualify for exemption as organizations described in section 501(c)(3) of the Code. Before 1969, the IRS viewed the term "charitable" in the limited sense of providing relief to the poor. Accordingly, in 1956, the first published position of the IRS regarding hospitals recognized them as charitable organizations provided they accepted patients without regard for their ability to pay, to the extent of the hospital's financial ability. Rev. Rul. 56–185, 1956–1 C.B. 202.

Three years later, in 1959, the IRS determined that the term "charitable" in section 501(c)(3) should be interpreted in its generally accepted legal sense and not limited to relief of the poor. Treas. Reg. section 1.501(c)(3)–1(d)(2). Although the regulation expanded the concept of charitable, it did not explicitly provide that promotion of health is a charitable purpose even though promotion of health was and is considered charitable under common law. Then, in 1965, Medicare and Medicaid were established. At the time, many believed these government programs would eliminate the need for indigent care.

Meanwhile, the "financial ability standard" set forth in the 1956 revenue ruling was being criticized for its imprecise standards concerning the extent to which a hospital must accept patients unable to pay in order to retain exempt status. An example of such criticism is that expressed in 1969 at Congressional hearings (see H.R. Rep. No. 43, 91st Cong., 1st Sess. Pt. 1 at 43 (1969)). These factors led the IRS to study the hospital industry and develop a new standard: the community benefit standard, set forth in Rev. Rul. 69–545, and outlined above. Under this standard, hospitals would no longer be required to provide a specific level of care to the poor in order to qualify for tax exemption, but instead must demonstrate that they benefit the community sufficiently.

In Rev. Rul. 69–545, the IRS recognized that the promotion of health is considered to be a charitable purpose under the common law of charity. Promotion of health is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from activities does not include all members of the community, provided that the class is not so small that its relief is not of benefit to the community. Therefore, in order to qualify as an organization described in section 501(c)(3), a hospital must demonstrate that it provides benefits to a class of persons that is broad enough to benefit the community and it must show that it is operated to serve a public rather than a private interest.

Rev. Rul. 69–545 presents a snapshot of the hospital industry as it existed in 1969. At that time, most for-profit hospitals were owned and operated by physicians as an adjunct to their private practice. Therefore, the particular facts illustrating the difference between the exempt hospital and the for-profit hospital are based upon this model.

The ruling was challenged by a group of private citizens who argued that the IRS should continue to require hospitals to provide free care to those unable to pay in order to qualify for tax exemption under section 501(c)(3). While the district court agreed with the plaintiffs' assertion that the ruling was an improper reversal of long-standing policy, the District of Columbia Circuit Court reversed that decision. It held that the definition of charity was not limited to the relief of poverty and the IRS was authorized to modify the requirements for tax exemption for non-profit hospitals. The Supreme Court subsequently vacated the Circuit Court's decision on jurisdictional grounds for plaintiff's lack of standing. *Eastern Kentucky Welfare Rights Organization v. Simon,* 370 F. Supp. 325 (D.D.C. 1973), *rev'd,* 506 F.2d 1278 (D.C. Cir. 1974), *vacated on other grounds,* 426 U.S. 26 (1976).

While the Supreme Court's decision on standing to sue effectively precluded litigation seeking a return to the financial ability standard as the sole method by which a non-profit hospital may qualify as a tax-exempt organization, the decision has not meant that the financial ability standard has no relevance. It was not repealed

when the community benefit standard was adopted. Rev. Rul. 69–545 did not revoke Rev. Rul. 56–185; it merely modified it. While a hospital is no longer required to operate to the extent of its financial ability for those not able to pay, doing so is a major factor indicating that the hospital is operated for the benefit of the community.

Rev. Rul. 69–545 was modified in 1983 with respect to the operation of an emergency room as a factor. In Rev. Rul. 83–157, 1983–2 C.B. 94, a hospital that did not operate an emergency room because the appropriate governmental health agency had determined that this would be unnecessary and duplicative could qualify for exemption by showing that it operated to benefit the community through other factors. Similarly, specialized hospitals, such as eye hospitals and cancer hospitals, treating conditions that are unlikely to require emergency treatment can qualify for exemption without operating an emergency room based on similar, significant factors demonstrating community benefit.

Thus, other factors that demonstrate that the hospital is operating for the benefit of the community may also be considered. Some factors that may be considered are whether the hospital conducts medical training or research activities, engages in activities to educate the public regarding health care matters, or provides types of health care services not otherwise available to the community.

The courts have adopted the Rev. Rul. 69–545 community benefit standard and applied it to determine whether other types of health care organizations qualify for exemption from tax. In *Sound Health Association v. Commissioner,* 71 T.C. 158 (1978), *acq.,* 1981–2 C.B. 2, the Tax Court used that test in deciding if a health maintenance organization qualified for exemption. Similarly, the community benefit standard was applied in *Geisinger Health Plan v. Commissioner,* 985 F.2d 1210 (3rd Cir., 1993), *rev'g* 62 T.C.M. 1656 (1991).

Since the issuance of Rev. Rul. 69–545, there have been a number of changes in the health care industry that have affected the application of the community benefit standard. Under the Medicare and Medicaid programs, hospitals were reimbursed for medical care of the elderly and poor. The availability of this reimbursement was a major factor in the rise of for-profit hospital chains. Thus, the typical model of the for-profit hospital is no longer the physician owned facility operated as an adjunct to a private practice. It has become the investor owned hospital systems. Additionally, hospitals that participate in Medicare and have an emergency room are required to treat any patient in an emergency condition (not just those covered by Medicare or Medicaid), regardless of ability to pay. Furthermore, to achieve cost containment, Medicare and other insurance providers have changed their reimbursement methodologies. With these changes in the health care industry, certain factors specifically discussed in Rev. Rul. 69–545 appear less relevant in distinguishing tax-exempt hospitals from their for-profit counterparts. Having an open medical staff, participating in Medicare and Medicaid, and treating all emergency patients without regard to ability to pay are now common features of tax-exempt and for-profit hospitals rather than distinguishing factors.

Nonetheless, the community benefit standard continues to be the basis for determining tax exemption for hospitals and health care organizations. More and more, the IRS looks to the independent board exercising its fiduciary duty to operate for the benefit of the community to differentiate the tax-exempt hospital from a for-profit operation. This approach was illustrated in the IRS rulings on integrated delivery systems and joint ventures.

In the 1990's a number of hospital systems were acquiring physician practices to integrate the delivery of hospital and physician services so that one organization could negotiate and bill for all of the services rather than having the hospital and physician services negotiated for and billed separately. Frequently, the acquired physician practice would be established as a separate clinic within the hospital system seeking exempt status under section 501(c)(3). In reviewing these applications, we were concerned about the role the physicians from the acquired practice played in the newly created exempt clinic, and whether the clinic had an independent community board based on the Rev. Rul. 69–545 community benefit standard. As part of our review of these types of cases, we developed a sample conflict of interest policy. Adopting a conflict of interest policy would establish a set of procedures to follow to help avoid the possibility that those in a position of authority, such as a director, officer, or manager, may receive an inappropriate benefit and would help preserve the independence of the community board. While not a requirement for exemption of health care organizations, we routinely encourage health care organizations to adopt such a policy.

Similarly, when developing guidance concerning hospital joint ventures, the independent community board factor was of critical importance when applying the community benefit standard of Rev. Rul. 69–545. In Rev. Rul. 98–15, 1998–1 C.B. 718,

an organization that contributed all of its hospital operating assets to a joint venture continued to qualify for exemption when the governing documents of the joint venture required the joint venture to operate for the benefit of the community and to give charitable purposes priority over profit maximization and the community members appointed to the governing board of the joint venture by the organization had voting control over major decisions thereby ensuring that the organization's participation in the joint venture furthered the organization's charitable purposes.

Administrative Treatment of Hospitals and Health Care Organizations by the Internal Revenue Service

General Overview.

The Internal Revenue Service's oversight of the hospital and health care organizations sector employs two programs: the determination letter process based on the organization's structure and proposed activities, and the examination process based on the organization's actual operations.

Determination Letter Process.

Like most other charitable organizations, hospitals and health care organizations are required to apply for tax exemption by an application. In FY 2004, we processed over 87,000 applications from organizations seeking recognition of exemption under section 501(c)(3).

When we receive an application, it is assigned for screening by specialists to determine whether it can be closed without further review because it presents matters that can be resolved based on established precedent and without further development. Cases that cannot be processed under our screening procedures are assigned for additional review and development. Due to their complexity, hospitals generally require additional development.

Over the last ten years, we processed, on average, between 100 to 150 exemption applications per year filed by organizations that are classified as hospitals, which includes hospitals, clinics, medical research organizations, and cooperative hospital service organizations. In FY 2004, we processed about 115 exemptions for these types of organizations. This includes both newly established hospitals as well as clinics formed by hospital systems that reorganize or that purchase medical practices.

To qualify for exemption, hospitals must provide information detailing their proposed operations, governance, and finances. In addition, hospitals must complete a specialized hospital schedule to Form 1023. In October, 2004, we undertook a major effort to overhaul Form 1023, *Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code,* to make it easier to comprehend and to allow us to identify exemption issues. For example, the hospital schedule now asks whether the hospital has adopted a conflict of interest policy consistent with a sample policy that is provided. If not, the schedule pointedly asks how the hospital will avoid the possibility of conflict of interest for those in a position of authority absent adoption of a policy. Other key questions include disclosures about joint ventures and other exemption issues based on the community benefit standard. There are specific questions concerning charity care.

In 2004, we issued a training document to assist our agents in processing exemption applications filed by hospitals entitled *Health Care Provider Reference Guide.* The guide provides a roadmap for agents to make sure that a hospital is organized and operated to promote health care consistent with exemption standards. This material is available on our internet site so that the interested public is also provided with information about how to comply as a tax-exempt hospital.

Review of Hospital Operations—Annual Reporting and the Examination Program

Hospitals and health care organizations have long comprised a part of the Exempt Organizations examination program, reflecting the significance of the health care industry in the tax-exempt sector.

These organizations, like most other types of tax-exempt entities must file annually a Form 990 that outlines their activities, revenues, expenses, balance sheet, certain compensation information related to key employees, officers and contractors, contributor information and certain other information. The Form 990, with the exception of certain contributor information, is publicly available. In addition, if the organization receives more than $1,000 in unrelated business income, it must file a Form 990T (Unrelated Business Income Tax Return). Electronic filing is now available for the Forms 990, 990EZ and 990PF. For 2005 returns, certain tax-exempt entities (*viz.,* those with over $100 million in assets and that file 250 or more returns with us) will be required to file the Form 990 electronically. The asset level that triggers this requirement will be lower in future years. The Form 990 is under

revision. As part of this revision, there will be a new schedule for hospitals that reflects the above-described 1023 schedule. Thus, hospitals will be asked how they meet the community benefit standard and its constituent components, including charity care.

While we expect improvements in light of the recent increase in resources and modified business practices outlined above, our coverage in the area of hospitals has not been robust. From FY 1995 through the first half of FY 2005, we examined over 375 health care organizations (out of a population of around 7,000), including both hospitals and related organizations or parts of hospital systems. There are two reasons for this level of coverage. The first is the overall lack of available examination resources. The second is that many of these entities were examined as part of our large case Team Examination Program (TEP). Comprehensive TEP examinations of large, complex organizations, which include related entities, are, by their nature, exceptionally resource intensive because they involve teams of agents looking at a wide variety of issues. Of the 375 plus examinations, many were included as part of 79 TEP audits of health care organizations or systems, including their myriad related entities.

In our TEP program, we examine large organizations on a team basis, reviewing numerous issues. As part of those audits we review whether the organization meets the community benefit standard, as well as other exemption issues such as compensation and inurement, and tax issues, including unrelated business income tax, allocations of income and expenses among related entities, taxable subsidiary taxation, joint venture income, employment tax, retirement plan issues and numerous other issues.

In more than one quarter of our TEP health care cases we found tax exemption issues. In these cases we can revoke the tax status of the organization. We have done so in only a few instances because traditionally we attempt to get a tax-exempt organization back on the right track. (We have generally reserved revocation for cases in which we believe the organization is incapable of furthering exempt purposes in the future.) We attempt to resolve exemption issues with the taxpayer short of revocation, often through the use of a closing agreement. Almost half of the health care TEP cases ended in this fashion.

The range of issues is even broader in our recent examinations, reflecting the changes in the health care industry that have resulted in ever more complex arrangements. For example, examinations of organizations engaged in whole-hospital joint ventures with for-profit partners present not only difficult exemption issues requiring analysis of the degree of control retained by the tax-exempt partner, but also issues of allocation of income and losses between the tax-exempt and for-profit entity, and other partnership flow-through issues. Other examinations raise the issue whether the organization is barred from exemption because it is primarily engaged in providing commercial-type insurance within the meaning of section 501(m). We also continue to see a variety of compensation arrangements that include components, such as deferred compensation, loan forgiveness, and non-accountable expense plans, that raise excess benefit or inurement issues.

IRS Focus Areas for Discussion of Reforms—Unresolved Issues

The tax-exempt world and, in particular, the non-profit health care industry have changed. We have indicated that the tax-exempt sector has increased in size and complexity. This growth impacts our ability to regulate, creates other pressures within the sector and has exacerbated the decline in our enforcement presence as our staffing available for examinations declined in the late 1990s.

In addition, the tax-exempt sector has not been immune from recent trends toward lax corporate practices. Like their for-profit brethren, many charitable boards appear to be lax in certain areas. In addition, we are increasingly seeing the importation of corporate practices and operating methods into the tax-exempt sector.

These factors have created opportunities for noncompliance. We believe that with the additional staff and new business processes underway, we are re-establishing meaningful oversight in this area. However, notwithstanding our revitalized and refocused program, we believe there are several areas that should be included as part of any discussion of reform in the tax-exempt sector, including any reforms in the area of hospitals and other health care organizations. We believe that any discussion of reforms should include the following questions.

Have changes in practice or the industry created gaps in the statutory or regulatory framework?

There has been huge growth in the tax-exempt sector, but much less change in the law governing those organizations that qualify for tax-exempt status. Since 1969

there has been only limited Congressional review of the rules relating to tax-exempt organizations.

As we regulate various parts of the tax-exempt community, compliance in some areas becomes difficult to administer where industry practice, or the industry itself, changes, but the rules remain constant decade after decade. As individual organizations and industries grew, the skyline changed with more organizations entertaining complex business structures and transactions. The transformation of health care providers, and increased merger activity in the health care sector in the 1980s and 1990s, is the prime example of this kind of change. The health care industry grew up in a different time, with different funding sources and competitive factors, and now has evolved into something substantially different from what it was. Yet the law remains largely unchanged.

Some have argued that it is time for a more thorough review. We welcome that suggestion, both in general with respect to the law of charities and other nonprofits, and more specifically with respect to hospitals and health care organizations. A key question here is whether there are additional bright-line tests that might be available to aid the public in complying with the law, and the IRS in administering it. Often in health care issues, the IRS is left with difficult and fact-intensive administrative challenges. For example, as indicated, some exempt providers have entered into joint ventures with for-profit organizations, sometimes placing their entire health care operation in the venture and transforming themselves into what is effectively a tax-exempt holding company with a charitable grant-making function. Although this is not impermissible, we insist that the charitable entity ensure that the charitable purposes of the venture are not sacrificed for the sake of maximizing profits. This is an example of how the health care industry has changed. To determine control requires our agents and courts to parse through reams of contracts, data and state law. This is a far cry from the industry as it existed in 1969.

This is not to say that the IRS believes the community benefit standard should be modified, but simply that many years have passed since 1969. The community benefit standard is a reasonable interpretation, within the current language of the statute, which speaks only to charitable purposes. The standard reflected, and still reflects, the economic rationale for tax exemption and allows for a variety of mechanisms by which a hospital may attain exemption. In a constantly changing health care market, this flexibility in approach may be exactly what is needed.

Does the IRS have the flexibility to respond appropriately to compliance issues?

We believe a discussion about reform should address whether we have the proper range of tools to enforce compliance in a measured way. In many areas of our jurisdiction, our remedial tools are not effective. Often our only recourse is revocation of tax-exemption, a "remedy" that may work a disproportionate hardship on innocent charitable beneficiaries. Moreover, even where we have an intermediate sanction, it may not work as intended. Thus, as seen in the examination process described above, we are left with many resolutions short of revocation that are nonetheless imperfect.

There are two examples in this area. First, under section 4958, certain compensation arrangements may be found to be excessive. In some cases, however, the amounts considered permissible under section 4958 may be viewed by some as too high. The second example concerns our ability to police expenditures and grants. In our attempts to ensure that exempt organization funds are not diverted to improper purposes, including terrorism, we do not have tools comparable to those applicable to private foundations to sanction public charities that fail to monitor their grants and expenditures.

Should more be done to promote transparency?

Transparency is a lynchpin of compliance within the tax-exempt sector. "Transparency" refers to the ability of outsiders—donors, the press, interested members of the public—to review data concerning the finances and operations of a tax-exempt organization. By creating a means by which the public may review and monitor the activities of tax-exempt organizations, we promote compliance, help preserve the integrity of the tax system, and help maintain public confidence in the charitable sector. To achieve these goals, we began in the mid-to-late 1990s to image Forms 990, the annual information returns filed by many tax-exempt organizations. Prior to 2005, the IRS only imaged returns of organizations described in section 501(c)(3). Beginning this year, we are imaging all Forms 990. We put this information on CDs, and provide it to members of the public, including a number of watchdog groups that monitor charitable organizations. These groups post the information to their websites, where it is available to the press and to the public. This process has resulted in increased press and public scrutiny of the tax-exempt sector, which we be-

lieve is highly desirable. It also has increased the ability of the IRS and state regulators to access Form 990 data, because they are more readily available.

However, there are legitimate questions about whether to further enhance transparency, and if so, how to proceed. For example, limitations exist on our ability to communicate with state charity officials, and these prevent us from fully leveraging the relationship and jurisdiction we share with them. Further, there are segments of the community that we are unable to track, including several categories of legal non-filers (for example, those exempt organizations that are not required to file a Form 990, such as churches and organizations with less than $25,000 in gross receipts). Our master-file is replete with errors concerning these organizations.

Finally, one of our key transparency initiatives is the establishment of electronic filing for Forms 990 and 990–PF. The recent interim report by the Panel on the Nonprofit Sector supports requiring electronic filing for all returns for nonprofits. As indicated, we have issued temporary regulations requiring such filing for certain groups. While this will markedly advance the ability of the Service, the states, and the public to access Form 990 data in real time, our ability to require e-filing is limited at present by statutory restrictions that prevent us from mandating electronic filing for any organization that files fewer than 250 returns. The Administration's 2006 Budget proposal echoes this concern. The Administration's proposal would lower the current 250-return minimum for mandatory electronic filing, but would maintain the minimum at a level high enough to avoid imposing undue burden on taxpayers.

Does the IRS have the resources it needs to do the job?

While this is a topic worthy of discussion, I have outlined what we have done to expand our resources in the tax-exempt area. I believe we have done a credible job of recognizing the task before us and preparing to meet that challenge. To continue this work, I ask the Committee to support the Administration's 2006 budget proposal, which calls for an 8 percent increase in our enforcement budget. If the Congress approves the request, the amount we plan to dedicate to the tax-exempt area would be used to combat abusive promotions involving tax-exempt entities, to start examinations quickly when we detect a risk, and to increase vigilance against the misdirection of exempt organizations' assets for illegal activities or private gain.

Conclusion

We welcome the Committee's review of the law of charities and other nonprofits, including the law of tax-exempt hospitals and health care organizations. We are ready to assist the Committee in this endeavor.

Form **990** Department of the Treasury Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

▶ The organization may have to use a copy of this return to satisfy state reporting requirements

OMB No 1545-0047 **2003** Open to Public Inspection

A For the 2003 calendar year, or tax year beginning and ending

B Check if applicable: Address change; Name change; Initial return; Final return; Amended return; Application pending

Please use IRS label or print or type. See Specific Instructions.

C Name of organization: SHRINERS HOSPITALS FOR CHILDREN

Number and street (or P O box if mail is not delivered to street address): POST OFFICE BOX 31356 | Room/suite

City or town, state or country, and ZIP + 4: TAMPA, FL 33631-3356

D Employer identification number: 36-2193608

E Telephone number: (813)281-0300

F Accounting method: ☐ Cash ☒ Accrual ☐ Other (Specify) ▶

• Section 501(c)(3) organizations and 4947(a)(1) nonexempt charitable trusts must attach a completed Schedule A (Form 990 or 990-EZ).

H and I are not applicable to section 527 organizations.

H(a) Is this a group return for affiliates? ☐ Yes ☒ No

H(b) If "Yes," enter number of affiliates ▶

H(c) Are all affiliates included? N/A ☐ Yes ☐ No (If "No," attach a list)

H(d) Is this a separate return filed by an organization covered by a group ruling? ☐ Yes ☒ No

I Group Exemption Number ▶

G Website: ▶N/A

J Organization type (check only one) ▶ ☒ 501(c) (03) ◀ (insert no) ☐ 4947(a)(1) or ☐ 527

K Check here ▶ ☐ if the organization's gross receipts are normally not more than $25,000 The organization need not file a return with the IRS, but if the organization received a Form 990 Package in the mail, it should file a return without financial data **Some states require a complete return.**

M Check ▶ ☐ if the organization is not required to attach Sch B (Form 990, 990-EZ, or 990-PF).

L Gross receipts Add lines 6b, 8b, 9b, and 10b to line 12 ▶ 4,276,422,659.

Part I Revenue, Expenses, and Changes in Net Assets or Fund Balances

Revenue	1	Contributions, gifts, grants, and similar amounts received.			
	a	Direct public support	1a 243,552,689.		
	b	Indirect public support	1b 1,566,707.		
	c	Government contributions (grants)	1c		
	d	Total (add lines 1a through 1c) (cash $ 243,139,018. noncash $ 1,980,378.)		1d	245,119,396.
	2	Program service revenue including government fees and contracts (from Part VII, line 93)		2	
	3	Membership dues and assessments		3	2,380,091.
	4	Interest on savings and temporary cash investments		4	
	5	Dividends and interest from securities		5	150,287,599.
	6 a	Gross rents	6a		
	b	Less rental expenses	6b		
	c	Net rental income or (loss) (subtract line 6b from line 6a)		6c	
	7	Other investment income (describe ▶ TRUST INCOME)		7	11,535,740.
	8 a	Gross amount from sales of assets other than inventory	(A) Securities 3843531913. 8a	(B) Other	
	b	Less: cost or other basis and sales expenses	3851144652. 8b	-238,245.	
	c	Gain or (loss) (attach schedule)	-7,612,739. 8c	238,245.	
	d	Net gain or (loss) (combine line 8c, columns (A) and (B))	STMT 1	STMT 2	8d -7,374,494.
	9	Special events and activities (attach schedule) If any amount is from gaming, check here ▶ ☒			
	a	Gross revenue (not including $ 0. of contributions reported on line 1a)	9a 15,747,476.		
	b	Less direct expenses other than fundraising expenses	9b 6,976,609.		
	c	Net income or (loss) from special events (subtract line 9b from line 9a)	SEE STATEMENT 4		9c 8,770,867.
	10 a	Gross sales of inventory, less returns and allowances	10a		
	b	Less cost of goods sold	10b		
	c	Gross profit or (loss) from sales of inventory (attach schedule) (subtract line 10b from line 10a)		10c	
	11	Other revenue (from Part VII, line 103)		11	7,820,444.
	12	Total revenue (add lines 1d, 2, 3, 4, 5, 6c, 7, 8d, 9c, 10c, and 11)		12	418,539,643.
Expenses	13	Program services (from line 44, column (B))		13	416,150,819.
	14	Management and general (from line 44, column (C))		14	28,107,207.
	15	Fundraising (from line 44, column (D))		15	14,369,814.
	16	Payments to affiliates (attach schedule)		16	
	17	Total expenses (add lines 16 and 44, column (A))		17	458,627,840.
Net Assets	18	Excess or (deficit) for the year (subtract line 17 from line 12)		18	-40,088,197.
	19	Net assets or fund balances at beginning of year (from line 73, column (A))		19	6689340396.
	20	Other changes in net assets or fund balances (attach explanation)	SEE STATEMENT 3		20 791,523,572.
	21	Net assets or fund balances at end of year (combine lines 18, 19, and 20)		21	7440775771.

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SCANNED JUN 1 7 2005

LHA For Paperwork Reduction Act Notice, see the separate instructions. Form 990 (2003)

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Form **990** — **Return of Organization Exempt From Income Tax**

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

▶ The organization may have to use a copy of this return to satisfy state reporting requirements

Department of the Treasury, Internal Revenue Service

OMB No. 1545-0047 — **2002** — Open to Public Inspection

A For the 2002 calendar year, or tax year period beginning JUL 1, 2002 and ending JUN 30, 2003

B Check if applicable: Address change; Name change; Initial return; Final return; Amended return; Application pending

Please use IRS label or print or type. See Specific Instructions.

C Name of organization: ST. VINCENT HOSPITAL

Number and street (or P.O. box if mail is not delivered to street address): P.O. BOX 2107 — Room/suite

City or town, state or country, and ZIP + 4: SANTA FE, NM 87501

D Employer identification number: 85-0106941

E Telephone number: 505-820-5446

F Accounting method: ☐ Cash ☒ Accrual ☐ Other (specify) ▶

• Section 501(c)(3) organizations and 4947(a)(1) nonexempt charitable trusts must attach a completed Schedule A (Form 990 or 990-EZ).

H and I are not applicable to section 527 organizations.

H(a) Is this a group return for affiliates? ☐ Yes ☒ No

H(b) If "Yes," enter number of affiliates ▶

H(c) Are all affiliates included? N/A ☐ Yes ☐ No (If "No," attach a list.)

H(d) Is this a separate return filed by an organization covered by a group ruling? ☐ Yes ☒ No

I Enter 4-digit GEN ▶

M Check ▶ ☐ if the organization is not required to attach Sch. B (Form 990, 990-EZ, or 990-PF)

G Web site: ▶WWW.STVIN.ORG

J Organization type (check only one) ▶ ☒ 501(c) (3) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

K Check here ▶ ☐ if the organization's gross receipts are normally not more than $25,000. The organization need not file a return with the IRS; but if the organization received a Form 990 Package in the mail, it should file a return without financial data. Some states require a complete return.

Gross receipts: Add lines 6b, 8b, 9b, and 10b to line 12 ▶ 143,627,904.

ENVELOPE POSTMARK DATE MAY 17 2004

SCANNED JUN 21 '04

Part I Revenue, Expenses, and Changes in Net Assets or Fund Balances

Revenue	1	Contributions, gifts, grants, and similar amounts received:			
	a	Direct public support	1a 459,933.		
	b	Indirect public support	1b		
	c	Government contributions (grants)	1c 251,939.		
	d	Total (add lines 1a through 1c) (cash $ 711,872. noncash $)		1d	711,872.
	2	Program service revenue including government fees and contracts (from Part VII, line 93)		2	140,126,665.
	3	Membership dues and assessments		3	
	4	Interest on savings and temporary cash investments		4	604,227.
	5	Dividends and interest from securities		5	839,713.
	6 a	Gross rents SEE STATEMENT 2	6a 273,420.		
	b	Less: rental expenses	6b		
	c	Net rental income or (loss) (subtract line 6b from line 6a)		6c	273,420.
	7	Other investment income (describe ▶ SEE STATEMENT 1)		7	234,891.
	8 a	Gross amount from sale of assets other than inventory — (A) Securities: 400,062.	8a (B) Other:		
	b	Less: cost or other basis and sales expenses	8b 106,542.		
	c	Gain or (loss) (attach schedule)	400,062. 8c <106,542.>		
	d	Net gain or (loss) (combine line 8c, columns (A) and (B)) STMT 3 STMT 4		8d	293,520.
	9	Special events and activities (attach schedule)			
	a	Gross revenue (not including $ of contributions reported on line 1a)	9a		
	b	Less: direct expenses other than fundraising expenses	9b		
	c	Net income or (loss) from special events (subtract line 9b from line 9a)		9c	
	10 a	Gross sales of inventory, less returns and allowances	10a		
	b	Less cost of goods sold	10b		
	c	Gross profit or (loss) from sales of inventory (attach schedule) (subtract line 10b from line 10a)		10c	
	11	Other revenue (from Part VII, line 103)		11	437,054.
	12	Total revenue (add lines 1d, 2, 3, 4, 5, 6c, 7, 8d, 9c, 10c, and 11)		12	143,521,362.
Expenses	13	Program services (from line 44, column (B))		13	113,180,691.
	14	Management and general (from line 44, column (C))		14	27,223,214.
	15	Fundraising (from line 44, column (D))		15	124,484.
	16	Payments to affiliates (attach schedule)		16	
	17	Total expenses (add lines 16 and 44, column (A))		17	140,528,389.
Net Assets	18	Excess or (deficit) for the year (subtract line 17 from line 12)		18	2,992,973.
	19	Net assets or fund balances at beginning of year (from line 73, column (A))		19	84,284,639.
	20	Other changes in net assets or fund balances (attach explanation) SEE STATEMENT 5		20	1,688,038.
	21	Net assets or fund balances at end of year (combine lines 18, 19, and 20)		21	88,965,650.

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Chairman THOMAS. Mr. Walker.

STATEMENT OF THE HONORABLE DAVID M. WALKER, COMPTROLLER GENERAL, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Mr. WALKER. Mr. Chairman and Mr. Rangel, members of the Ways and Means Committee, it is a pleasure to be back before you again to discuss current tax exemptions for not-for-profit hospitals. Since my entire statement has been entered into the record, I will provide an executive summary for the benefit of the members. At

this Committee's recent hearing on the tax-exempt sector as a whole, I emphasized the importance of reviewing this sector, drawing parallels to our agency's call to reexamine all major Federal policies and programs in light of 21st century challenges. There are a number of issues that merit reexamination, including whether not-for-profit hospitals perform sufficiently different services of benefit to the public to justify their tax exemption. At the request of this Committee, we examined whether or not not-for-profit hospitals provide levels of uncompensated care, specifically care provided to a patient that a hospital is not reimbursed for, and other community benefits that are different from other hospitals. To examine the provision of uncompensated care by the three major hospital ownership groups, we analyzed cost data from two perspectives; namely, each hospital's group percentage of total uncompensated care cost in a State and patient operating expenses devoted to uncompensated care. We obtained data for the year 2003 from five States: California, Florida, Georgia, Indiana and Texas. Hospitals in these States included 46 percent of the Nation's for-profit hospitals and more than a quarter of all hospitals in the three major ownership groups.

In summary, the cost burden of providing uncompensated care varied among the three hospital groups, but the burden was generally concentrated in a small number of hospitals. In four of the five States, government hospitals as a group devoted substantially larger shares of their patient operating expenses to uncompensated care than did not-for-profit or for-profit hospitals. The not-for-profit hospitals' uncompensated care costs as a percentage of their patients' operating expenses were higher on average than those of for-profit hospitals in four of the five States, but the differences were not nearly as great as the differences between the government hospitals in both these groups. Further, the burden of uncompensated care was not evenly distributed within each hospital group, but instead was concentrated in a small number of hospitals. Regardless of ownership status, the hospitals we reviewed reported providing a wide range of other community benefits, which in many cases they had the opportunity to define and in some cases were defined by the States. Other community benefit hospitals that reported providing involved many types of items, but there was no clear distinction among the government, not-for-profit or for-profit hospital group with regard to these community benefits.

These observations illustrate a larger point that I raised at the last hearing; namely, that current tax policy lacks specific criteria with respect to tax exemptions for charitable entities, in general, including not-for-profit hospitals, in particular. If these criteria are articulated in accordance with desired public policy goals, standards could be established that would allow not-for-profit hospitals to be held accountable for providing services that benefit the public commensurate with their tax-favored status. In conclusion, Mr. Chairman, I would like to refamiliarize the members with this book that was published on February 16 by GAO. It is on our Web site. Every Member received one in February—"21st century Challenges: reexamining the Base of the Federal government." Candidly, Mr. Chairman, I think it is important that you are looking at this issue, because we are currently on an imprudent and

unsustainable fiscal path. We need to reexamine the base of the Federal government both on the spending side and the tax side in light of 21st Century changes, challenges, and realities. With regard to this hearing, Mr. Chairman, we need to ask the basic question—why are we giving a preference? Who are we giving a preference to? What does it cost? What public benefit is achieved for that preference? These are the types of basic questions that need to be asked about every major Federal spending program and tax preference and you have to start somewhere. So, thank you, Mr. Chairman.

[The prepared statement of Mr. Walker follows:]

Statement of The Honorable David M. Walker, Comptroller General, U.S. Government Accountability Office

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss issues regarding tax exemptions for nonprofit hospitals. At this Committee's recent hearing on the tax-exempt sector as a whole, I emphasized the importance of reviewing this sector, drawing parallels to our agency's call to reexamine all major federal policies and programs in light of 21st century challenges.[1,2] Provisions granting federally recognized tax-exempt status and associated policies have been layered on one another to respond to challenges at the time, but they need to be reviewed and revised to reflect 21st century changes and challenges. On a broad scale, a comprehensive reexamination could help address whether exempt entities are providing services and benefits to the public commensurate with their favored tax status, whether the current number and nature of exemptions continue to make sense, whether the conditions and restrictions on the activities of tax-exempt entities remain relevant, and whether the framework for ensuring that exempt entities adhere to the requirements attendant to their status is satisfactory.

There are a number of issues that merit reexamination, including whether nonprofit hospitals perform sufficiently different services of benefit to the public to justify their tax exemption. To examine these hospitals' tax-exempt status, we must look back several decades. Before 1969, the Internal Revenue Service (IRS) required hospitals to provide charity care to qualify for tax-exempt status. Since then, however, IRS has not specifically required such care for a hospital to be exempt from federal taxation and have access to tax-exempt bond financing and charitable donations, as long as the hospital provides benefits to the community in other ways. Community benefits include such services as the provision of health education and screening services to specific vulnerable populations within a community, as well as activities that benefit the greater public good, such as education for medical professionals and medical research. Nonprofit hospitals may also be exempt under state law from state and local taxes.

Seeking a better understanding of the benefits provided by nonprofit hospitals, this Committee requested that we examine whether nonprofit hospitals provide levels of uncompensated care—care provided to a patient that a hospital is not reimbursed for—and other community benefits that are different from other hospitals. My remarks today will focus on our examination, for selected states, of (1) the provision of uncompensated care by state and local government-owned, nonprofit, and for-profit hospitals and (2) hospitals' reporting of other community benefits.

To examine the provision of uncompensated care by the three hospital ownership groups,[3] we analyzed cost data from two perspectives, namely each hospital group's percentage of (1) total uncompensated care costs in a state and (2) patient operating expenses devoted to uncompensated care. We obtained 2003 data from five states—California, Florida, Georgia, Indiana, and Texas. Hospitals in these states include 46 percent of the nation's for-profit hospitals and more than a quarter of all hospitals in the three ownership groups. We selected these states because they represented geographically diverse areas; had a number of hospitals in each ownership group sufficient to make comparisons; and collected hospital-specific uncompensated

[1] GAO, *Tax-Exempt Sector: Governance, Transparency, and Oversight Are Critical for Maintaining Public Trust, GAO–05–561T* (Washington, D.C.: Apr. 20, 2005).

[2] GAO, *21st Century Challenges: Reexamining the Base of the Federal Government, GAO–05–325SP* (Washington, D.C.: February 2005).

care data, which not all states maintain.[4] We compared each hospital ownership group's provision of uncompensated care by examining each group's uncompensated care costs[5] as a percentage of its total patient operating expenses.[6] Our measure of uncompensated care includes the cost of charity care as well as bad debt and deducts any payments made by or on behalf of individual patients. We limited our analysis of uncompensated care to nonfederal, short-term, acute care general hospitals.[7] In doing our work, we tested the reliability of the state data and determined they were adequate for our purposes.[8] To examine hospitals' provision of community benefits other than uncompensated care, we reviewed 21 hospital or hospital systems' reports and Web sites for information about such benefits. These reports and Web sites covered nonprofit, for-profit, and government hospitals in the five states. We also examined laws in the five states regarding community benefit requirements for nonprofit hospitals, reviewed the literature, and interviewed state officials and state hospital association representatives. In addition, we interviewed officials from the Centers for Medicare & Medicaid Services (CMS), the American Hospital Association, and the Federation of American Hospitals. We conducted our work from February 2005 through May 2005 in accordance with generally accepted government auditing standards. (See app. I for more detail on our scope and methodology.)

In summary, the cost burden of providing uncompensated care varied among the three hospital groups, but the burden was generally concentrated in a small number of hospitals. In four of the five states, government hospitals, as a group, devoted substantially larger shares of their patient operating expenses to uncompensated care than did nonprofit and for-profit hospitals. The nonprofit hospitals' uncompensated care costs, as a percentage of patient operating expenses, were higher on average than those of the for-profit hospitals in four of the five states, but the differences were generally not as great as the differences between the government hospitals and both these groups. Further, the burden of uncompensated care costs was not evenly distributed within each hospital group but instead was concentrated in a small number of hospitals. For example, in California's nonprofit hospital group, the top quarter of hospitals, ranked by uncompensated care as a percentage of patient operating expenses, averaged 7.2 percent devoted to uncompensated care compared with an average of 1.4 percent for hospitals in the bottom quarter.

Regardless of ownership status, the hospitals we reviewed reported providing a wide range of other community benefits, from health education to clinic services specifically for the community's indigent population. Variations in the types of community benefits hospitals in the five states reported providing could be explained by differences in the services hospitals chose to provide as well as by variation in the applicability, specificity, and breadth of state requirements.

Background

In 2003, of the roughly 3,900 nonfederal, short-term, acute care general hospitals in the United States,[9] the majority—about 62 percent—were nonprofit. The rest included government hospitals (20 percent) and for-profit hospitals (18 percent). States varied—generally by region of the country—in their percentages of nonprofit hospitals (see fig. 1). For example, states in the Northeast and Midwest had relatively high concentrations of nonprofit hospitals, whereas in the South the concentration was relatively low.

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[3] The state and local government-owned hospitals in this statement refer to state-owned hospitals, such as those at state universities, and locally owned hospitals, such as county and city hospitals. In this statement we will refer to these as government hospitals. Federal hospitals, such as those operated by the Department of Veterans Affairs, are not included in this definition.

[4] Reliable, hospital-specific data were not available nationwide. In addition, some states do not have sufficient diversity in hospital ownership to make comparisons for the purpose of this analysis; in particular, some states have very few for-profit hospitals.

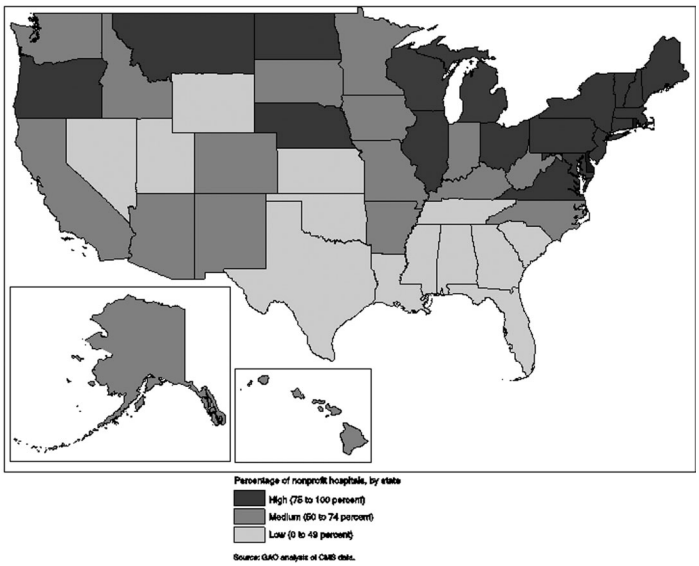
[5] To obtain uncompensated care costs, we multiplied hospitals' uncompensated care charges reported in the state data by hospital-specific, cost-to-charge ratios from Medicare hospital cost reports. These cost-to-charge ratios are specific to hospital costs and charges as a whole, not to Medicare costs and charges.

[6] Patient operating expenses include those expenses incurred for patient care. They exclude such expenses as those incurred for operating a parking garage, gift shop, and certain other nonmedical expenses.

[7] Cost, charge, and other data obtained from the states and other sources are for individual hospitals, even if a hospital is part of a larger hospital system.

[8] We excluded 8 percent of the hospitals in the five states because certain key information, such as total patient operating expenses, was not available.

Figure 1: Geographic Distribution of Nonprofit Hospitals in 2003



Note: Hospitals include nonfederal, short-term, acute care general hospitals, but not critical access hospitals that provide general acute care.

The five states we reviewed varied in number and ownership composition of hospitals (see table 1). For example, in California and Indiana, nonprofit hospitals accounted for over half of each state's hospitals. In Texas, government hospitals made up the state's largest percentage, although the distribution between nonprofit, for-profit, and government hospitals was similar; in Florida, most hospitals were either nonprofit or for-profit, while 11 percent were government.

Table 1: Distribution of Hospitals Reviewed, by Ownership Type, 2003

	Total number of hospitals	Percent non-profit	Percent for-profit	Percent state and local government
California	331	51	27	22
Florida	169	43	46	11
Georgia	133	43	21	36
Indiana	97	56	9	35
Texas	332	33	32	35

Source: GAO analysis of state and CMS data.
Note: Hospitals include nonfederal, short-term, acute care general hospitals.

The average size of hospitals in our study, as measured by patient operating expenses, varied across the three ownership groups. (See table 2.) On average, nonprofit hospitals were larger than for-profit hospitals. The pattern held in all five states but the magnitude of the difference varied. For example, in California, nonprofit hospitals were twice as large as for-profit hospitals, whereas in Texas, this difference was smaller.

Table 2: Average Hospital Size as Measured by Patient Operating Expenses, 2003

	Average patient operating expenses (in millions)		
	For-profit	Nonprofit	State and local government
California	$71.7	$143.4	$141.2
Florida	$90.8	$181.8	$229.3
Georgia	$52.7	$ 91.8	$ 72.4
Indiana	$62.1	$116.1	$ 47.6
Texas	$73.9	$112.9	$ 43.0

Source: GAO analysis of state and CMS data.
Note: Hospitals include nonfederal, short-term, acute care general hospitals.

Hospital's Qualifications for Federal and State Tax-exempt Status

Hospitals may be extended a federal tax exemption by IRS if they meet the Internal Revenue Code's qualifications for charitable organizations under section 501(c)(3).[10] Hospitals that qualify for nonprofit status are exempt from federal income taxes and typically receive other advantages, including access to charitable donations—which are tax deductible for the individual or corporate donor—and tax-exempt bond financing. To qualify forfederal tax-exempt status, a hospital must demonstrate that it is organized and operated for a "charitable purpose," that no part of its net earnings inure to the benefit of any private shareholder or individual, and that it does not participate in political campaigns on behalf of any candidate or conduct substantial lobbying activities.[11]

Before 1969, IRS required hospitals to provide charity care to qualify for tax-exempt status.[12] Since then, however, IRS has not specifically required such care, as long as the hospital provides benefits to the community in other ways. This "community benefit" standard came into existence with an IRS ruling, which concluded that a hospital's operation of an emergency room open to all members of the community without regard to ability to pay promoted health in a way consistent with other activities—such as advancement of education and religion—that qualify other organizations as charitable.[13] In addition, the 1969 ruling identified other factors that might support a hospital's tax-exempt status, such as having a governance board composed of community members and using surplus revenue to improve facilities, patient care, medical training, education, and research.

Nonprofit hospitals may also receive exemptions from state and local income, property, and sales taxes, which, in some cases, are of greater value than the federal income tax exemption. Some states have defined community benefits for nonprofit hospitals, but their statutes vary considerably in their specificity and scope. Appendix II provides more information on statutory definitions of community benefits in the states we reviewed.

Government Payments for Uncompensated Care and Other Costs

Hospitals may receive direct payments from different government sources to help cover their unreimbursed costs, including those for charity care, bad debt, and low-income patients. For example, Medicare and Medicaid make payments to hospitals that serve a disproportionate share of low-income patients under their respective disproportionate share hospital (DSH) programs. Medicare bad debt reimbursement partially reimburses hospitals for bad debt incurred for Medicare patients. Other state payments may also be available to hospitals, although their specific types vary widely. For example, hospitals may receive payments from special revenues such as tobacco settlement funds, uncompensated care pools that are funded by provider contributions, and payment programs targeted at certain services such as emer-

[10] Section 501(c) specifies 28 types of entities that are eligible for tax-exempt status. Over 1.5 million entities have been recognized as exempt by IRS.

[11] Charitable activities may include those that relieve the poor, distressed, or underprivileged; those that lessen the burdens of government; and those that promote social welfare.

[12] See, for example, IRS Rev. Rul. 56–185, 1956–1 C.B. 202.

[13] See IRS Rev. Rul. 69–545, 1969–2 C.B. 117. A revenue ruling is a formally published interpretation of tax law by the IRS upon which taxpayers are entitled to rely.

gency services. (See app. III for more information on payments for uncompensated care and other costs.)

Burden of Providing Uncompensated Care Varied among Hospital Groups, but Burden Was Generally Concentrated in a Small Number of Hospitals

In our review of hospitals' provision of uncompensated care in five states, we analyzed cost data from two perspectives—namely, each hospital group's percentage of (1) total uncompensated care costs in a state and (2) patient operating expenses devoted to uncompensated care. The former relationship showed hospitals' uncompensated care costs in dollars, aggregated by groups; whereas the latter relationship showed hospitals' uncompensated care costs as a proportion of their operating expenses, thereby accounting for differences in hospital number and size among the hospital groups. In general, government hospitals, as a group, accounted for the largest percentage of total uncompensated care costs and devoted the largest share of patient operating expenses to uncompensated care costs. The uncompensated care cost burden was not evenly distributed within each hospital group but instead was concentrated in a small number of hospitals.

Government Hospitals Generally Accounted for the Largest Percentage of the Uncompensated Care Costs in States Reviewed

Government hospitals, as a group, accounted for the largest percentage of the total uncompensated care costs in three of the five states—California, Georgia, and Texas. Nonprofit hospitals, as a group, accounted for the largest percentage of the uncompensated care costs in Florida and Indiana. For-profit hospitals, as a group, provided 20 percent or less of total uncompensated care costs in each state we reviewed. (See table 3).

Table 3: Total Uncompensated Care Costs Incurred by Hospitals Reviewed, by State, 2003

	Total uncompensated care costs(in millions)	Nonprofit (percent of total)	For-profit (percent of total)	State and local government (percent of total)
California	$2,307	34	9	57
Florida	$1,561	46	20	34
Georgia	$ 830	43	10	47
Indiana	$ 342	79	3	17
Texas	$2,101	39	18	43

Source: GAO analysis of state and CMS data.
Note: Hospitals include nonfederal, short-term, acute care general hospitals.

In each of the five states, the nonprofit hospital groups accounted for a larger percentage of total uncompensated costs compared with the for-profit hospital groups. This difference was due, in part, to the larger number of nonprofit hospitals and their larger size relative to the for-profit hospitals. For example, in California, the nonprofit group's percentage of total uncompensated care costs was almost four times higher than that of the for-profit group, but this is not surprising, as nonprofit hospitals outnumbered for-profit hospitals almost 2 to 1 and were twice the size in patient operating expenses.

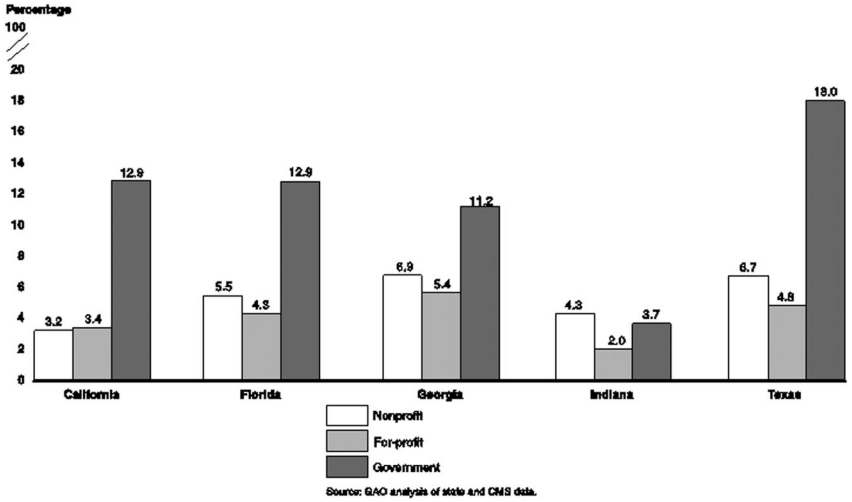
Government Hospital Groups Generally Devoted Largest Share of Patient Operating Expenses to Uncompensated Care, but Shares Varied across States

In four of the five states reviewed, government hospitals devoted substantially larger shares, on average, of their patient operating expenses to uncompensated care than did nonprofit and for-profit hospitals.[14] (See fig. 2.) In those four states,

[14] These results are consistent with studies showing a similar relationship. See L. Fishman, "What Types of Hospitals Form the Safety Net?" Health Affairs, vol. 16, no. 4 (July/August 1997); J. Mann, et al., "A Profile of Uncompensated Hospital Care, 1983–1995," Health Affairs, vol. 16, no. 4 (July/August 1997); and S. Zuckerman, et al., "How Did Safety-Net Hospitals Cope in the 1990s?" Health Affairs, vol. 20, no. 4 (July/August 2001).

the differences in average percentages between the government hospital groups and the nonprofit hospital groups ranged from about 4.3 percentage points in Georgia to 11.3 percentage points in Texas. In contrast, in the fifth state, Indiana, the nonprofit hospital group devoted the largest share, on average, of patient operating expenses to uncompensated care. Between the nonprofit and for-profit hospital groups, the nonprofit hospitals' average percentages were greater in four of the five states—ranging from 1.2 percentage points greater in Florida to 2.3 percentage points greater in Indiana. In contrast, in the fifth state, California, the nonprofit group's average percentage was similar to that of the for-profit group.

Figure 2: Average Percent of Patient Operating Expenses Devoted to Uncompensated Care, by Hospital Onwership Type, 2003



Notes: The average percent of patient operating expenses devoted to uncompensated care for a hospital ownership group is calculated by dividing the sum of uncompensated care costs for hospitals in that group by the sum of the group's total patient operating expenses. Hospitals include nonfederal, short-term, acute care general hospitals.

The five states varied in their hospitals' shares of patient operating expenses devoted to uncompensated care, ranging from an average 4.1 percent for all Indiana hospitals to an average 8.3 percent for Texas hospitals. (See table 4.) Similar state-to-state variation found in other studies was due, in part, to differences in states' proportions of uninsured populations, variation in Medicaid eligibility or payment levels, and the presence of state programs that provide health insurance to low-income uninsured individuals.[15] Specifically, prior research showed that hospitals located in states with more uninsured individuals and hospitals in states with relatively more eligibility-restricted Medicaid programs may have higher levels of uncompensated care. Our data are consistent with these studies' findings on the uninsured. For example, in our five-state review, Texas had the highest percentage of uninsured—25 percent—and the highest share, on average, of patient operating expenses devoted to uncompensated care, whereas Indiana had the lowest percentage of uninsured—13 percent—and the lowest average share.

[15] See G. Atkinson, W. Helms, and J. Needleman, "State Trends in Hospital Uncompensated Care," Health Affairs, vol. 16, no. 4 (July/August 1997); L. Fishman, "What Types of Hospitals Form the Safety Net?" Health Affairs, vol. 16, no. 4 (July/August 1997); A. Davidoff, A. LoSasso, G. Bazzoli, and S. Zuckerman, "The Effect of Changing State Health Policy on Hospital Uncompensated Care," Inquiry, vol. 37 (Fall 2000); K. Thorpe, E. Seiber, and C. Florence, "The Impact of HMOs on Hospital-Based Uncompensated Care," Journal of Health Politics, Policy and Law, vol. 26, no. 3 (June, 2001); and GAO, Nonprofit Hospitals: Better Standards Needed for Tax Exemption, GAO/HRD–90–84 (Washington, D.C.: May 30, 1990).

Table 4: Average Percentage of Patient Operating Expenses Devoted to Uncompensated Care, by State, 2003

	Average percentage of patient operating expenses devoted to uncompensated care
California	5.6
Florida	6.4
Georgia	8.2
Indiana	4.1
Texas	8.3

Source: GAO analysis of state and CMS data.

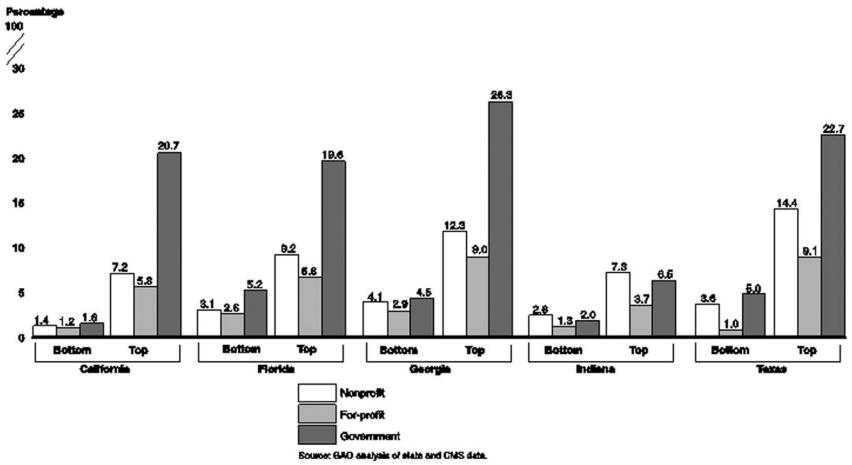
Notes: We calculated the average percent of patient operating expenses devoted to uncompensated care for each state by dividing the sum of uncompensated care costs for hospitals in the state by the sum of the hospitals' total patient operating expenses in the state. Hospitals include nonfederal, short-term, acute care general hospitals.

For Each Hospital Group, Uncompensated Care Costs Were Concentrated in a Small Number of Hospitals

For each group, uncompensated care costs were concentrated in a small number of hospitals. We observed this pattern when examining the percentages of patient operating expenses devoted to uncompensated care costs as well as hospitals' shares of total uncompensated care costs in a state. For the three hospital ownership groups, we ranked hospitals according to their share of patient operating expenses devoted to uncompensated care.

We found that, for all three hospital groups, the top quarter of hospitals devoted substantially greater percentages of their patient operating expenses to uncompensated care, on average, compared with the bottom quarter of hospitals. (See fig. 3.) For example, in California's nonprofit hospital group, the top quarter of hospitals devoted an average of 7.2 percent compared with 1.4 percent for the bottom quarter of hospitals. Similarly, in Florida's government hospital group, the top quarter of hospitals devoted an average 19.6 percent compared with an average 5.2 percent for the bottom quarter of hospitals. From state to state, the difference in ranges between top and bottom quarters was also substantial. For example, in Indiana's government group, the average share of operating expenses devoted to uncompensated care for hospitals in the top quarter was about 3 times larger than for those in the bottom quarter; whereas in California, the average share for the top quarter of hospitals was almost 13 times higher than that of the bottom quarter.

Figure 3: Average Share of Patient Operating Expenses Devoted to Uncompensated Care for Hospitals Ranked in Top and Bottom Quarters, by Ownership Type, 2003



Notes: Hospitals were ranked by percentage of patient operating expenses devoted to uncompensated care. The average percent of patient operating expenses devoted to uncompensated care for a hospital ownership group is calculated by dividing the sum of uncompensated care costs for hospitals in that group by the sum of the group's total patient operating expenses. Hospitals include nonfederal, short-term, acute care general hospitals.

When examining hospitals' shares of total uncompensated care costs in a state, we found that uncompensated care costs remained concentrated in a disproportionately small number of hospitals. Specifically, each state's top quarter of hospitals accounted for a disproportionately large share of the state's uncompensated care costs. For example, in Texas, the top quarter of hospitals accounted for about 50 percent of total uncompensated care costs, yet accounted for only 18 percent of the total beds. (See table 5). Moreover, in Texas, six major government teaching institutions accounted for 34 percent of total uncompensated care costs, which amounted to over half of the contribution of the hospitals in the top quarter. This pattern was also true for California, Florida, and Georgia. For example, in California, 13 major teaching hospitals accounted for 42 percent of total uncompensated care costs.[16] In contrast, in Indiana, total uncompensated care costs were distributed more evenly across a greater number of hospitals.

Table 5: Percentage of Total Uncompensated Care Costs in a State for Hospitals Ranked in Top Quarter, 2003

State	Percentage of state's total uncompensated care	Percentage of states' hospital beds
California	68	25
Florida	47	22
Georgia	39	19
Indiana	21	14
Texas	50	18

Source: GAO analysis of state and CMS data.
Notes: Hospitals were ranked by percentage of patient operating expenses devoted to uncompensated care. Hospitals include nonfederal, short-term, acute care general hospitals.

[16] We defined major teaching hospitals as those hospitals having an intern or resident-to-bed ratio of 0.25 or more and minor teaching hospitals as those having an intern or resident-to-bed ratio greater than 0 and less than 0.25.

Several factors explain which hospitals were likely to be in their group's top and bottom quarters. For example, in our five-state analysis, we found that whether a hospital was a teaching institution was an important predictor of whether it would be in the top quarter of a state's government hospital group. Hospitals that had teaching programs were more likely to be in the top quarter of a government hospital group. In contrast, teaching status was not an important predictor for either the nonprofit or for-profit hospital groups' top quarter. For nonprofits, hospitals in rural areas were more likely to be in the top quarter than hospitals located in urban areas. Other factors that were outside the scope of this study, such as differences in the proportion of uninsured populations in the hospital market, may have also influenced the likelihood of a hospital's inclusion in the top or bottom quarter.

Hospitals Reported Providing a Wide Range of Other Community Benefits

In addition to providing uncompensated care, hospitals may provide other services to their communities for which they are not reimbursed. In our review of hospitals' Web sites and reports about community benefits—published documents specifying the types and value of services hospitals provide to communities—we found that, regardless of ownership status, hospitals reported providing a wide range of community benefits.[17] Variations in the types of community benefits hospitals reported providing could be explained by differences in the community benefits hospitals chose to provide as well as by variations in the applicability, specificity, and breadth of state requirements.

Certain hospital industry guidance defines community benefits as the unreimbursed goods and services hospitals provide that address their communities' health needs, including health education, screening, and clinic services, among others. Consistent with this industry definition, we found through our review of reports and Web sites that hospitals reported providing similar types of services, including:

- community health education such as parenting education, smoking cessation, fitness and nutrition, health fairs, and diabetes management;
- health screening services such as screening for high cholesterol, cancer, and diabetes;
- clinic services, including clinics targeted to specific groups in the community, such as indigent patients;
- medical education for physicians, nurses, and other health professionals;
- financial contributions, including cash donations and grants, to community organizations;
- coordination of community events and in-kind donations—such as food, clothing, and meeting room space—to community organizations; and
- hospital facility and other infrastructure improvements.

Community health education and health screenings were listed by most of the reports and Web sites we reviewed. Clinic services, support groups, community event coordination, cash contributions to charities, and medical education for health professionals were listed by over half of the reports we reviewed.[18]

Because of the wide variation in hospitals' reporting of community benefits, we were not able to discern clear patterns in the provision of these benefits across hospital ownership groups. The variation could be explained by differences in the community benefits hospitals chose to provide as well as by variations in the applicability, specificity, and breadth of state requirements. Specifically, the five states reviewed require all hospitals to report financial data, including data on the cost of charity care they provide. However, as shown in table 6, California, Indiana, and Texas also have statutory requirements for nonprofit hospitals to develop plans for meeting their communities' health needs and to report annually on the types and value of the community benefits they provide.[19] Of these three states, only Texas and Indiana require nonprofit hospitals to report using standardized forms and have the explicit statutory authority to impose fines for noncompliance as part of the re-

[17] To determine the types of community benefits hospitals reported providing, we reviewed 15 publicly available reports about community benefits for nonprofit and for-profit hospitals and six government hospitals' Web sites.

[18] Our findings on the types of community benefits hospitals reported providing are consistent with our findings in GAO/HRD–90–84 and industry publications.

[19] Georgia requires all "hospital authorities," which create or operate nonprofit hospitals, to submit "community benefit reports" that disclose the cost of charity and indigent care provided. GA. CODE ANN. § 31–7–90.1 (2004). However, this information is otherwise required of hospitals in all groups in Georgia as part of financial reporting requirements. GA. CODE ANN. § 31–6–70 (2004).

quirements.[20] The Texas form is more specific, as it includes line-items that capture the hospitals' unreimbursed costs associated with providing traditionally "unprofitable" health services such as trauma care and community clinics, education of medical professionals, medical research, and cash and in-kind donations made by the hospital to local charities. Indiana's form provides nonprofit hospitals more flexibility in delineating the types and value of their community benefits but includes supplementary guidance to nonprofit hospitals about what should be considered community benefits, including financial or in-kind support of public health programs, community-orientated wellness and health promotion programs, and outreach clinics in economically depressed communities. California has no form for annual community benefit reports but requires that hospitals classify the services provided into broad, statutorily defined categories, including cash and in-kind donations to public health programs, efforts to contain health care costs and enhance access, and services that help maintain a person's health.

Table 6: Community Benefit Requirements for Nonprofit Hospitals

State	Description of requirements	Penalties for noncompliance
California[a]	Maintain community benefit plans that include measurable objectives for meeting the community's needs within specified time frames and mechanisms to evaluate effectiveness. In addition, report annually on the plans, as well as the types and value of community benefits provided.	None explicitly authorized as part of requirements.
Florida	None.	Not applicable.
Georgia[b]	None.	Not applicable.
Indiana[c]	Maintain and report annually on community benefit plans that include measurable objectives for meeting the community's health care needs within a specified time frames, evaluation strategies, and a budget. In addition, must describe the types and value of any additional community benefits.	Fines explicitly authorized as part of requirements for failure to make annual report.
Texas[d]	Maintain and report annually on community benefit plans that include measurable objectives for meeting the community's health care needs within specified timeframes, mechanisms for evaluating effectiveness, and a budget. In addition, must describe the types and value of community benefits provided. At a minimum, hospitals are required to provide: (1) charity and government-sponsored indigent care at a level that is reasonable in relation to community needs, the available resources of the hospital, and the tax-exempt benefits received; (2) charity and government-sponsored indigent health care equal to 100 percent of state tax-exempt benefits; or	Fines explicitly authorized as part of requirements for failure to make annual report. Hospitals that fail to provide the required community benefits must be reported annually to attorney general and comptroller.

[20] In Texas, for-profit and government hospitals receiving Medicaid DSH payments are generally required to meet the same community benefit reporting requirements as nonprofit hospitals. TEX. HEALTH & SAFETY CODE ANN. § 311.046(e) (2004).

Table 6: Community Benefit Requirements for Nonprofit Hospitals—Continued

State	Description of requirements	Penalties for noncompliance
	(3) charity care and other community benefits equal to at least 5 percent of net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least 4 percent.	

Source: GAO analysis.

[a] CAL. HEALTH & SAFETY CODE §§ 127345, 127350, and 127355 (2004).

[b] Georgia requires all "hospital authorities," which create or operate nonprofit hospitals, to submit "community benefit reports" that disclose the cost of charity and indigent care provided. GA. CODE ANN. § 31–7–90.1 (2004). However, this information is otherwise required of hospitals in all groups in Georgia as part of financial reporting requirements. GA. CODE ANN. § 31–6–70 (2004).

[c] IND. CODE § 16–21–9–4—16–21–9–8 (2004).

[d] TEX. HEALTH & SAFETY CODE ANN. §§ 311.043—311.047 (2004).

According to state officials or state hospital association representatives in the five states we reviewed, for-profit and government hospitals are not required to report on the community benefits they provide outside of the requirements to report financial data, including data on the cost of charity care they provide. However, as we found through our review, some of these hospitals report publicly—for promotional purposes—on the community benefits they provide, either through published reports or by posting general information on their Web sites.

Moreover, the three states with community benefit reporting requirements—California, Indiana, and Texas—conduct limited monitoring of nonprofit hospitals' community benefit reports. For example, according to officials from state agencies, none of the three states conducts audits of nonprofit hospitals' self-reported community benefits information, although Texas reviews the reports to ensure that "reasonable" types of services are listed as community benefits. In addition, these states do not routinely use the data collected through community benefit reports to review hospitals' tax-exempt status.

Concluding Observations

Our comparison of the hospital ownership groups' uncompensated care costs, as a percentage of patient operating expenses, was instructive. Differences between the nonprofit and for-profit groups were often small when compared with the substantial differences between the government group and the other two groups. Moreover, the burden of uncompensated care costs was not evenly distributed among hospitals, which meant that a small number of nonprofit hospitals accounted for substantially more of the uncompensated care burden than did others receiving the same tax preference.

As for the other community benefits hospitals reported providing, we were not able to discern a clear distinction among the government, nonprofit, and for-profit hospital groups. Hospitals in the five states reported conducting a variety of activities, which the hospitals themselves considered community benefits. We were unable to assess the value of these benefits or make systematic comparisons between hospitals or across states.

These observations illustrate a larger point that I and others raised at the hearing last month—namely, that current tax policy lacks specific criteria with respect to tax exemptions for charitable entities and detail on how that tax exemption is conferred. If these criteria are articulated in accordance with desired goals, standards could be established that would allow nonprofit hospitals to be held accountable for providing services of benefit to the public commensurate with their favored tax status.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer questions you or the other Committee Members may have.

Contact and Acknowledgments

For further information regarding this testimony, please contact A. Bruce Steinwald at (202) 512–7101. Kristi Peterson, Thomas Walke, Joanna Hiatt, Kelly DeMots, Mary Giffin, Emily Rowe, Craig Winslow, and Hannah Fein contributed to this statement.

Appendix I: Scope and Methodology

To examine the provision of uncompensated care by the three hospital ownership groups, we obtained 2003 uncompensated care data from five states—California, Florida, Georgia, Indiana, and Texas. We obtained all other data, such as cost-to-charge ratios,[21] patient operating expenses,[22] and all descriptive statistics, from 2002 and 2003 Medicare hospital cost reports.[23] We selected the five states because they represented geographically diverse areas; had a number of hospitals in each ownership group sufficient to make comparisons; and collected hospital-specific uncompensated care data, which not all states maintain.[24] The 2003 state uncompensated care data and 2002 and 2003 Medicare hospital cost reports were the most recent available at the time of our analysis. We also interviewed health officials from all five states as well as officials from the Centers for Medicare & Medicaid Services (CMS), the American Hospital Association, and the Federation of American Hospitals. We limited our analysis to nonfederal, short-term, acute care general hospitals for which a cost report was available.[25] This analysis included critical access hospitals that provide general acute care. Our study included about 92 percent of nonfederal, short-term, acute care hospitals in the five states.

We defined uncompensated care as the sum of charity care and bad debt costs as reported in the state data. To determine uncompensated care costs, we multiplied uncompensated care charges by a hospital-specific cost-to-charge ratio. Although specific definitions of charity care varied, states generally defined it as charges for patients deemed unable to pay all or part of their bill, less any payments made by, or on behalf of, that specific patient. States generally defined bad debt as the uncollectible payment that a patient is expected to, but does not pay. Our definition of uncompensated care does not include any contractual allowances or cost shortfalls.[26] In addition, we did not subtract any charity care-specific block grants or donations a hospital may receive, as this information was not available for all states.

We analyzed uncompensated care cost data from two perspectives—namely, each hospital ownership[27] group's percentage of (1) total uncompensated care costs in a state, and (2) average patient operating expenses devoted to uncompensated care. To examine factors that could explain differences in the provision of uncompensated care by hospital ownership groups, we examined certain hospital characteristics including a hospital's size, teaching status, and location. We used patient operating expenses to measure hospital size. For teaching status, we defined major teaching hospitals as those hospitals having an intern/resident-to-bed ratio of 0.25 or more and minor teaching hospitals as those having an intern/resident-to-bed ratio greater than 0 and less than 0.25. We defined a hospital as urban if it was located in a metropolitan statistical area and as rural if it was not located in a metropolitan statistical area. We supplemented our analysis with a review of the literature to determine other factors that could explain differences in the provision of uncompensated care by hospital ownership groups.

We assessed the reliability of the hospital Medicare cost reports and the reliability of state uncompensated care cost data from California, Florida, Georgia, Indiana, and Texas in several ways. First, we performed tests of data elements. For example, we examined the values for uncompensated care costs and patient operating expenses to determine whether these data were complete and reasonable. We also verified that the dollar amount of uncompensated care in the 2003 data was consistent with the amount in 2002. Second, we reviewed existing information about

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[21] These cost-to-charge ratios are specific to hospital costs and charges as a whole, not to Medicare costs and charges.

[22] Patient operating expenses include those expenses incurred for patient care. They exclude such expenses as those incurred for operating a parking garage, gift shop, and certain other nonmedical expenses.

[23] The reporting period of certain hospitals differed between the state data and the cost reports. Therefore, we combined the 2003 state data with the cost report, either 2002 or 2003, that best overlapped the state data's reporting period.

[24] Reliable, hospital-specific data were not available nationwide. In addition, some states do not have sufficient diversity in hospital ownership to make comparisons for the purpose of this analysis; in particular, some states have very few for-profit hospitals.

[25] Cost, charge, and other data obtained from the states and other sources are for individual hospitals, even if a hospital is part of a larger hospital system.

[26] Contractual allowances are the difference between a hospital's full charges for a service and the payment it has agreed to accept for that service from a particular insurer. Cost shortfalls are the difference between the accepted payment for a service and the actual cost of that service, in the case that the payment is less than the cost.

[27] In order to determine a hospital's ownership status, we compared its ownership from the state data (if available) to that from the Medicare cost report data. Where the two sources did not match, we used the 2002–2003 *AHA Guide* to confirm one of the sources as correct. If possible, we also confirmed ownership status using the hospital's Web site.

the data elements. For example, we compared descriptive statistics we calculated from the Medicare hospitals cost reports with statistics published by CMS. Third, we interviewed state and agency officials knowledgeable about the data in our analyses and knowledgeable about hospital uncompensated care costs. We determined that CMS and all five states performed quality assurance tests on the data before releasing them. Overall, we determined that the data we used in our analyses were sufficiently reliable for our purposes.

To examine hospitals' provision of community benefits other than uncompensated care, we reviewed 21 hospital reports and Web sites for information about such benefits in five states. Specifically, we reviewed 12 publicly available reports about the community benefits provided by nonprofit and for-profit hospitals and 3 reports for for-profit hospital systems representing multiple hospitals. We also reviewed 6 government hospitals' Web sites to determine the extent to which they publicized the provision of services that are generally considered community benefits. We also examined laws in five states regarding community benefit requirements for nonprofit hospitals, reviewed the literature, and interviewed state officials and hospital association representatives.

We conducted our work from February 2005 through May 2005 in accordance with generally accepted government auditing standards.

Appendix II: Statutory Definitions of Community Benefits in the Five States Reviewed

Table 7 summarizes the statutory definitions of community benefits for nonprofit hospitals in the states we reviewed. We found that the statutes vary considerably in their specificity and scope. In addition, of the five states we reviewed, only the Texas statute contains an explicit link between the statutory definition of community benefits and hospitals' qualifications for state tax exemptions.

Table 7: Statutory Definitions of Community Benefit for Purposes of Requirements Specific to Nonprofit Hospitals

State	Statutory definition of community benefit	Cross-reference to tax exemption in community benefit provisions
California[a]	Hospital activities to address community needs and priorities through disease prevention and improvement of health status, including, but not limited to:. (1) health care services, rendered to vulnerable populations (e.g., charity care and unreimbursed costs of providing services to uninsured and underinsured); (2) health promotion, prevention services, adult day care, child care, medical research and education, nursing and other professional training, home delivered meals, aid to the homeless, and outreach clinics; (3) financial or in-kind support of public health programs; (4) donation of funds, property, or other resources for a community priority; (5) health care cost containment; (6) enhancement of access to health care; (7) services offered without regard to profitability to meet a community need; and (8) goods and services to help maintain a person's health.	No provisions explicitly cross-referencing definitions and related requirements to tax exemption..
Florida	Not defined.	Not applicable.
Georgia[b]	Not defined, but community benefit reporting requirement refers to charity and indigent care.	No provisions explicitly cross-referencing definitions and related requirements to tax exemption.

Table 7: Statutory Definitions of Community Benefit for Purposes of Requirements Specific to Nonprofit Hospitals—Continued

State	Statutory definition of community benefit	Cross-reference to tax exemption in community benefit provisions
Indiana[c]	Unreimbursed cost to hospitals of providing charity care, government-sponsored indigent care, donations, education, government-sponsored program services, research, and subsidized health services. Does not include hospital taxes or other government assessments.	No provisions explicitly cross-referencing definitions and related requirements to tax exemption.[d]
Texas[e]	Unreimbursed cost to hospitals of providing charity care, government—sponsored indigent health care, donations, education, government-sponsored program services, research, and subsidized health services, but not hospital taxes or other government assessments.	Numerous provisions cross-referencing definition of community benefit and related requirements to tax exemption.

Source: GAO analysis.
[a] CAL. HEALTH & SAFETY CODE §§ 127340 and 127345(c) (2004).
[b] GA. CODE ANN. § 31–7–90.1 (2004).
[c] IND. CODE ANN. §§ 16–18–2–64.5 and 16–21–9–1 (2004).
[d] There are no provisions explicitly cross-referencing community benefits to nonprofit hospitals' tax exemption, but hospital-owned physician offices or practices, or other property not substantially related to inpatient facilities, must provide or support charity care or community benefits, as it is defined above, to qualify for property tax exemption. IND. CODE ANN. § 6–1.1–10–18.5 (2004).
[e] TEX. HEALTH & SAFETY CODE ANN. §§ 311.042 and 311.045 (2004).

Appendix III: Government Payments for Uncompensated Care and Other Unreimbursed Costs

Hospitals may receive direct payments from different government sources to help cover their unreimbursed costs. Such payments may include special Medicare and Medicaid payments, known as disproportionate share hospital (DSH) payments, Medicare bad debt reimbursement, and other state payments.

Medicare DSH: The Medicare DSH adjustment provides payments to hospitals that serve a disproportionate share of low-income patients. The Congress mandated this adjustment in 1986 to address the concern that hospitals that serve such patients have higher Medicare costs per case because they have higher overhead and labor costs and their patients are in poorer health with more complications and secondary diagnoses. Hospitals qualify for the Medicare DSH adjustment based on their low-income patient share.[28] The low-income patient share is computed as the percentage of a hospital's Medicare inpatient days attributable to patients that are eligible for both Medicare part A and Supplemental Security Income[29] plus the percentage of total inpatient days attributable to patients eligible for Medicaid, but not Medicare part A. For hospitals that qualify for a DSH adjustment, their actual adjustment is based on several factors, including the number of acute care beds, number of patient days for low—income patients, and location (rural or urban). See table 8 for Medicare DSH payments in 2003 to the hospitals in the selected states we analyzed.

Table 8: Medicare DSH Payments to Hospitals Reviewed, 2003 (in millions)

State	Medicare DSH payment to hospitals (in millions)
California	$1,122
Florida	486
Georgia	209
Indiana	94

[28] To qualify for Medicare DSH, a hospital must have a share of low-income patients that exceeds 15 percent. Alternately, large hospitals located in urban areas can qualify if more than 30 percent of their total net inpatient care revenue is for indigent care and comes from state and local governments (excluding Medicare and Medicaid funds).

[29] Medicare Part A pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. The Supplemental Security Income program makes payments to people with low income who are at least 65 or are blind or have a disability.

Table 8: Medicare DSH Payments to Hospitals Reviewed, 2003 (in millions)

State	Medicare DSH payment to hospitals (in millions)
Texas	637

Source: GAO analysis of state and CMS data.
Note: Hospitals include nonfederal, short-term, acute care general hospitals.

Medicaid DSH: The Medicaid statute requires that states make DSH adjustments to the payment rates of certain hospitals treating large numbers of low-income and Medicaid patients. The Medicaid DSH adjustment was established by the Congress in 1981 and establishes broad guidelines for hospital eligibility to receive Medicaid DSH and for the methods used to compute the amount of payment. States have discretion in designating DSH hospitals and calculating adjustments for them.[30] States also vary in terms of program rules and resource levels as well as the degree to which they target payments to different types of hospitals.[31]

Medicaid DSH is the largest source of financial support for hospital uncompensated care and is funded jointly by the states and the federal government. State approaches to financing the state portion of Medicaid DSH include obtaining funds from hospitals through provider taxes or intergovernmental transfers in order to establish the state's contribution required to obtain the federal match for Medicaid DSH funding. Therefore, it is not always possible to determine what portion of Medicaid DSH payments to individual hospitals is the net additional payment to the hospital.

Medicare bad debt reimbursement: Medicare partially reimburses acute care hospitals for bad debts resulting from Medicare beneficiaries' nonpayment of deductibles and co-payments after providers have made reasonable efforts to collect unpaid amounts. If a hospital can document that a Medicare patient is indigent, the hospital can then forgo collection efforts from the patient. Medicare pays hospitals 70 percent of their reimbursable bad debts, except critical access hospitals,[32] for which it pays 100 percent of their reimbursable bad debts. See table 9 for total Medicare bad debt reimbursements in 2003 to the hospitals in the selected states we analyzed.

Table 9: Medicare Bad Debt Reimbursements to Hospitals Reviewed, 2003

State	Medicare bad debt reimbursement to hospitals (dollars in millions)
California	$160
Florida	55
Georgia	45
Indiana	20
Texas	78

Source: GAO analysis of state and CMS data.
Note: Hospitals include nonfederal, short-term, acute care general hospitals.

Other state sources: Other state sources of payment to hospitals for uncompensated or unreimbursed care vary widely, and may include special revenues such as tobacco settlement funds, uncompensated care pools that are funded by provider contributions, and payment programs targeted at certain services such as emergency services. For example, Massachusetts has used a portion of the state's tobacco settlement fund to help cover uncompensated care costs.

[30] Congressional Research Service, Medicaid Disproportionate Share Payments (Washington, D.C.: 2005), 15.

[31] Congressional Research Service, Medicaid Reimbursement Policy (Washington, D.C.: 2004), 36.

[32] See GAO, Medicare: Modest Eligibility Expansion for Critical Access Hospital Program Should Be Considered, GAO–03–948 (Washington, D.C.: September 2003).

Chairman THOMAS. Thank you very much, Mr. Walker. Dr. McClellan.

STATEMENT OF THE HONORABLE MARK MCCLELLAN, M.D, PH.D., ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Dr. MCCLELLAN. Chairman Thomas, Congressman Rangel, distinguished Committee members, thank you for inviting me to testify about how the Medicare and Medicaid programs assist hospitals that provide uncompensated care. We recognize the need for hospitals to provide health care to those who are uninsured and underinsured as well as the other important contributions to the community and to public health made by hospitals. CMS supports these efforts through a variety of programs. With respect to forgiving bills for the uninsured and discounting, hospitals are at liberty to establish their own indigency policies, including defining eligibility indicators such as income level. Furthermore, the provider payment rules for Medicare and Medicaid in no way restrict the ability of hospitals and other providers to offer free or discounted care to patients who do not have coverage under Medicare or Medicaid or to offer relief to Medicare and Medicaid beneficiaries who can't afford their copayments and deductibles. We issued guidance on this topic in early 2004.

Because hospitals may bear a significant burden for providing uncompensated care, Congress has mandated that CMS make certain payments to hospitals partially in recognition of that role. Since 1986, certain hospitals have received enhanced reimbursements under the Medicare Disproportionate Share Hospital or DSH program. Hospitals qualify for Medicare DSH payments if they treat a disproportionate share of patients with only Medicaid insurance or with Medicare and SSI. The payments are a percentage add-on to the normal hospital payments to Medicare. The Medicaid program also provides DSH payments which vary with each State program, but are targeted to hospitals treating a large share of low-income Medicaid and uninsured patients. Our preliminary data show that during 2004, Medicare DSH payments amounted to $8½ billion, while Medicaid DSH payments totaled nearly $17.2 billion.

Since academic medical centers that engage in graduate medical education have higher costs per discharge because of their teaching activities, when Congress implemented that Medicare payment system, it created add-on payments for these teaching institutions. Congress deliberately crafted these payments to exceed the measured costs associated with teaching. One of those add-on payments, the Indirect Medical Education payment, or IME, is projected to total $5.2 billion during fiscal 2004, rising to 5.7 billion in fiscal year 2005. Hospitals can bill Medicare directly for bad debt resulting from an inability to collect deductibles and copayments from Medicare beneficiaries. Hospitals are not required to use very aggressive measures to collect this bad debt. Rather, if the hospital wants to bill Medicare for bad debt, they must use the same level of reasonable collection efforts as they do to secure collection of debts by non-Medicare patients.

In fiscal year 2000, the latest year for which we have final data, CMS, our agency, provided $1.03 billion in bad debt payments and we expect this to rise to about $1.6 billion in 2005. Mr. Chairman, we and many States are trying to take steps to shift the uncompensated care that occurs in relatively costly settings like emergency rooms and hospital admissions for costly but preventable disease complications to community settings where complications can be prevented to reduce the cost of using the emergency room and using inpatient care. Many States have used the Medicaid waiver authority to move from reimbursing providers for direct care in hospitals to increasing community care and health insurance coverage. The goal of these demonstration programs is to obtain better quality care at a lower cost for more people. Some specific examples include redirecting DSH funds in order to provide insurance coverage rather than uncompensated care. Hawaii, Tennessee, New York, Vermont, Massachusetts, Maine, and the District of Columbia have all established innovative programs with the use of section 1115 demonstration authority in Medicaid.

Community health centers provide preventive and primary care to low-income individuals in their communities. Nearly 40 percent of the care provided by these centers is uncompensated and funding supplied to them under the President's Health Care Initiative reduces the amount of uncompensated care that otherwise would have been provided in hospitals. Recent evidence shows that this approach can be more cost effective than in-patient hospital delivery of care for patients without insurance. The fiscal year 2005 appropriation for community health centers exceeds $1.7 billion. Finally, undocumented immigrants use medical services, and this has been a longstanding issue for emergency medical services for medical providers. To help address this problem and ensure the continued availability of emergency services in border areas, section 1011 of the Medicare Modernization Act provides $1 billion through 2008 to help hospitals and other emergency providers to recoup some of the expenses of providing this critical care to undocumented immigrants. In total, these Federal payment mechanisms will provide about $30 billion this year to our hospitals. In addition, as you have heard, nonprofit hospitals will realize substantial additional financial support through tax exemptions. I am familiar with how often these institutions provide uncompensated care and I know how valuable they can be to a community. However, some of the results I describe in my written statement suggest that there may be better ways to target funds that support uncompensated care to the programs and settings that provide the best value in terms of the types of care they can provide. I thank you for the opportunity to appear before you today and I am looking forward to any questions you might have.

[The prepared statement of Dr. McClellan follows:]

Statement of The Honorable Mark McClellan, M.D., Ph.D., Administrator, Centers for Medicare and Medicaid Services

Chairman Thomas, Representative Rangel, distinguished Committee members, thank you for inviting me to testify today about the tax exempt status of many of our nation's hospitals and the way in which the Centers for Medicare & Medicaid Services (CMS) assists hospitals who provide uncompensated care.

As you are aware, our nation's hospitals frequently treat patients who do not have the ability to pay, or who can only pay a portion of their bill. This is one of the many ways in which a nonprofit hospital can promote the health of the community it serves. The Federal government and state governments have granted non-profit, tax preferred status to hospitals that operate for the benefit of the community. Today's hearing primarily seeks to review what we know about the value of the uncompensated and under-compensated care provided by these non-profit hospitals, and the tax benefits and other support they receive. Although the Committee is focusing on the issue of tax exempt status for hospitals, which is within the purview of the Treasury Department and the Internal Revenue Services, it might also want to review current policies that exist to assist hospitals that provide uncompensated care and to consider whether funds used in those efforts are providing care in the most efficient and effective manner possible. To address this issue, a number of related questions are relevant, including the extent to which quality, costs, and behavior of non-profit hospitals differ from for-profit and public hospitals.

Current Research

Some believe that the financial rewards inherent in for-profit ownership might provide incentives for hospitals to contain costs and respond effectively to patients' needs—for the same reasons that free markets work in the economy at large. Others believe that, because it is difficult for patients and society to evaluate the quality of health care, the opportunity to earn profits might lead hospitals to take advantage of patients or otherwise "cut corners."

These differences are at the root of several important policy debates. Should non-profits' exemption from taxes, access to tax-exempt bonds, and ability to solicit tax-deductible charitable contributions be preserved or be limited? To what extent does tax status correlate with hospital performance or better patient outcomes? To assist the Committee with its deliberations on these questions, we have compiled findings from relevant research.

Economists and health policy scholars have conducted numerous studies to better understand the relationship among for-profit, non-profit and public hospitals. Prior to my government service, as an academic researcher, my colleagues and I analyzed data on the medical expenditures, mortality, and rates of cardiac complications of elderly Medicare beneficiaries hospitalized for new heart attacks between 1985 and 1996. We found that geographic areas with for-profit hospitals have approximately 2.4 percent lower levels of hospital expenditures per patient as areas without for-profit hospitals but virtually the same patient health outcomes.[1]

Areas with for-profits have both lower labor and lower capital costs. When an area's elderly population declines, for-profit hospitals eliminate unneeded beds quickly, whereas non-profits eliminate them much more slowly. (Interestingly, public hospitals are almost as responsive to population declines as for-profits.)

These effects are a combination of direct effects of for-profits on their own patients' costs and of "spillover" effects on neighboring non-profits' behavior. That is, the neighboring non-profits also start lowering their costs. The bulk of the 2.4 percent savings is achieved when the for-profit presence increases from near zero to only a small fraction of admissions in the area. Direct effects of for-profits on their own patients' costs cannot by themselves account for the savings we observe.

Our study is only one piece of a larger puzzle. We evaluated the effects of ownership on only one facet of health care—productivity, or the quality and cost of care for individual patients. Other studies find that ownership may affect important social and economic outcomes, such as hospitals' propensity to exploit Medicare's complex regulated price system, or the volume and quality of care for uninsured patients. Also, we examined only one illness and one patient population; the effects may be different in other settings. Finally, although our measures of health outcomes cover the common adverse outcomes that matter to patients (serious enough complications to cause readmission to the hospital), they may fail to capture fully all of the health consequences of differences in ownership. Other studies have addressed these additional issues.

Most studies have found little difference in the community benefits provided by for-profit versus non-profit hospitals, where community benefits are defined to include uncompensated care and the provision of unprofitable or non-reimbursable services.[2] Indeed, some studies find that non-profits actually treat fewer indigent

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[1] Kessler, Daniel P. and Mark B. McClellan. "The Effects of Hospital Ownership on Medicaid Productivity." RAND Journal of Economics. Vol 33(3). Autumn 2002: 488–506.

[2] Young, Gary J., and Kamal Desai. "Non-profit Hospital Conversions and Community Benefits: New Evidence from Three States." *Health Affairs* 8 (1999):146–55.

patients than do for-profits.[3] There is some evidence that public hospitals that convert to for-profit status reduce the amount of uncompensated care that they supply. However, public hospitals that convert supply much lower levels of uncompensated care pre-conversion than public hospitals that do not convert.[4]

I worked jointly on a study that compared patient outcomes in for-profit and non-profit hospitals between 1984 and 1994 using a new method for estimating differences across hospitals that yields much more accurate estimates of hospital quality than previously available. While we found that, on average, for-profit hospitals have higher mortality among elderly patients with heart disease, much of the difference appears to be associated with the location of for-profit hospitals. We noted in our paper for the National Bureau of Economic Research, "Within specific markets, for-profit ownership appears, if anything, to be associated with better quality care. Moreover, the small average difference in mortality between for-profit and non-profit hospitals masks an enormous amount of variation in mortality within each of these ownership types." In other words, hospital-specific factors besides ownership were much more important influences on hospital performance than ownership alone.[5] A later study by Yu-Chu Shen examined the effect of hospital ownership type on patient outcomes after treatment for acute myocardial infarction. Shen found that for-profit and government hospitals have higher incidence of adverse outcomes than non-profit hospitals.[6]

The debate over the effects of for-profit ownership of hospitals must reflect a range of policy considerations. But with expenditures on hospital care running into the hundreds of billions of dollars each year, the productivity benefits of free markets and competition deserve careful consideration.

Uncompensated Care Provided by Hospitals

CMS does collect data on uncompensated care through the hospital cost reports, but we do not have data on the value of the tax exemptions that non-profit hospitals receive. Much of the data that CMS collects in hospital cost reports are tied to payment and the Medicare trust fund. CMS ensures that these data are rigorously audited. Data on uncompensated care, however, do not impact Medicare payment, and hence, are not audited. Further, the most complete data collection instrument in the cost report is relatively new, and hospitals are still becoming accustomed to reporting uncompensated care data in a standard format. Thus, these data are somewhat less reliable than those used to make payments. CMS staff has engaged in discussions with the Medicare Payment Advisory Commission (MedPAC) and the Government Accountability Office (GAO) concerning this issue and is considering ways to make the data on uncompensated care more reliable and useable. However, at this time, it is not possible for CMS to make the sorts of comparisons that are needed to answer the primary question of today's hearing. Congress has, however, mandated that CMS make certain payments to hospitals in recognition of their role in providing uncompensated or under-compensated care and I would like to describe those payments here today.

Before detailing these payment mechanisms, it is important to review the requirements of CMS' regulations with respect to the uninsured, or underinsured. The provider payment rules for Medicare and Medicaid in no way restrict the ability of hospitals and other providers to offer free or discounted care to patients who do not have coverage under these two programs, or to offer relief to Medicare and Medicaid beneficiaries who simply cannot afford to fulfill their responsibility for co-payments and deductibles.

Nearly two years ago, CMS was approached by a number of hospitals requesting guidance concerning whether it was permissible to discount charges to low-income, uninsured, or underinsured patients. In December of 2003, then-Secretary Thompson received a letter from the American Hospital Association (AHA) that alleged that Medicare program rules, as well as restrictions imposed by statutory authorities within the jurisdiction of the Health and Human Services (HHS) Office of Inspector General, hindered the ability of hospitals to provide discounts to low-income patients or to patients who were medically indigent. Secretary Thompson responded to the AHA letter in February 2004.

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[3] Duggan, Mark. "Hospital Market Structure and the Behavior of Not-for-profit Hospitals." *RAND Journal of Economics* 33 (2002):433–46.

[4] Desai, Kamal, Carol V. Lukas, and Gary J. Young. "Public Hospitals: Privatization and Uncompensated Care." *Health Affairs* 19 (2000):167–72.

[5] McClellan, Mark, and Douglas Staiger, "Comparing Hospital Quality at For-Profit and Not-For-Profit Hospitals," Working Paper 7324, National Bureau of Economic Research, August 1999.

[6] Shen, Yu-Chu, "The Effect of Hospital Ownership Choice on Patient Outcomes After Treatment for Acute Myocardial Infraction," in *The Journal of Economics,* vol. 21, 2002, pp. 901–922.

There are three central ideas addressed in the guidance provided by HHS to the hospital community:

Discounts

Medicare billing requirements do not prevent discounts to uninsured patients as long as:

- Full charges, not discounted charges, are reported on the cost report.
- Accounts and records are maintained in a manner that would be necessary for any business.

Indigency

Medicare indigency requirements do not prevent discounting to uninsured patients.

- Providers may make indigency (including medical indigency) determinations using their customary methods.
- In order to protect all patients and the Medicare program, the methods used in determining indigency for non-Medicare patients should be similar to those used for Medicare patients.
- Indigency should be supported by documentation (good business practices would dictate that).
- Indigence should be determined on a patient-by-patient basis because financial need is specific to each patient.
- Medicare does not reimburse the bad debts of non-Medicare patients.
- Once indigence is determined, collection is no longer undertaken with regard to the patient for the forgiven amount.

Collection

Medicare does not require providers to be aggressive in their collection of accounts. Medicare rules state that:

- Efforts to collect from non-Medicare patients must be similar to the efforts to collect from Medicare patients. Medicare wants parity in the treatment of Medicare and non-Medicare patients to protect the program and all patients, not just our beneficiaries.
- Efforts to collect on accounts should be more than a token effort. Rather, they should be proactive efforts that would be used by any prudent business.

Since the enactment of the Medicare program in 1965, the program's rules have attempted to prevent "cross-subsidization"—in other words, preventing the Medicare program from subsidizing a service that should be paid for by another payor, or preventing another payor from subsidizing a service the Medicare program should be reimbursing. One way that Medicare's regulations do that is to require hospitals to list their stated charges for a service on their cost reports and maintain a uniform charge for a service. To repeat, nothing in CMS regulations prevents a hospital from providing a discount off of that stated charge. But when filing its cost report, the hospital must list its full charges.

Without question, Medicare program rules permit a hospital to provide free care or discount charges to uninsured or underinsured patients. As we noted in our response to the American Hospital Association, "[n]othing in the Centers for Medicare & Medicaid Services' (CMS') regulations, Provider Reimbursement Manual, or Program Instructions prohibit a hospital from offering discounts to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals."

Therefore, in reference to the ability of a hospital to develop an indigency policy, it is overstating matters to say that the Medicare program imposes a "restriction" on this. Hospitals—not the federal government—set their own indigency policies and have the discretion and flexibility to define eligibility indicators including income level. This makes sense because a hospital, as a community institution, is in the best position to know what policy best suits the community that it serves.

As I have stated earlier, if a hospital wishes to provide a discount off of its customary charges as part of an indigency policy, it can do so, but it must report the ***full charge*** for that service on its Medicare cost report.

Turning to the issue of bad debt, we often hear from hospitals that Medicare somehow "requires" aggressive collection efforts that include seizing a patient's home, use of a bill collector, and other similar tactics. The reality is otherwise. The Medicare program does not require any particular level of collection activity. It does not require that collection activities be "aggressive." It does not require that hospitals seize patients' homes or bank accounts. What the program does require, however, is that if the hospital wants to bill the Medicare program for bad debt related

to unpaid deductibles and coinsurance by Medicare beneficiaries, it must use the same level of collection activity as it does to secure collection of debts by non-Medicare patients. For example, if a hospital wants to use a bill collection agency for its bad debts, it cannot turn only non-Medicare patient bills over to that collection agency; rather, the hospital must treat all bad debts the same. But nothing requires a hospital to use a bill collection agency for its bad debts. The principle, again to prevent cross-subsidization, is that collection of Medicare and non-Medicare debts need to be treated similarly.

In addition, a hospital may make an individualized indigency determination for a particular Medicare patient and excuse that patient from any efforts to collect unpaid deductibles and coinsurance. Doing so would not prevent the hospital from collecting bad debt payments from Medicare on those unpaid amounts, provided the hospital treats all indigent patients the same. This is also true if the patient is a dually-eligible Medicare and Medicaid beneficiary. In such a case, the hospital would submit a bill for the unpaid deductible and coinsurance amounts to the state Medicaid plan. If the state Medicaid plan was not liable and denied payment on the account, the hospital could bill the Medicare program for it as a bad debt.

It is also important to note that in very limited circumstances, Medicare payment could be affected by the "lesser of cost-or-charges," or "LCC" principle. This principle was of significant importance in the early years of the program, but is admittedly less so now that most providers are reimbursed on the basis of a prospective payment methodology rather than on the basis of costs. However, where the LCC principle is applicable, a Medicare provider is paid the *lesser* of its actual costs or its actual charges. Implementing a reduced charge program for uninsured patients could potentially trigger the LCC principle because if a hospital lowered charges for enough patients, a hospital's fiscal intermediary could take the position that a hospital's charges were not its posted, or stated, charges, but rather, the charges applicable to most of its patients who were receiving discounted services. If the FI did take that position, it could then invoke the LCC principle and pay the hospital that lower charge-based amount.

Few providers are subject to the principle at all. The only example I am aware of is a pediatric or cancer hospital in its first year of operation, before it becomes subject to the TEFRA methodology, because there are no base year costs upon which to calculate a TEFRA target rate limitation. Other providers, including critical access providers, are not subject to the LCC provision.

Medicare and Medicaid Payments to Hospitals Providing Care to Uninsured Individuals

A recent study calculated the revenue cost of the tax subsidy provided to non-profit hospitals and found that in 1994–95 it amounted to $9.21 billion 2002 dollars, including an exemption from income taxes of $5.43 billion, an exemption from property taxes of $2.01 billion, tax deductibility of donor contributions of $1.34 billion, and tax-exemption of interest paid on debt of $0.43 billion.[7] In addition, Medicaid and Medicare have several payment mechanisms to compensate hospitals for providing care to uninsured individuals. The President's FY 2006 Budget includes proposals to ensure that funds provided to hospitals to reimburse for uncompensated care are used appropriately.

1. Disproportionate Share Hospital Payments

Since 1986, select hospitals have received payment under the Medicare disproportionate share hospital (DSH) program. The original intent of DSH payments was to reimburse hospitals for increases in their Medicare costs that were associated with treating a large share of low-income patients. Since that time, several changes to the statutory formula have increased the likelihood that DSH payments also compensate hospitals for the costs of treating uninsured patients. Hospitals qualify for Medicare DSH payments if they treat a "disproportionate share" of low-income patients—defined in the statute as the share of a hospital's total inpatient days attributable to Medicare patients who are also eligible for SSI compared to days attributable to all Medicare patients, plus days attributable to patients who are eligible for benefits under Medicaid and also not eligible for Medicare compared to all patients. That ratio, along with consideration of urban/rural status and bed size, plays into a specific formula that yields 16 different categories of hospitals for DSH payment purposes. The payments themselves are a percentage add-on to the Medicare

[7] Gentry, William M., and John R. Penrod. "The Tax Benefits of Not-for-Profit Hospitals." In David M. Cutler, ed., "The Changing Hospital Industry: Comparing Not-for-profit and For-profit Institutions." Chicago: University of Chicago Press, 2000.

diagnosis related group (DRG) payments used to reimburse hospitals for inpatient services.

The Medicaid program also provides DSH payments. The formulas for establishing those payments vary with each state program, although there are certain categories of hospitals which must be designated as DSH hospitals by state Medicaid plans. States must designate hospitals as eligible for Medicaid DSH payments if they have a low-income utilization rate of 25 percent or more (LIUR is calculated as the sum of the ratio of Medicaid revenues divided by total revenues and the ratio of inpatient charity charges divided by total charges); or their Medicaid utilization rate (Medicaid days divided by total days) is more than one standard deviation above the mean Medicaid utilization rate in the state.

The Medicaid DSH program is also advantageous for states because DSH payments to a hospital under a state plan are not counted in determining whether or not the state has exceeded the Medicaid upper payment limit, thus enabling states to increase payments to other providers participating under their state plan. Preliminary data show that during 2004, Medicare DSH payments amounted to about $8.5 billion, while Federal and State Medicaid DSH payments totaled nearly $17.2 billion.

2. Bad Debt Payments

As I mentioned above, Medicare also reimburses hospitals and certain other providers for the bad debt that arises from treating Medicare beneficiaries who are unable to pay their cost sharing and deductible amounts. Providers who make reasonable efforts to collect Medicare co-payments and deductibles, but are unable to do so, can report those amounts as bad debt. Hospitals are paid for this bad debt at a rate of 70 percent. Other eligible providers receive payments amounting to 100 percent of their bad debt. In FY 2000, the latest year for which we have finalized data, CMS provided $1.03 billion in bad debt payments. For FY 2005, we estimate that bad debt payments will total around $1.6 billion.

3. A Portion of Indirect Medical Education (IME) Payments

As with the DSH, the IME is intended to recognize legitimate variations in hospitals' costs for treating Medicare patients. Academic medical centers that engage in graduate medical education incur higher costs per discharge as a result of their teaching activities. In recognition of that fact, when Congress instituted the inpatient prospective payment system (IPPS), it created add-on payments for these teaching institutions. One of those payment types was meant to cover the indirect costs of providing such education and is referred to as IME. IME payments are based on the estimated relationship between the hospitals' Medicare costs per discharge and their teaching intensity as measured by the ratio of residents to beds. Because Congress was unsure about the ability of the IPPS to fully capture differences in patient severity and other factors that might account for teaching hospitals' higher costs, the Congress required the Secretary to double the empirically estimated IME adjustment. Current law and the most recent data indicate that IME payments are still set at twice the estimated empirical effect of teaching activities on a hospital's cost per discharge. Some say that the difference between the empirical estimate and the current level of IME payments is a subsidy for uncompensated care. Projected spending for IME during 2004 stands at $5.2 billion and that projection rises to $5.7 billion for FY 2005.

The Medicare Payment Advisory Commission (MedPAC) has recommended revising this situation, but at the same time, recognizes that doing so may cause problems for these institutions. Teaching hospitals provide a high level of uncompensated care, amounting to 20 percent in major public teaching hospitals, but only 5 percent in major private teaching institutions. Medicare patients account for only a portion of total patient population, so even increased payments for Medicare services do not necessarily cover costs incurred for all uncompensated care. Nevertheless, the IME payments do provide funds that these institutions can and do use to cover that gap. Whether this approach to funding hospitals that provide uncompensated care actually results in the most healthcare per dollar invested, and is the most appropriate method for targeting those dollars to the uninsured, or indigent, is not clear.

4. Medicaid Waivers

Medicaid waivers allow states to explore new approaches to delivery and payment for health care services. In particular Medicaid section 1115 waivers have been used to develop new mechanisms to provide health insurance for uninsured individuals with a limited income.

The 1993 approval of the Hawaii Quest Demonstration program includes redirected DSH funds in order to provide insurance coverage rather than uncompen-

sated care. Similar initiatives were included in the early TennCare program, New York Partnership, Vermont Health Access Program, Massachusetts MassHealth Program—all broad comprehensive statewide section 1115 demonstration programs that included eligibility expansions to uninsured populations. Also, more recently, CMS has collaborated with the State of Maine and the District of Columbia to reprogram Medicaid DSH funds to provide health insurance instead of uncompensated care. These two states have used demonstration authority to focus on redirecting Medicaid DSH payments to increase the insurance coverage in the states.

The State of Maine currently has a HIFA waiver under the authority of Section 1115 of the Social Security Act, implemented October of 2002, that has allowed the State to expand coverage to childless adults up to 125 percent of the Federal Poverty Limit. Maine chose to use its unspent Medicaid DSH Federal allotment to extend coverage to this population. This program has provided health insurance coverage to an additional 26,000 residents of the State of Maine (as of February 28, 2005).

The District of Columbia currently has a Section 1115 demonstration, implemented February of 2003, to provide primary and preventive health care services to non-disabled, childless adults, between the ages of 50 and 65, with income at or below 50 percent of the Federal Poverty Limit. The funding source for this demonstration is the District of Columbia's Medicaid DSH Federal allotment. This program was implemented with an enrollment cap of up to 2,400 people.

These two programs have expanded insurance coverage to more than 20,000 low-income childless adults. At the start of 2004 there were 20,900 childless adults up to 100% of the Federal poverty level (FPL) insured through the program in Maine and 2,400 childless adults up to 50% of the FPL in the District of Columbia. In both of these programs the participants receive benefit of the full Medicaid benefit package. These examples illustrate that states have options available, under demonstration authority, to move from reimbursing providers for direct care to increasing health insurance coverage.

In the state of Massachusetts, demonstration authority will be used to reimburse forprimary care services for the uninsured and encourage the utilization of services that can prevent the need for more costly hospital services for these individuals. Under the MassHealth Section 1115 Demonstration, effective with the extension period beginning July 1, 2005, a Safety Net Care Pool will be established to pay for costs related to providing health care services to the uninsured. The Safety Net Care Pool (SNCP) will be established using a combination of demonstration savings, in addition to the Commonwealth's Medicaid DSH allotment.

5. Increased Funding for Community Health Centers

This Administration has undertaken other initiatives to provide health care services to individuals who otherwise lack access to health insurance or who may be under-insured. Community health centers (CHCs) serve as the "front line" treatment option for low-income uninsured individuals. They provide professional, family-oriented preventive and primary care to low-income individuals within their communities. Typically, about 40 percent of the patients of a community health center are uninsured. A study published in Health Affairs earlier this year illustrated the important role of CHCs as a reliable source of primary and preventive care for a vulnerable population.[8] According to the study, visit rates for uninsured CHC patients, individuals for which a chronic disease condition was "managed", and established CHC patients all increased. Furthermore, CHC patients experienced fewer hospitalizations and emergency room visits for ambulatory care, compared with similar people living in the same areas who seek care elsewhere. The President's Health Centers Initiative, which began in FY 2002, will open or expand 1,200 health center sites to serve another 6.1 million patients by 2006. The FY 2005 appropriation for community health centers exceeded $1.7 billion. The President has set a new goal to open a health center or rural health clinic in every poor county that can support one. The FY 2006 Budget level includes $26 million to open new health center sites in 40 of the Nation's poorest counties and will support 25 planning grants as well. These expansions complement the President's proposals to increase health insurance coverage in private and public insurance programs, to help ensure that all Americans have access to health care. The President's Health Centers Initiatives will broaden the health center safety net and increase access to primary

[8] O'Malley, Ann S., Forrest, Christopher B, Politzer, Robert M., Wulu, John T. and Shi, Leiyu. "Health Center Trends, 1994–2001: What Do They Portend For the Federal Growth Initiative," *Health Affairs* 24(2) 2005: 465–472.

health care for the Nation's underserved populations, thus reducing the amount of uncompensated care that must be provided by our hospitals.

6. Section 1001 of the Medicare Modernization Act (MMA)

Under the Emergency Medical Treatment and Labor Act (EMTALA), hospitals participating in Medicare must medically screen all persons requesting a medical screening examination to determine whether or not the individual is suffering from an emergency medical condition. In addition, if the hospital determines that the individual has an emergency medical condition, it must provide the treatment necessary to stabilize that individual, regardless of payment method or insurance status. As a result, hospital emergency departments treat uninsured or underinsured individuals who cannot pay for the services they receive.

Undocumented immigrants' use of medical services has been a long-standing issue for medical providers, particularly for hospitals located along the U.S.-Mexican border. Section 1011 of the Medicare Modernization Act (MMA) provides $1 billion through 2008 to help hospitals and other emergency providers recoup some of the expenses of providing this critical care to undocumented immigrants. Earlier this month, CMS announced the final implementation plan for hospitals and other providers to being receiving reimbursement under section 1011.

Between Medicare and Medicaid DSH, IME, bad debt payments, and the other mechanisms I have mentioned, the Federal and state governments will provide tens of billions of dollars this year to our hospitals to compensate them for the provision of uncompensated care. In addition to these payments, according to the study I cited earlier, non-profit hospitals will realize several billion dollars more in tax exemptions. As someone who trained as a physician in a teaching hospital, and who has conducted some published research this topic, I am familiar with how often these institutions provide uncompensated care and I know how valuable they can be to a community. However, the question that should be asked is whether the funding mechanisms I have mentioned most effectively target those funds to the programs and settings that provide the best value in terms of the type of care they provide.

Other Administration Initiatives for the Uninsured

The Administration has approached the issue of the uninsured along other lines as well, advocating giving an advanced health coverage tax credit to certain individuals who are receiving a pension from the Pension Benefits Guaranty Corporation or who have become unemployed due to the adverse effects of international trade and are eligible for Trade Adjustment Assistance. This tax credit pays 65% of the premium for qualifying health insurance, including either employer-sponsored "COBRA" coverage or a state-designated private health insurance plan. The Administration's Medicaid waivers, state plan amendments, and HIFA waivers have provided health insurance for 2.6 million people who would have otherwise lacked coverage.

Many of you in Congress voted for and deserve credit for the provisions in the MMA that accelerate adoption ofhealth savings accounts and help make insurance more affordable for millions of Americans. In addition to creating a Medicare prescription drug benefit and providing interim savings and subsidies through Medicare-approved discount cards, this historic legislation allows people to establish health savings accounts (HSAs) in conjunction with affordable, high-deductible major medical coverage. These new products will make health insurance more affordable to businesses large and small, as well as to individuals whose employers do not sponsor coverage.

Conclusion

CMS strives to make sure that the payments we provide are in line with statutory requirements and that they meet the legitimate, data-driven needs of our partnering providers. The programs we administer serve some 80 million Americans and we want to be sure that we are supplying them, and those who serve them, with the best we are capable of. I appreciate the chance to appear before you this morning and look forward to any questions you may have.

Chairman THOMAS. Thank you all for your testimony. I believe out of necessity, Dr. McClellan, what you were reviewing were in essence payments made to hospitals for a category that could be broadly called the indigent or those who are not able to benefit; the old under Medicare and the poor under Medicaid, is that correct?

Dr. MCCLELLAN. That is correct.

Chairman THOMAS. What is the rough dollar in that area?

Dr. MCCLELLAN. About $30 billion per year.

Chairman THOMAS. But that does not include the traditional benefit of tax exemption either from Federal, State, or local taxes?

Dr. MCCLELLAN. That is correct.

Chairman THOMAS. Do any of you have a number on that, or ballpark number, or do we need to research that?

Mr. EVERSON. I think you are suggesting about the joint Committee. We have a lot of data that would go into that. In the hospital area, I understand the revenues are something like 374 billion and expenses are 287.

Chairman THOMAS. I am looking for pure benefit from the enjoyment of tax-exempt status. If you give it at the Federal level, there is reverberation down to the State and local. Clearly if you didn't have the Federal exemption, the pressure at the State and local would be greater. Mr. Walker.

Mr. WALKER. Mr. Chairman, I think additional research is necessary in this area, because there are a number of dimensions here. Number one, you have Federal tax exemption, and State income tax exemptions. You have the fact that individuals who make contributions to not-for-profit hospitals get a tax deduction. You have State and local property tax exemptions as well. I don't think there has been a comprehensive study done on this, but clearly it would involve a lot of money.

Chairman THOMAS. Well, I appreciate that technical term, a lot of money. Clearly 30 billion, which can be determined more precisely—and if we look at the other, I assume we are around 50 billion or more. The whole point is this is the reason why I think it is essential that Congress look at it. One of the things I did in preparation for us beginning to look at the area was to examine the history. What I found, and frankly striking, was the history of examining three separate timelines. One is tied to IRS rulings and the date that IRS rulings were made; Federal statutes which affected who the Federal government provided funds for in assisting health care, principally Medicare and Medicaid; and what was going on in the real world in terms of not-for-profit hospitals and for-profit hospitals. When you then examine all three of those timelines, certain things just popped out to me in a very striking way.

I guess one of the framing questions and answers would be what I found in 1990 in terms of the Chairman at that time, the Aging Committee, the gentleman from California, Mr. Roybal, in questioning IRS and the American Hospital Association. As you might guess, as we get more and more into the timeline coming more and more to the present time, some of this stuff starts to sound like tautologies rather than rationale for why people did things. For example: "Mr. Chairman, what gives you tax-exempt status?" Mr. McGovern, who is the IRS person: "A determination by the Internal Revenue Service that you have met the criteria for tax exemption." "That is good, because what has happened is there has been a change in definition of what it is that allows you the privilege of tax exemption." I mention that is a particular timeline that might be useful to look at.

Here is the question and answer from the American Hospital Association representative, and the Chairman asked Mr. Pugh, who was the AH representative to discuss the relationship between for-profit and not-for-profit, and his answer was: "The for-profit hospitals, although they may provide a variety of services and do an excellent job, the bottom line is, the bottom line is that they are investments by individual owners who are concerned about the return of net income, which will accrue back to them." The Chairman says, "These are the hospitals that are organized for profit?" The AH representative says, "Yes, these are the for-profit hospitals." The Chairman says: What about the not-for-profit hospitals?" The representative says: "The not-for-profit hospitals, as I just described, are the ones owned by the community. There is a community benefit there. The assets are owned by the community."

That is an important concept. It is not just charity care. Then they go on to examine the fact being owned by the community has some virtue beyond the fact that they are owned by the community. When you begin to pull all of these strings together, this is what I get out of comparing these three timelines. The principal historical reason for establishing not-for-profit hospitals was to serve those who otherwise wouldn't have care, principally the indigent. In fact, that was the definition that was codified by the IRS in 1956, although it had a common law basis over a long period of time. One of the key and principal reasons—and if you examine any of the organizations and that is why many of them were religious-based or otherwise humanitarian-based in providing the reason in creating these hospitals. Then in 1965, the government passed legislation which said the government is going to provide payment to those who provide services to the indigent, the old, Medicare and Medicaid.

Well, it is pretty obvious if the definition for giving tax exemption is that you provide aid to the poor, and the government is now going to pay you for providing aid to the poor, that you would be in danger of losing your tax-exempt status. So, it would be convenient to have a different definition of tax exemption. Lo and behold in 1969, the IRS provides a definition which removes the test of giving service to the poor. It gives a broader definition of community benefit, which was sited by Mr. Everson, including for example, emergency room service provided 24 hours a day, 7 days a week, to anyone who called, not just those who can pay.

Interestingly enough, in a subsequent IRS ruling, that was removed as well. When you examine the for-profit and the not-for-profit history from the very beginning, if there was something called a for-profit hospital, it was essentially an adjunct to a physician providing services and providing for a structure which assisted them in doing that. The early hospitals were really all not for profit. So, where was the real growth of the for-profit hospitals? Well, if in fact the only difference between a for-profit and a not-for-profit today is that one is owned by the community and the other one is not, the idea of a business plan or an administrative flow chart being the difference between the two, it is obvious that once the government began making payments to the poor beginning in the mid-sixties, you saw the development for-profit hospitals. Then when the government went beyond that and said we are going to

create diagnostic-related group payments so you can have a source of money based upon particular services offered, the for-profit hospitals continued to grow far faster, because they could figure out how as a business to be able to make money principally because the government was making the payments. At the same time, the for-profit hospitals began to grow because they could figure how to make a business principally based on government payments.

The definition for the tax exemption continued to change, which brings us to today, when one of our witnesses that will come before us shortly provides a definition, a partial definition, I will admit, of what it is that not-for-profits do, which require us to make the tax-exempt benefits. Moreover, the ability to use tax-exempt financing allows facilities to borrow at lower costs, thereby allowing them to make the necessary capital investments to replace or update the facilities and equipment to fulfill their mission. The ability to update facilities in technology and health care is closely tied to quality and health outcomes. We get the tax break to be able to buy new modern equipment. How in the world are for-profit hospitals who have the burden of paying taxes able to stay competitive because, frankly, in the marketplace they have to buy quality equipment to update and stay modern as well, but they carry the extra burden of paying taxes.

Back to the original question: What do we get for our money? Here is a more curious underlying question. It appears based upon the timelines that not-for-profit hospitals found that they got a far greater return on their investment lobbying the IRS to get changes in the revenue rulings than they did to undergo the difficult reexamination of their mission and change what they did, because the society was changing and in fact, the society decided to pay for low-income, instead of relying on tax exemptions for nonprofits to perform that particular function. My real concern is as things changed, including the definition of charity, what hasn't changed to a certain extent is the role and the action of the not-for-profit hospitals and that they got a greater return on their time and energy in getting IRS rulings, which were actually health policy decisions, than they did in attempting to figure out what a new and more appropriate role would be to receive that tax exemption benefit.

Although it is true, as the gentleman from California said, Congress has examined this a number of times and hasn't done anything about it, I do think, based upon the testimony and the rationale provided, there will be ample evidence to say that we need to look at this and figure out how we can help not-for-profit hospitals redefine their mission and to examine what it is they think we are getting for the tax-exempt billions of dollars that are being offered, so we can reconcile again people with a mission that deserves a tax-exemption status.

You folks are going to be absolutely critical to our ability to begin to look at a changing definition to be able to assist the society and those institutions in the society who have changing roles and that simply redefining what it is you do to get the tax exemption has largely placed us where we are today; and that is, we really can't tell the difference all that much between a for-profit and a not-for-profit. That, frankly, isn't a sufficient answer to cover tens of bil-

lions of dollars currently offered by taxpayers for getting what they think is something. Gentleman from New York.

Mr. RANGEL. Thank you, Mr. Chairman. Mr. Everson, the Chairman indicated that because there is loss revenues at hospitals that this will be an area we should give some priority. Do you agree with that?

Mr. EVERSON. Mr. Rangel, I agree first, as I indicated, that looking at tax exemptions and charities more broadly is important. This is an area that was highlighted.

Mr. RANGEL. I agree with you on that 100 percent. We ought to look at whatever there is, tax exemptions. I am talking about hospitals.

Mr. EVERSON. We did this priority—we did a list a couple of months ago for finance. They asked——

Mr. RANGEL. Who asked?

Mr. EVERSON. The Finance Committee did. We included this on the list of the top 20 issues of concern to us because we do see it as an area——

Mr. RANGEL. Are there other areas where there is lost income that you need some congressional direction?

Mr. EVERSON. We have particular concerns in areas like credit counseling. This is an important subject of inquiry because, as you know, under the new bankruptcy bill, people will be steered toward these.

Mr. RANGEL. Besides credit unions and hospitals, what else is on the list?

Mr. EVERSON. Excessive compensation across the entire sector——

Mr. RANGEL. I want to talk about industries, not across the sector. Would you agree we ought to start off with a flat-tax concept, eliminate all deductions and everything, and then go revisit and then see what is worthwhile?

Mr. EVERSON. You are over my head there when you are getting into a policy call like that. That is for the administration and Congress to work out.

Mr. RANGEL. Considering the IRS has been lobbied by the not-for-profits in order to get you to include what the standards should be, is that policy? Are you influenced by outside lobbyists?

Mr. EVERSON. We interpret the law. The Chairman is substantially correct in what he said. I think Congress had a role too. Some of the hearings back in the sixties, pointed out that there can be many benefits other than indigent care, an example being, emergency rooms——

Mr. RANGEL. Do you make a determination what the emergency room should be?

Mr. EVERSON. We consider that as an important factor.

Mr. RANGEL. Is that policy?

Mr. EVERSON. We interpret the law that you pass.

Mr. RANGEL. You interpret that emergency rooms is a part of the law, even though it is not written into it?

Mr. EVERSON. We are attempting to determine whether a charity or an entity is operating for the public good. This is a common law standard. The hospitals aren't mentioned in the Code itself, in the law you have written.

Mr. RANGEL. What about our university systems? They get tremendous tax exemptions. What guides you in that area for profit and not for profit? Was that on your list?

Mr. EVERSON. Universities per se are not, we don't believe. We make judgments all the time.

Mr. RANGEL. Was that on your list to the Senate Finance Committee?

Mr. EVERSON. No, it wasn't, I don't believe.

Mr. RANGEL. Did you have it listed and the amount of money of lost revenue to the government in order to determine the priority?

Mr. EVERSON. We did not look at it solely from the point of view of money and we did not quantify the money. As noted by the Chairman, there are multiple factors here.

Mr. RANGEL. Multiple factors? He wants to go where the money is lost. That is not multiple.

Chairman THOMAS. Will the gentleman yield?

Mr. RANGEL. If you want to tell me about churches and synagogues.

Chairman THOMAS. There is a fundamental First Amendment constitutional right, rather than a privilege, dealing with that. The gentleman will remember—and I recall back when I was young—we began looking at universities on the basis of activities that universities engaged in which were in direct competition with the private sector, and it was surrounding the unrelated business income tax, whether or not they should pay for it. So, each of these various tax-exempt areas need to be looked at in terms of what peculiarities are about them. The Chair invites, in fact welcomes, an examination in all these areas, because we found it quite interesting at the time, as you recall, why university presidents were explaining why they ran gas stations, bowling alleys, gyms, travel agencies out of book stores, and that sort of thing. It was because it was in the pursuit of knowledge. That is the kind of thing where we haven't shown the rigor necessary to get a better answer. The Chair is excited about the gentleman's direction of going beyond just the big money areas, but if we start with those and move onto the others, we can create a list and move fairly quickly.

Mr. RANGEL. The Chair would be even more surprised how all of us want to work to get rid of abuse and corruption and loss of revenues. The problem we have, especially with the IRS, is that some people really believe they were on the list, there is a reason for them to be on the list rather than other people. The earned income tax credit. There are some people in this country believe that you are putting resources against the poor and not enough resources against the higher-income people. Of course, that is ridiculous. When you get on the IRS list, there is something that allows people to believe that they think you are doing something wrong. When you start talking about credit unions and then you are talking about hospitals, I would like to see the list. That is all. I don't think there should be a private list that just the IRS has and you share it with the Finance Committee. Could we get that whole list?

Mr. EVERSON. It is a public document.

Mr. RANGEL. Name some institutions so that we can make the hospitals feel more comfortable.

Mr. EVERSON. We haven't singled them out.

Mr. RANGEL. Who else is on the list?

Mr. EVERSON. You mentioned universities, but supporting organizations. The Chairman talked about that.

Mr. RANGEL. No. No. I may be a supporting organization. When you say hospitals, everyone knows who you are talking about. When you say credit unions, everyone knows who you are talking about.

Mr. EVERSON. We are concerned about issues like Indian gaming.

Mr. RANGEL. Indians are on your list. Who else?

Mr. EVERSON. I didn't say Indians. I said Indian gaming.

Mr. RANGEL. There are 20?

Mr. EVERSON. Eighteen or 20. It covers a range——

Mr. RANGEL. Just give me some idea of who will have to get lobbyists in a hurry.

Mr. EVERSON. As I said, it ranges across issues like credit counseling.

Mr. RANGEL. You mentioned them three times.

Mr. EVERSON. Pardon me. There are some issues like Indian gaming or credit counseling. There are other pervasive problems like supporting organizations that touch a variety of sectors such as education. There is excessive compensation, which is a problem across the entire sector. So, there are a variety of problems that are stated. Inflated deductions is another.

Mr. RANGEL. I support all of the things you have said categorically.

Mr. EVERSON. Easements.

Mr. RANGEL. You are talking about people gaming the system and all of us want you to give us direction to have hearings or do whatever is necessary. But that is not like saying hospitals. We want to know what industries that you believe deserve to be questioned as to their tax exemption.

Mr. EVERSON. I mentioned three.

Mr. RANGEL. You said there were 20.

Mr. EVERSON. I said there are some segments and other issues as to structure, like supporting organizations. There are issues that cut across the spectrum like donor revised funds. There are issues like, as I indicated, the excessive deductions people give. Easements, conservation easements.

Mr. RANGEL. You have any recommendations to make as it relates to determining whether or not a hospital should be tax exempt or not? Do you have any recommendations to make to this Committee that would allow us to better determine which hospitals deserve tax exemption and which don't?

Mr. EVERSON. I think it is a difficult subject. We rely increasingly on the community judgment. There is a standard where community members on the board be represented over half of the membership.

Mr. RANGEL. Can you recommend to this Committee how we can legislate a better way to do it than what we already have on community organizations and whether they have emergency rooms? Is there a better way which you can recommend that we can determine which hospitals deserve to be tax exempt and which hospitals

will be taxed as commercial organizations? Can you help us out there?

Mr. EVERSON. I am happy to take that back and talk broadly in the Department. I am concerned that if you put any bright-line test in there, it might be helpful to us, but they perhaps would have unintended consequences. Let me just raise one issue with the emergency room. If you say you have to have an emergency room, but one entity has a burn unit——

Mr. RANGEL. I didn't say that; the IRS said that.

Mr. EVERSON. It is a factor in our decisionmaking process. We have an application process that, for hospitals, runs a couple of pages, it asks the question, "Do you have an emergency room?"

Mr. RANGEL. Are you saying you need guidance from this Committee?

Mr. EVERSON. If you want to write something in the law, we will implement it. I ask you to move carefully only because this can have unintended consequences.

Mr. RANGEL. We leave it alone?

Mr. EVERSON. I am not suggesting that. I am telling you it is difficult to administer because of just what the Chairman said, the indistinguishable nature between the two, profit and not-for-profit. I am concerned about these joint ventures. That is a big issue where profit-making entities will shift the income into the nonprofits and the cost will go into the profit-making entity. There is a lot of money at stake.

Mr. RANGEL. I don't have a problem with that. If we have a problem, we should have a hearing and try to assist you in correcting it. General Walker.

Mr. WALKER. Mr. Rangel, I would respectfully suggest that today's subject is illustrative of a much broader need that the Congress needs to address. Specifically, there are many areas both on the tax preference side, such as not-for-profit hospitals, as well as on the spending side with regard to programs where I would respectfully suggest there needs to be more guidance provided as to principles and criteria are needed. For example, what factors should be considered in determining whether and to what extent tax-favored status should be granted, to whom it should be granted, under what circumstances it should be granted; and therefore, what is expected that the public will benefit from, so that we can monitor and evaluate. I will give you three possible examples. One, you could look at community need from the standpoint of whether or not there is adequate capacity in a community or a particular area, which is geographic. You could look at certain types of services and activities, which would be something that wouldn't be geographic necessarily but could be considered. Then you could look at certain types of individuals, namely the poor. You could end up deciding that there are certain principles or criteria that you would like to make sure are considered and then delegate to the IRS some discretion to come up with the details considering changes over time, but then you have a chance of having more consistency. Then you have a basis to be able to provide certain standards that you could evaluate what people are doing and then you could oversee it, report back to the Congress, and then make changes periodically if you deem it appropriate.

Mr. RANGEL. I have 18 municipal hospitals in the city of New York, and they have standards by the city and by the State. Why in God's name do we have to now reinterpret what good a tax-exempt city hospital is doing when we got the city and we got the State? Do you have recommendations to make to us as to additional criteria that would assist the IRS?

Mr. WALKER. Mr. Rangel, I will be happy to take that back and talk to our people about some areas that might be of assistance to this Committee. You properly point out that the States and localities have a number of criteria. At the same point in time, that doesn't moot the need that to the extent that you decide to provide Federal tax preferences—and it is not just the issue of income tax. That might not be the big issue, quite frankly, given the profitability of the industry. It could be more of an issue from the standpoint of the fact that people get to have deductions when they make contributions to not-for-profit hospitals. There could be issues that involve frankly, much more money than the income tax exemption. I would not be surprised if it was 50 billion-plus by the time you end up counting all the different tax preferences.

Mr. RANGEL. If we were to have a flat tax that we can take into consideration, all the deductions, all the exemptions—and I understand that the President intends to bring to the Congress a new reform bill and it may be part of the Social Security bill. Who knows where that is going or if it is going anywhere? But having said that, isn't that the best way to find out how much money we are not collecting? Just start from the beginning and have an evaluation as to whether or not some of these deductions and exemptions were politically motivated? Wouldn't you think that would be the best way to do it so everyone is on the list and they have to come forward and they have to justify why they were able to get preferential treatment, instead of just picking on hospitals?

Mr. WALKER. Mr. Rangel, I think that is a much bigger subject for a different hearing. One clear basis that I can think of as to why the Chairman may have chosen to start with this is because we have done work in this area over a number of years that has shown there is not a substantial difference between for-profit and not-for-profit. This study basically reconfirms the findings we had in 1990. If you look at the amount of money involved alone, these are the big numbers.

Mr. RANGEL. I am glad to hear that, because most of us thought the Chairman had a very bad experience with a not-for-profit and that is why he keeps coming back on this list. But if this is it, it is the dollar factor and you can help us to sort this out and do it in a better way—but you ought to think of a way where institutions that have not been charged with wrongdoing, and the general public believes they are providing a service and deserve to be recognized for it, that they don't get on a hit where constantly they have to come forward. I would hate to believe that I am the only Member of Congress that is being investigated because they keep calling me and they said, oh, no, we are calling everybody in a very general way. It doesn't allow for the morale of people who are trying to do the right thing to constantly believe that we are reviewing them when they are not only not doing harm, but when they are providing good. That is what bothers me, because people are no

more vigorous in routing out those people that are abusing the law and tax law—because as I told the Commissioner, if we don't keep the law where people believe it is going to be enforced, more and more people would be inclined to abuse it. Thank you, Mr. Chairman, for your generosity and your time.

Chairman THOMAS. I thank the gentleman. Does the gentlewoman from Connecticut, Chairman of the Subcommittee on Health, wish to inquire?

Mrs. JOHNSON. I thank you, Mr. Chairman.

Chairman THOMAS. Would the gentlewoman yield briefly?

Mrs. JOHNSON. Yes.

Chairman THOMAS. Mr. Everson, I find it totally ironic that you are concerned that if the Congress acts in this area there may be unintended consequences. If you will examine the IRS rulings, the primary reason there is no real difference, discernible difference, between not-for-profit and for-profit is fundamentally based upon the IRS rulings which continued to blur the clear difference between the two. As I said, the timing of those IRS rulings were when what it was that you used to call charity was changed by virtue of government statute. What you have failed to admit, even today, based upon the history, is that the health policy that was changed by the IRS rulings is the real reason we are in the problem we are today. My question is, did you consult any health experts when you decided to make the change in the definition of charity in terms of services provided? I think the answer is no. You will take a look at what Congress did. Congress made changes that didn't allow for compensation to the poor. You changed the IRS ruling to say that taking care of the poor was not a criteria to determine tax exempt status. What happened was the IRS rulings chased reality to create the current situation. You can't tell the difference between the two because society has augmented and assisted in ways that the definition that we started with wouldn't allow, and it is easier to change an IRS ruling than it is to figure out what your new mission is, and that is why we are here. I appreciate the gentlewoman's yielding.

Mr. EVERSON. If I could take just a very brief moment, sir. I don't disagree with your analysis of the history. The only point I was trying to make about my remark about unintended consequences is that this right now, I don't want to risk drawing Mark into this, but in reading his testimony—I will just read you one or two sentences which I think get to the nub of this. It says hospitals, not the Federal government, set their own indigency policies and have the discretion and flexibility to define eligibility indicators, including income level. This makes sense, because a hospital as a community institution is in the best position to know what policy best suits the community that it serves. The only point I am trying to raise is that, go ahead, we will implement whatever you put in there, but recognize you are going to be having an impact on communities that may be at variance——

Chairman THOMAS. All I ask you to do is recognize the fact that in making IRS rulings you made health policy and you put us in this position.

Mr. EVERSON. I don't quibble with that, sir.

Chairman THOMAS. I thank the gentlewoman and recognize her for her time.

Mrs. JOHNSON. Mr. Everson, thank you. I think it is important to know what we are paying for and where our money is going. I think it is also extraordinarily important that we begin to understand the unsustainable costs that are going to be on the shoulders of our children in the future. So, I don't oppose this hearing. I do believe that we are not yet able to talk to ourselves honestly about this issue, and so I want to put a word of caution out there. First of all, the three of you sitting at the table, if you wanted to, could agree on a single report that all hospitals made available within 6 months of the close of business of the fiscal year. Every hospital in my State provides an audited statement within 6 months from which we can talk about their fiscal state, who they are serving, what kind of job they are doing and so on. So, the load of paperwork, the difference between the IRS forms, the Medicare forms, the State forms, it is ludicrous. This Committee asked for reports to help us get to a single document. None of those reports were useful, I might add. This is imperative. Second, we have no uniform definition of what uncompensated care is, what charitable care is, what even bad debt is. So, we cannot talk to ourselves honestly about whether the costs of the nonprofit in these areas are equal to the cost of the for-profit. Any guesstimates we hear in testimony are just that, guesstimates. Even in Connecticut there is no consistent definition. So, we have to be cautious, because we don't actually know what we are talking about.

Now, we also don't actually know what we are talking about because we have been regulating Medicare, the biggest health care system, on average for years. For 3 years, I have been trying to get a better look at negative margin hospitals. We don't know whether negative margin hospitals are mismanaged or whether they just have a lot of uncompensated care, a lot of injuries, they are inner city or whatever. We do not know why they are negative margin. We can have gross things like occupancy rate. We have some other gross things. We know small hospitals in rural areas, we not only have to pay the Medicare rate, we have to pay cost. So, you know, we know very little. You mentioned, Mr. Walker, that government hospitals, in a sense you get the best return because of the most uncompensated care. Where there are no government hospitals in those whole regions of the country, the nonprofits are carrying that. Do we distinguish between those nonprofits who have that kind of burden in their emergency room and other nonprofits? No, we don't. We are experiencing an explosion of construction of hospitals. They happen to be outside of our tax-regulated body. Do we look at whether there is a need for those? Do we look at whether they are carrying their share of uncompensated costs? Do we look at what the future sustainability of health care costs will be?

One of the reports that one of the government agencies gave my Committee said there was no impact of the new specialty hospitals on the existing community hospitals. But when you actually talk to the community hospitals, they negotiated higher reimbursement of managed care costs, managed care contracts. So, overall, national health care costs will rise. Now, that is not an impact? No, it didn't impact the Medicare margin, which is what we looked at.

How myopic can you be? Now, let me just point out that the taxes the for-profits pay, which I respect, but they go to government's ability to provide public education, national defense, roads and bridges, so on and so forth. The tax benefit that we provide goes directly to health care access in that community. When my friend, Mr. McNulty, talks about Albany, we could all talk about hospitals that have to be open 24 hours a day, 7 days a week, and not just provide emergency care, we all know that is a loser, or trauma care, that is a loser, or neonatal units, that is a loser. They have to be able to provide the most sophisticated care and every single type of care, and that is not reflected in our public analysis of uncompensated care or anything else, maybe a little bit in overhead, but you see, that 24 hour/7 across all medical disciplines is the real mission. That is the real community benefit. The real community benefit is not whether or not you take more or less uninsured cases. They all have to do that.

In my area, the hospitals do—the not-for-profits, because we don't have any for-profits, do take more than their share. I think we have to know more about mission. It isn't just people who don't have insurance. We don't take into account whether you are in a State where there is a low Medicaid reimbursement rate or a generous Medicaid reimbursement rate. So, we really have to think about what is that community mission that not-for-profit community hospitals fulfill, and when we are able to analyze the cost of that, which we have not done, then we will have a better grasp of whether or not the tax benefit that flows directly to health, in the case of nonprofits, is worth it. We will be able to see what happens to the tax benefit of taxpaying entities in terms of their impact on health. I would just note—and I know the Chairman is trying to cut me off here, and I don't blame him but——

Chairman THOMAS. The gentlewoman's 5 minutes has expired. We have a few minutes left on the vote.

Mrs. JOHNSON. I do think we have to look at this issue of mission. What do we know about it? What can we analyze about it? We have to look at the issue of the accuracy and inaccuracy, really gross inaccuracy, of our database at this time. We have to work on those things so that in the end we can have the right policy and then decide how much of it should be tax incentivized and how much of it should be tax collected. Thank you, Mr. Chairman.

Chairman THOMAS. I thank the Chairwoman for her statement. Had that been the function in the sixties as the government's role of paying at the Federal level for the elderly and the poor, you would have not have had the lobbying of the IRS for a new ruling to change the definition of tax exempt. You would have changed the mission of those hospitals that provided care for which they got tax exemption. That is primarily the reason we are here today.The Committee will stand in recess for 15 or 20 minutes or so. I appreciate you folks staying for the other members to inquire.

[Recess.]

Chairman THOMAS. The Committee will reconvene. Our guests will find seats, and the Chair would recognize the gentleman from Florida, Mr. Shaw.

Mr. SHAW. Thank you. Thank you, Mr. Chairperson. I congratulate you for really opening up a bucket of worms here. I thought

I knew what a nonprofit hospital was until I started listening this morning, and now I am convinced that nobody really has a good definition that is going to satisfy us and we are going to have to kind of work our way through it.Mr. Everson, I have got a couple of questions I would like to ask you, and I would invite the other two panelists to respond if they feel that they have something to contribute. Would you just give us a short definition of community service or community benefit?

Mr. EVERSON. The community——

Mr. SHAW. Define what the community is.

Mr. EVERSON. The standards—we have really listed five factors that are in that community benefit standard. One is the nature of the control. As the Chairman indicated, having a community board, in that case a truly independent board that is making decisions on behalf of the community.

Mr. SHAW. Is that a requirement?

Mr. EVERSON. What we have is, we have a series of factors. They are not gauged per se, like the emergency room that was mentioned. That is another factor that is available to all. Some hospitals might have a burn unit or something that is very worthwhile instead of an emergency room, so it is not an absolute. The second factor is these emergency rooms. A lot of the for-profit hospitals grew out of practice groups of doctors. For a not-for-profit, a consideration is whether any doctor from the community who is qualified can participate at the hospital. Acceptance of the Federal payment programs, Medicare, Medicaid; and then finally how the institution uses the earnings. Do they plow the earnings back into more care or is it going to the benefit of individuals? For a profit making business, of course, it goes to investors. Those are the five general factors. What happens is we have a questionnaire where we ask as someone is applying—about 100 hospitals apply for exemption each year. We consider these factors, and if there is a no answer, say, on the emergency room, then we say why, what else do you have? They are considered as a whole.

Chairman THOMAS. Will the gentleman yield briefly?

Mr. SHAW. Yes, I will be glad to yield.

Chairman THOMAS. You indicated one of the indices, the five that you mentioned, was that they plow money back in for more care. That was an example that you gave. In fact, isn't it true there is no requirement that that money go for care, that they just can't show a profit and it can't inure to any individual? So, I wouldn't want us to leave the assumption that they take this money and reinvest it to provide better care. That is not a requirement to retain your——

Mr. EVERSON. Fair enough. What I meant is—what you are talking about, the equipment and using it in a broad sense.

Chairman THOMAS. I understand. I understand. But when you do that, you are giving a justification as to why they are getting the tax exempt status, which isn't actually a criteria they need to meet. Now, if that were a criteria, then we could judge whether or not the amount of money ploughed back in and the care received is commensurate with the benefit they get. Those are the kinds of measuring tools we need to look at. I just want to make sure that people understood that your example was, in fact, not reality.

Mr. SHAW. Commissioner, it would be helpful if we could have a copy of that questionnaire.

Mr. EVERSON. Absolutely, sir.

[The information follows:]

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Schedule C. Hospitals and Medical Research Organizations

Check the box if you are a **hospital.** See the instructions for a definition of the term "hospital," which includes an organization whose principal purpose or function is providing **hospital** or **medical care.** Complete Section I below.

Check the box if you are a **medical research organization** operated in conjunction with a hospital. See the instructions for a definition of the term "medical research organization," which refers to an organization whose principal purpose or function is medical research and which is directly engaged in the continuous active conduct of medical research in conjunction with a hospital. Complete Section II.

Section I **Hospitals**

1a Are all the doctors in the community eligible for staff privileges? If "No", give the reasons why and explain how the medical staff is selected.

☐ **Yes** ☐ **No**

2a Do you or will you provide medical services to all individuals in your community who can pay for themselves or have private health insurance? If "No", explain.

☐ **Yes** ☐ **No**

b Do you or will you provide medical services to all individuals in your community who participate in Medicare? If "No," explain.

☐ **Yes** ☐ **No**

c Do you or will you provide medical services to all individuals in your community who participate in Medicaid? If "No," explain.

☐ **Yes** ☐ **No**

3a Do you or will you require persons covered by Medicare or Medicaid to pay a deposit before receiving services? If "Yes," explain.

☐ **Yes** ☐ **No**

b Does the same deposit requirement, if any, apply to all other patients? If "No," explain.

☐ **Yes** ☐ **No**

4a Do you or will you maintain a full-time emergency room? If "No," explain why you do not maintain a full-time emergency room. Also, describe any emergency services that you provide.

☐ **Yes** ☐ **No**

b Do you have a policy on providing emergency services to persons without apparent means to pay? If "Yes," provide a copy of the policy.

☐ **Yes** ☐ **No**

c Do you have any arrangements with police, fire, and voluntary ambulance services for the delivery or admission of emergency cases? If "Yes," describe the arrangements, including whether they are written or oral agreements. If written, submit copies of all such agreements.

☐ **Yes** ☐ **No**

5a Do you provide for a portion of services and facilities to be used for charity patients? If "Yes," answer 5b through 5e.

☐ **Yes** ☐ **No**

b Explain your policy regarding charity cases, including how you distinguish between charity care and bad debts. Submit a copy of your written policy.

c Provide data on your past experience in admitting charity patients, including amounts you expend for treating charity care patients and types of services you provide to charity care patients.

d Describe any arrangements you have with Federal, state, or local governments or government agencies for paying for the cost of treating charity care patients. Submit copies of any written agreements.

e Do you provide services on a sliding fee schedule depending on financial ability to pay? If "Yes," submit your sliding fee schedule.

☐ **Yes** ☐ **No**

6a Do you or will you carry on a formal program of medical training or medical research? If "Yes," describe such programs, including the type of programs offered, the scope of such programs, and affiliations with other hospitals or medical care providers with which you carry on the medical training or research programs.

☐ **Yes** ☐ **No**

b Do you or will you carry on a formal program of community education? If "Yes," describe such programs, including the type of programs offered, the scope of such programs, and affiliation with other hospitals or medical care providers with which you offer community education programs.

☐ **Yes** ☐ **No**

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7 Do you or will you provide office space to physicians carrying on their own medical practices? If "Yes," describe the criteria for who may use the space explain the means used to determine that you are paid at least fair market value, and submit representative lease agreements.

☐ **Yes** ☐ **No**

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8 Is your board of directors comprised of a majority of individuals who are representative of the community you serve? Include a list of each board member's name and business, financial, or professional relationship with the hospital. Also, identify each board member who is representative of the community and describe how that individual is a community representative.

☐ **Yes** ☐ **No**

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9 Do you participate in any joint ventures? If "Yes," state your ownership percentage in each joint venture, list your investment in each joint venture, describe the tax status of other participants in each joint venture (including whether they are section 501(c)(3) organizations), describe the activities of each joint venture, describe how you exercise control over the activities of each joint venture, and describe how each joint venture furthers your exempt purposes. Also, submit copies of all agreements.

Note. Make sure your answer is consistent with the information provided in Part VIII, line 8.

☐ **Yes** ☐ **No**

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10 Do you or will you manage your activities or facilities through your own employees or volunteers? If "No," attach a statement describing the activities that will be managed by others, the names of the persons or organizations that manage or will manage your activities or facilities, and how these managers were or will be selected. Also, submit copies of any contract, proposed contracts, or other agreements regarding the provision of management services for your activities or facilities. Explain how the terms of any contracts or other agreements were or will be negotiated, and explain how you determine you will pay no more than fair market value for services.

Note. Answer "Yes" if you do manage or intend to manage your programs through your own employees or by using volunteers. Answer "No" if you engage or intend

to engage a separate organization or independent contractor. Make sure your answer is consistent with the information provided in Part VIII, line 7b.

☐ **Yes** ☐ **No**

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11 Do you or will you offer recruitment incentives to physicians? If "Yes,", describe your recruitment incentives and attach copies of all written recruitment incentive policies.

☐ **Yes** ☐ **No**

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12 Do you or will you lease equipment, assets, or office space from physicians who have a financial or professional relationship with you? If "Yes," explain how you establish a fair market value for the lease.

☐ **Yes** ☐ **No**

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13 Have you purchased medical practices, ambulatory surgery centers, or other business from physicians or other persons with whom you have a business relationship, aside from the purchase? If "Yes," submit a copy of each purchase and sales contract and describe how you arrived at fair market value, including copies of appraisals.

☐ **Yes** ☐ **No**

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14 Have you adopted a conflict of interest policy consistent with the sample health care organization conflict of interest policy in Appendix A of the instructions? If "Yes," submit a copy the policy and explain how the policy has been adopted, such as by resolution of your governing board. If "No," explain how you will avoid any conflicts of interests in your business dealings.

☐ **Yes** ☐ **No**

Section II **Medical Research Organizations**

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1 Name the hospitals with which you have a relationship and describe the relationship. Attach copies of written agreements with each hospital that demonstrate continuing relationships between you and the hospital(s).

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2 Attach a schedule describing your present and proposed activities for the direct conduct of medical research; describe the nature of the activities, and the amount of money that has been or will be spent in carrying them out.

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3 Attach a schedule of assets showing their fair market value and the portion of your assets directly devoted to medical research.

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Mr. SHAW. That may put some light on what we are trying to accomplish here today. Is research one of questions on there?

Mr. EVERSON. Research can be a factor, because you have teaching hospitals. Obviously, that is not activity necessarily that is engaged in by all hospitals in some of the smaller communities, but that could be something that we would consider, as an example, favorably where they might fall short in some other area.

Mr. SHAW. I am concerned about one part of your testimony. I think it was you, maybe one of the other witnesses also mentioned it. It is a question—I think maybe Mr. Walker mentioned it—a question of these nonprofit hospitals, when they see a chance for a profit jettison out a new corporation of which then would be for profit. That would keep the cost of the non—or put the costs over

there or somehow they we would jimmy their books so they could get the most favorable tax treatment and still make a profit. Now, that is of great concern to me, and I think that is something that this Committee is going to really have to focus hard on.

Mr. EVERSON. Yes, sir. I was going to mention that. These joint ventures, which can be quite large in scale, our concern is—and what we do is, we try to work it from both sides. We see something that concerns us on the not-for-profit examination, we will look over to the profit making corporation as well and marry up our audit teams. It is just like in the corporate world where you have a lot of concerns about shelters, of course, it is the same sort of set of issues.

Mr. SHAW. Now, community can be the entire country, couldn't it, as well as a small community in which we, you know, think about just community health care, but actually when you think of some of these specialized hospitals, as some of these large cancer centers, which I have a great deal of concern about, their community is much broader than just the local community.

Mr. EVERSON. Absolutely, Congressman. I was looking at this last night. Look at Shriners. Shriners, as an example, has 7 billion—over $7 billion in assets and operates 22 hospitals. Most of the work they are doing, I think, is without compensation at all. They are getting a couple hundred million in contributions, but they are operating off of a large endowment, and it is a large organization that has a governing structure at the top. I don't know the details on a hospital-by-hospital basis, but they are running a national program. Yes, sir.

Mr. SHAW. Their home is in Tampa, but their community is all the way across this country.

Mr. EVERSON. Absolutely, and I think they even have one facility in Mexico.

Mr. SHAW. They are doing some good work, and a lot of these people are doing some wonderful work. Just one other quick question, if the Chairman would just indulge me for another minute, one of the things that concerned me about hospitals is everybody I think on this Committee has insurance. Our insurance companies will go and negotiate down on fees and hospital costs. The non-insured, their bill will be double what our insurance company would pay. I think that is a little concerning, particularly when you get into a situation where you find that it is usually the poor or the lower economic rung of people who are getting really stung with those big bills, and we are also seeing a great deal of bankruptcies coming out of that. Is that looked at when you do your audits or trying to figure out whether a hospital is actually performing a community service?

Mr. EVERSON. I would want to check as to how—what level of detail we would get into on a specific question like debt forgiveness or other areas before answering that. I think that would be a factor.

Mr. SHAW. There is a lot of people who don't qualify for Medicaid but can get wiped out with large hospital bills.

Mr. EVERSON. Of course. Yes, sir.

Mr. SHAW. Mr. Walker?

Mr. WALKER. Mr. Shaw, one of the reasons that we reported based upon operating costs was exactly because of the issue you talked about. The irony is that individuals who do not have insurance many times are charged quite a bit more money than individuals who do have insurance, because they don't have the benefit of the contractual arrangements that have been negotiated. Therefore there would be higher writeoffs. Therefore, our data is based upon the cost side in order to recognize that reality. The matter you noted is of increasing concern.

Mr. EVERSON. Mr. Walker has helped me here, because I have got the questionnaire, I have now looked at our form. One of the questions is, do you provide services on a sliding fee schedule depending on financial ability to pay? So, that is in there. This is the application for exemption. I would imagine the audits follow this fairly closely.

Mr. SHAW. Thank you.

Chairman THOMAS. Thank you, gentlemen. The gentleman from California, Mr. Stark, wish to inquire?

Mr. STARK. Thank you, Mr. Chairman. I heard in passing a previous reference by Mr. Walker, in answer to somebody else's question, that he mentioned in his answer that he thought profit and for-profit hospitals were of equal quality. Mark, you cite your own personal research in your testimony. One could interpret that research—although I gather it was limited in that case to cardiac—that you thought that for-profit and not-for-profit hospitals were the same quality. Now—and I am prejudiced. I just don't think that is so, and I don't think there is any, absolutely any statistics that will support that. But, I know, Mark, that you are intimately familiar with Stanford and Brigham and Women's. Would it surprise you that U.S. News consistently has them in the top dozen hospitals in the country?

Mr. MCCLELLAN. Not at all. Not because of my association there.

Mr. STARK. That is what I thought it was. Can you name one for-profit hospital that—what anybody would rank in the top 10 of anybody's list of——

Mr. MCCLELLAN. Congressman, we don't do rankings.

Mr. STARK. No. No. Your knowledge. We asked Donald Relman this in testimony some years ago in Rhode Island. In response to that question, he said there isn't one premier hospital in the United States that is for-profit. Would you disagree with——

Mr. MCCLELLAN. I think one of the main findings from our research is that there are a lot of hospitals that are very good in terms of quality and in terms of efficiency that are nonprofit, but also some that are for-profit. There is a lot of variation in the quality out there.

Mr. STARK. Name three for-profit hospitals that you think are any good.

Mr. MCCLELLAN. Well, I am not going to name names in my current job.

Mr. STARK. Let us do it this way then. Would it surprise you that HCA, Tenet, Triad, together over 400 hospitals, which is half of the for-profits? Would it surprise you further that HCA has probably been under indictment a dozen times and that Tenet Hospital

killed 167 cardiac patients in Redding, California, and is either under indictment or should be, and the executive of Tenet should be charged with murder?

Mr. MCCLELLAN. I know there are investigations ongoing.

Mr. STARK. Now, and that is not to say that some for-profit hospitals haven't—not-for-profit hospitals haven't snitched a little. University of Pennsylvania, Stanford as a matter of fact got caught overcharging the Federal government. But nonetheless, can you make the case or would you say that you think for-profit hospitals come anywhere close to being in the top tier of hospital quality in the country?

Mr. MCCLELLAN. There are a lot of aspects of quality. For some of the ones that we looked at for the delivery of care to individual patients, they have good or better outcomes——

Mr. STARK. Let me ask you this way——

Mr. MCCLELLAN. —and lower cost.

Mr. STARK. You have a new quality data that you are collecting. In this quality data that you are currently collecting, would we be able to rank hospitals or tell us how many for-profit hospitals will be getting the bonus and how many not-for-profit or are you——

Mr. MCCLELLAN. That is exactly why we are doing more of the quality rating. As you know, putting this information out there is a good way to increase transparency about exactly what we are getting for what we are paying and to help patients and doctors make better choices.

Mr. STARK. Although you went on to MIT and got a Ph.D. and I flunked out, so I will defer to you. What did you learn when you were getting your economics doctorate that would suggest that anything in a for-profit structure in the delivery of medical care improves it?

Mr. MCCLELLAN. Well, just to give you one example, they have been seen in some of these research studies to be more responsive. If the population in an area goes down, they are more likely to close beds faster——

Mr. STARK. Does that improve medical care?

Mr. MCCLELLAN. Well, it reduces cost and it enables the focus——

Mr. STARK. Does reducing cost necessarily provide better quality medical care?

Mr. MCCLELLAN. If they can shift the resources to patients' care that can really make a difference, such as to outpatient care, or to new ways of delivering care.

Mr. STARK. Give me an example of—let us suggest one of the things you learned, I am sure, in your economics study, that for a free market to operate there has to be good information.

Mr. MCCLELLAN. Absolutely.

Mr. STARK. Do you think patients in general have any way that they can as individuals select a hospital? Do patients have any way of knowing, individually, other than reading U.S. News and World Reports?

Mr. MCCLELLAN. Many patients get advice from physicians——

Mr. STARK. Bingo.

Mr. MCCLELLAN. —who are experts in the community.

Mr. STARK. They are the only ones who can decide. Now what about the cost of capital? What did you learn about the cost of capital at MIT? What is the most expensive form of capital?

Mr. MCCLELLAN. I am not quite sure what you are——

Mr. STARK. Well, wouldn't you suggest that equity is the most expensive form of capital for an enterprise?

Mr. MCCLELLAN. Well, it depends on the risks associated with the enterprise. There are a lot of factors that determine the cost of capital.

Mr. STARK. I think you better go back. Would you suggest the cheapest form of capital is, what, for an enterprise? Debt, right?

Mr. MCCLELLAN. Congressman, it depends on the debt, the interest rates that can be obtained. It depends on a lot of specific characteristics of the financing——

Mr. STARK. Mr. Chairman, I know why I flunked out. I didn't have enough vague answers to go through MIT's economic issues.

Chairman THOMAS. The Chair sympathizes with the gentleman from California, because the witness simply won't provide the answer he is looking for, and I understand the difficulty when they don't respond the way you want them to. That is one of the dangers of actually asking questions, and I understand the gentleman's frustration.

Mr. STARK. Well, I would just close and ask Dr. Walker, if you have any information? I know you have done some studies on JACO recently, which we appreciate, but do you have any studies at GAO that would indicate that for-profits hospitals are equal in quality than not-for-profit?

Mr. WALKER. Mr. Stark, we have not done that work. There is nothing in my testimony that would say that, nor is there anything that I have said today that would reflect one way or the other on that issue.

Mr. STARK. Do you have any estimate on—if we did tax hospitals any idea how much revenue we could raise? Do you have any statistics along that line?

Mr. WALKER. I don't. It is something where additional research is needed. I would respectfully suggest it wouldn't just be the issue of the tax exempt status. You would also have to look at the fact that individuals who are able to make contributions to these entities get a tax deduction. There are a variety of issues that would have to be considered.

Mr. STARK. Bingo. Right. I guess it would be, Mr. Everson and I were talking before, foundations could no longer contribute to for-profit, the way NABKC or Robert Wood Johnson could contribute to Harvard or to Stanford to help Dr. McClellan.

Mr. EVERSON. There would be many effects. You have got tax exempt bond offerings, you have got the property taxes. There are a host of effects that if you really want to look at that have broad ramifications.

Mr. STARK. I would just close, Mr. Chairman, and say it would be so easy, I believe, between Joint Tax and GAO, to what, less than 6,000 hospitals, for us to get a compendium, without identifying any particular hospital, and say let us just add it up. I don't think it would take 3 months, honestly, to get some figures in terms of how much debt is out there, and get an idea just in the

aggregate of what we are talking about. I mean we know generally, but I think we could get very specific. I don't know that we could identify the uncompensated care. We could start with a broad database that would help us in future hearings. I would urge the Chair, as a result of these hearings, to see if he wouldn't ask, I would like to join him in requesting that kind of a study if he would. Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman, and the Chair agrees, because notwithstanding the imprecision, a ballpark figure, at least in broad generalities, begins to guide us in terms of where it makes sense to make policy and get a return on that investment. The Chair awaits the next IRS ruling which will redefine health policy as we move forward. The gentleman from California wish to inquire?

Mr. HERGER. Yes. Thank you, Mr. Chairman. Commissioner Everson, could you tell me how many times in the last 10 years the IRS has revoked the tax exempt status of a hospital?

Mr. EVERSON. It is extremely limited, sir, it is fewer than 10 times. It is a true rarity. My understanding is that in general, if we see problems, what we try to do is work them out because, as you can imagine, this is a very serious step that could have real ramifications on a community. As I mentioned at the top in my oral statement, one of the things that we are interested in is getting better intermediary sanctions here so that you don't just have a de minimis penalty or that very strong option. That is something I would ask the Committee to think about as we go forward.

Mr. HERGER. Because of the concern for that revocation of status was a punishment not likely to be used, in 1996, Congress gave the IRS the ability to impose intermediate sanctions on nonprofits. Could you tell me how often have intermediate sanctions been imposed on tax exempt hospitals and for what types of infractions?

Mr. EVERSON. They are being used—I don't think they are particularly common. My understanding, if you look at the compensation issue as an example, what happens is we can impose a 25 percent tax on the individual if the compensation for that officer is deemed to be out of line with commercial practices. That is the tough part of this, making the judgment. Is a hospital director being overpaid vis-a-vis the commercial or other standard? There could be a lot of argument about that, but I would hasten to say there is no impact on the institution. In talking to my people, that may attach to the individual when it is invoked, which is rare, but there is no impact on the organization.

Mr. HERGER. When the IRS testified before this Committee 14 years ago about the standards of hospital tax exemption, the audit rate for nonprofit hospitals was 1.5 percent. What is the rate today? Given IRS resources, is there any prospect that rate will significantly increase?

Mr. EVERSON. That rate is about a third of what it was, and it is about a half a percent, which is a low rate in line with other exempt organizations. If you look at my written testimony, you will see a continuing decline over the years, recent years, in the number of revenue agents, people who do these audits. We are bringing them back now. We have been increasing enforcement more broadly at the IRS during the last several years. The administration has

requested additional funding to do that. I don't think we are doing enough in this area and across exempt organizations. What I indicate at the top is that this year, though, we only got a half a percent increase for the whole budget of the agency. That obviously doesn't even cover inflation. We are making a 20 percent increase in our audit count, number of auditors for exempt organizations, because we think it is such a serious problem.

Mr. HERGER. Thank you very much. Thank you, Mr. Chairman.

Chairman THOMAS. Thank the gentleman. Gentleman from Michigan wish to inquire?

Mr. LEVIN. There is no disagreement about the need to get at abuse. None at all. I will give you my reaction to the hearing so far and to the back and forth between the Chairman and the Ranking Member and Mr. Stark and others. This is an issue that cries out for true collegial, bipartisan discussion, to talk about what the problem is, to talk about how a hearing is shaped, and where we go after that. What has been I think the typical pattern doesn't work for this kind of a problem, and everybody is wondering why we are here. It isn't because we don't care about abuse. We do, very much so. It raises all kinds of reactions. It would be much better if we could sit down, well in advance, and discuss collegially, as I said, in a bipartisan basis, is there a problem, what is it? Where do we go? Let me just ask you quickly. As I understand it, nonprofits, the assets cannot go for private benefit, right? Right?

Mr. EVERSON. Yes, sir.

Mr. LEVIN. Also this emergency requirement applies across the board, right, to all tax exempt hospitals, right?

Mr. EVERSON. It is a factor. As I have indicated, it is a factor in our consideration of the application for exemption, yes, sir.

Mr. LEVIN. For all hospitals, for all not profits?

Mr. EVERSON. For all the hospitals we ask that question. If the answer is no, and I will read you the question. It says——

Mr. LEVIN. Anyway, you ask the question of everybody?

Mr. EVERSON. Yes. Yes, sir.

Mr. LEVIN. They have to say—if they say no——

Mr. EVERSON. If they say no, then we say what other things are you doing that entitles you to an exemption?

Mr. LEVIN. Okay. Let me just talk to you about oversight, because I am deeply concerned with your answer so far. You talk about the number of returns that are audited. I take it they are the 990 returns?

Mr. EVERSON. Yes, sir.

Mr. LEVIN. As I understand it in terms of oversight you have mainly been looking when there is an abuse, a tax shelter, something like that. How much oversight have you been doing all these years as to whether nonprofits are undertaking community work? How much of that has there been by the IRS?

Mr. EVERSON. I don't think there has been enough.

Mr. LEVIN. When has there been?

Mr. EVERSON. The rate of inquiry has declined steadily over the years, and we are now starting to bring that back.

Mr. LEVIN. The rate of inquiry as to the nature of the activities or as to tax shelters or compensation?

Mr. EVERSON. It is the combination of factors. We would address this issue that you are raising in an audit, or in the front end process of the exemption application. We get about a hundred applications each year from hospitals for exemption.

Mr. LEVIN. That is new. I would like you to send to us within the rules of, the appropriate rules, an indication as to the last 10 years what inquiry there has been that relates to the basic activities of nonprofits and profits, not just the issue of tax shelters, you know, kind of the typical IRS stuff, but relating to this basic issue as to whether nonprofits have been pursuing their purpose. I would like you to send that, because my guess is we are going to find that there has been a huge, huge gap, and so all we are doing here is conjecturing and everything is ad hoc, is anecdotal at best. For example, is any major nonprofit hospital—have you found any major nonprofit that was overcompensating their executives?

Mr. EVERSON. I believe we have. I think we have revoked the exemptions in one or two instances. Some of them are actually in court now.

Mr. LEVIN. So, it has been one or two, and I would like to know which ones, because it is so easy to take out after hospitals, after the nonprofits. I don't think we really know what we are talking about, to put it in simple English. I think your testimony and your warning to us about where we go from here and being careful about unintended consequences is so cogent. So, I would hope, Mr. Chairman, Mr. Stark threw out a suggestion to you that we now go back and sit down and talk about what is the problem, how do we get all the data, which we don't have, and where do we go from here? Thank you.

Chairman THOMAS. The Chair appreciates any and all assistance in trying to begin to look at this in a disciplined way. The Chair would be very anxious to see—as that information that the gentleman from Michigan requested, the Chair would be curious that in creating the specific revenue rulings and the modification of those revenue rulings to what extent you reached out to health care experts inside the government, or not, in redefining those particular rules to make sure that they were in fact health care oriented and addressed the changing nature of health care delivery vis-a-vis statutes and competition. The gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman. As to why we are having this hearing, it should be obvious why we are having this hearing. We are beginning the examination of tax exempt entities. Today's hearing is on hospitals, which do represent the largest segment of tax exempt entities. As far as I know, there is no bill that has been filed by anyone in Congress to revoke the tax exempt status of hospitals. I certainly don't have that intention sitting here today, and I don't know of anyone on this Committee, including the Chairman of the full Committee, that has that intention. I do I think it is incumbent upon this Committee, it is our obligation, to occasionally review tax exempt entities, tax breaks of all sorts that we give to see if the original rationale for giving those tax breaks still exists. That is the purpose of this hearing. Should we have more? Perhaps. Should we gather more data? Probably. That doesn't mean we shouldn't be having this hearing today. So, I am

glad we are having the hearing. I really appreciate this first panel and the expertise that you bring, and I also want to thank each of you for agreeing to serve the public. You are each outstanding individuals in terms of your background, your education, and for you to offer yourselves for public service is a testament to the greatness of this country. So, thank you. One thing that I am curious about is this bad debt and uncompensated care, and any of you may wish to address this. What is the difference between uncompensated care and bad debt? Or are they the same in most instances? Or is there any difference? Dr. McClellan.

Mr. MCCLELLAN. Congressman, the hospitals may set policies to provide care for indigent patients for whom they know they are not going to be compensated. We would encourage hospitals to have a written policy and base it on characteristics of the patients that are associated with just not being able to pay the bills. That is where uncompensated care should be targeted. In addition to that, hospitals may also fail to collect payments from patients who probably should have the ability to pay the co-pays or the deductibles or who are wealthy enough and don't have insurance to pay maybe even the whole cost of their care. That is the bad debt. In our Medicare policies, we try to make sure that we are not doing anything to stand in the way of offering discounts to patients who need it, the indigent patients, and at the same time are helping to support the regular business practices that hospitals would use to collect on their bad debt paying. So, it is the difference between patients who can pay but don't and patients who cannot pay and who need indigent help who receive truly uncompensated care.

Chairman THOMAS. Gentleman yield briefly on that? You might leave the impression that in fact when a person in a bed in a hospital fits that poverty structure on uncompensated care, that a hospital would get the payment because of who is in the bed. We know that is not true, correct? The money goes out even though the person in the bed doesn't match the profile for which the money is being given?

Mr. MCCLELLAN. Right. The additional payments that we do provide are based on formulas. The hospitals can report on bad debt that they try to collect but don't collect on Medicare beneficiaries and we will pay that. We pay over a billion dollars——

Chairman THOMAS. The only point I wanted to establish was uncompensated care is supposed to pay for people in bed. There are some hospitals who don't get uncompensated care, even though they have those people in the beds. There are hospitals who get that payment who don't have those people in the beds. But that is another story.

Mr. MCCRERY. Commissioner Walker, I will let you answerin a second. The DSH payments that Medicare and Medicaid pay, are those related to uncompensated care, in any way? Dr. McClellan?

Mr. MCCLELLAN. For Medicare DSH payments are related to the share of Medicare only patients that a hospital treats and the share of SSI patients, and the idea is that that is related to the burden of uncompensated care, as well as higher costs that low income patients who do have coverage may have, but it is not, as the Chairman said, directly related to the uncompensated care that is actually provided, and it is not compensated from other sources.

Mr. MCCRERY. In those two policies, DSH and bad debt reimbursement, the government is in some way trying to compensate hospitals for providing care to the indigent?

Mr. MCCLELLAN. That is certainly at least part of the goal. Again, there may also be some cost differences for these lower income patients who are covered by Medicare or Medicaid. As the Chairman said, the formulas aren't directly based on the uncompensated care provided. It is based on these other measures that may be related to uncompensated care.

Mr. MCCRERY. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you, gentlemen. Prior to calling on the gentleman from Maryland, it is indicated that it isn't absolutely essential that Dr. McClellan be at the witness table, and I know that you have been beckoned based upon your fundamental responsibilities back to the White House for some meetings. So, the Committee wants to thank you. This is probably a good time to bow out because I don't want anyone to think that I asked you to leave because the gentleman from Maryland is just beginning.

Mr. CARDIN. I don't want to give you an impression that we didn't think that you were a very important witness.

Mr. MCCLELLAN. No offense taken. Thank you very much.

Chairman THOMAS. Bye. Gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman, and I thank you for this hearing, I found the testimony to be very, very helpful. Mr. Walker, you raised a point that I think we need to explore more in reviewing this subject, and that is that as we look at the revenue that is affected by the direct status of a not-for-profit hospital, that that might be a very small part of the overall revenue impact if we were to remove the tax preference status. You raised the issue of contributions that are made, and being tax preferenced. We also have the State and local government revenue impact, and I would at least put on the table in another part of this, and that is that not-for-profit hospitals have generally community support. That community support comes in different ways. If it is a church affiliated hospital, it might be one way. If it is a hospital that is in a particular community and it is the only hospital that they have, it might be in a different way, and it may affect the type of support it has to carry out the mission related to the community itself.

I am just wondering, you know, a not-for-profit hospital does not have stockholders, it is the profits, to the extent that they have profits, are put back into the hospital. As you pointed out, they are not big profits that are being made, whereas for-profit hospital it is more driven toward the economics of the issue. So, I am just wondering whether we have any information as to what impact we need to take a look at if we removed the tax preference status as it relates to the support from the community and the impact on State and local government, not just the direct revenues to the Federal treasury.

Mr. WALKER. Mr. Cardin, first I would say that I think this is a legitimate subject to be examining. I would also agree that more data is necessary in order to be able to get a fuller picture of this particular sector and what the potential implications are. If this Committee and the Congress decided that you wanted to revisit

what criteria should be considered by the IRS in granting tax exempt status, what factors should be used to evaluate not-for-profit hospitals, and what factors should be considered in monitoring and periodically reporting back to the Congress on them, we can help. We do need more data. I think this is a perfect example of a major segment of the Tax Code where more clarity is needed, where more data is needed, and where more in oversight is needed.

Mr. CARDIN. Mr. Everson, in my community I have a lot of faith-based hospitals that have direct relationships with different religions. If the 501 status of the hospital was removed, would it affect the ability of the charitable institution to provide direct support to the hospital?

Mr. EVERSON. I think that is a question that the Congress would have to address. There are contributions that are made to States, people give moneys to States, they donate park lands or other things all the time that don't necessarily—they aren't precluded from doing so because of questions of tax exemption or issues I think. So, I think you can address that up here. I don't think it is something we would address.

Mr. CARDIN. Under current law, if it is a 501 organization, would it be permitted to provide direct assistance to a hospital that was not tax preferenced, not a 501 organization, and still be able to maintain its status as a 501 organization?

Mr. EVERSON. The prohibitions in that area are not from helping. It is from political, direct political intervention or lobbying. I will just ask my colleague. There is nothing that would preclude that, no. The prohibitions you have written into law are more in this area, the political world, and I don't think this would be interpreted as a political world.

Mr. CARDIN. One last question. Many of these hospitals have foundations or have endowments. Would there be any additional challenges if the tax status was different as it relates to these endowments?

Mr. EVERSON. I think you would have to sort through that. I think there may very well be.

Mr. CARDIN. I thank you. Mr. Chairman.

Chairman THOMAS. Gentlemen yield briefly before his time expires. This is related to a point that I believe Mr. Everson tried to bring up earlier, and perhaps some people aren't aware, in terms of various organizations, type 1, type 2, and type 3, and the ones that we are most interested in focusing on are the type 3 supporting organizations that don't have to have any affiliation with the particular entity, and in fact don't even require the permission of the entity to contribute to it and list it as one of the factors that they contribute to. This area has exploded in the last few years. We are going to have to look at what we mean by type 1, type 2, and especially type 3, and the relationships to what would otherwise be 501(c)(3)s and other activities, private foundations vis-a-vis charitable structures. This is all an area that is overdue for us to examine in some detail, and as we do that you will begin to see the cross ripple effect between the points that you are making and the structures that are growing very rapidly, and we are going to do that. The gentleman from Michigan wish to inquire?

Mr. CAMP. I do. Thank you, Mr. Chairman. Thank you for your testimony today. I certainly understand why we are having this hearing, and I do want to say that I think it is appropriate that we look at the tax exempt nature of hospitals. I do want to say that I have obviously heard from many hospitals in Michigan. In my district we only have not-for-profit hospitals in our State, and obviously they are very concerned about continuing the tax exempt policy for hospitals. I have a large rural district, and just the fact that they are there is a challenge, and to keep hospitals providing health care in rural communities is critical. I want to get back to this idea of uncompensated care and the lack of data. Dr. McClellan said that they really don't have the information to make the kinds of comparisons that we need to make to answer the questions raised by today's hearing, and yet they are mandated to make certain payments to hospitals in recognition of that care. I just wondered if you had any ideas, either of you, on how we might get a better handle on that issue. I know I hear from my hospitals that that is a growing item in terms of, you know, the challenges that they face, and I wondered if we can somehow standardize that or get better information on that. If you would any thoughts, please.

Mr. WALKER. Mr. Camp, my understanding is that Mr. McClellan may have been talking about the quality data. But with regard to the cost data, let me explain briefly what we did, which directly relates to your question, and Mr. McCrery's question. You need to try to have a standard definition in order to be able to have comparability. The definition that we use for compensated care was a sum of a hospital's charity care and bad debt costs as it related to the cost of providing the services, not what was actually billed. That is my understanding. The definition that we used is consistent with what the AHA uses, as well as the Federation of American Hospitals. It is generally agreed that it is better to do it that way, in part for the reason that Mr. Shaw mentioned before, namely that the billing rates vary dramatically and, ironically, sometimes people who are uninsured get billed a lot more money than people who are insured because they are not covered by a preferred provider arrangement or some type of managed care arrangement where there has been some type of negotiated cost. So, I think, at least as it relates to uncompensated care, I think the approach that we have used in reporting today in our testimony is pretty generally accepted and reasonable. The question is where do we not have enough data? We don't have enough data on quality. We don't have enough data on tax expenditures and tax benefits, and these are areas where I think we need more data.

Mr. CAMP. Any quick comment?

Mr. EVERSON. I don't have any particular observation on this, sir.

Mr. CAMP. The other comment that he made was that, you know, it is really not ownership, and this is on the performance or quality side. It really isn't the type of ownership that determines hospital performance, but it is really other hospital specific factors. Is that something that you would agree with, Mr. Walker?

Mr. WALKER. Well, I would say that there are a number of factors, but one of the things you have to keep in mind is to the extent that you are a for-profit entity, your governance model and your ac-

countability mechanisms are likely to be a lot more stringent and rigorous than otherwise might be the case if you are a not-for-profit entity for a variety of reasons.

Mr. CAMP. I am just referring—and I mentioned briefly the geography aspect of it. It seems to me a lot of this depends on where the hospital is and what sort of patient population they are serving, much more than the structure that they are organized under. I just wanted your thoughts on that.

Mr. WALKER. Absolutely. Some of the things that Mrs. Johnson said before I would wholeheartedly agree with. The fact of the matter is where is the facility? What type of services is it providing? To whom is it providing it? I think there are a variety of factors that are legitimate to be considered in determining whether or not a not-for-profit status or tax-favored status should be conferred. I would expect that a vast majority of the entities out there probably meet whatever criteria you come up with. However, the mere absence of clearly defined criteria means you can't consistently apply it, which by definition means that you also can't hold people accountable over time.

Mr. CAMP. All right. Thank you very much. Thank you, Mr. Chairman.

Chairman THOMAS. Thank the gentleman. Gentlemen from Washington wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman. As I listened to this discussion, I keep coming away with a fundamental question. I have a hospital in my district that takes care of 26 percent of the charity care in the whole State. They get about 4 percent of the money that is put out there through the various methods that we use to distribute it. My question is, does it make sense, or can you see, I would like to hear your idea about how to change our present disproportionate share legislation and whatever that would make it possible for this hospital to receive what it really ought to get, which is a much larger share, of the money that comes out to the State for the fact that it is the only place that is really doing any significant amount of charity care.

Chairman THOMAS. Gentleman yield briefly, and I apologize because Dr. McClellan had to go back to the White House, and although these gentlemen are certainly free to respond to that question it sounds to me like it is one that is right down the middle for Dr. McClellan. Let us see what these guys do.

Mr. EVERSON. I would just say, the Chairman already told me I was making health policy. I don't totally agree with him. If I go this way, I certainly will be. So, I don't want to get in more trouble with the Chair by answering that question.

Mr. MCDERMOTT. You won't be in trouble with me though.

Chairman THOMAS. The gentleman is free to choose.

Mr. EVERSON. I will stand down and leave it to Mr. Walker.

Mr. WALKER. I am a prudent individual, Mr. McDermott. I think I will pass on that one.

Chairman THOMAS. Gentlemen yield briefly, because the Chair is interested in pursuing exactly the concern the gentleman has, and what was brought up during conversation by the gentleman from Louisiana to Dr. McClellan was the point that uncompensated care is currently paid on a formula basis and does not necessarily

go to those hospitals who have the people for which uncompensated care was designed for in their beds. The Chair is interested and to the maximum extent possible paying for the people who are supposed to be paid for based upon the criteria for which the money is offered.

Mr. MCDERMOTT. Thank you. Now, the next question I have in my mind is let us suppose we decide we are going to save some money and take away this tax exemption for everybody but those hospitals that are giving charity care, any not-for-profit hospital or anybody else. What impact would there be in the health care system?

Mr. WALKER. Well, first it is almost impossible, Mr. McDermott, to be able to say what the impact would be because without knowing what criteria would be used to determine which entities would continue to receive tax favored status, which I would respectfully suggest would probably be a vast majority of the current ones, including the one that you gave as an example, it is virtually impossible to say what the impact would be because you don't know who would be affected and the related magnitude. I think this is a perfect example of what something Mr. Stark said before, and others, we need some more data in this area in order to be able to make a more informed judgment on that.

Mr. MCDERMOTT. You are suggesting that Murphy's law may be around the corner if we wade into this too quickly, the law of unintended consequences?

Mr. WALKER. I think this is a perfectly legitimate area for you to be concerned with, because it is illustrative of the need to reexamine tax preferences, spending programs, et cetera, that have been put into place many years ago, especially in light of our current and future fiscal challenges. You need to have solid data in order to be able to make informed decisions. We gave you some today on uncompensated care. I would respectfully suggest you probably need some more.

Mr. MCDERMOTT. It would probably not surprise the Chairman that I would suggest that the only answer here is a universal health care system, that as long as we try and figure out who has the hot potato today and who do we pay for the hot potato and what, who will shift the hot potato to somebody else, we are going to wind up doing this endlessly because this situation of trying to get hospitals to do charity care has been going in the wrong direction for the last—at least as long as I have been involved in it, since the 1970s, when hospitals are closing emergency rooms. There was a time in Seattle, in the State of Washington, when if you were hit in an automobile accident 50 miles from Seattle, you had to wait for a police helicopter to lift you to Seattle because that was the only emergency room that would take those kinds of cases. Now that is the situation in at least one State, and I think that that is going on everywhere. Everybody is trying to get rid of those people who don't bring in money. As long as their basic motivation is how to keep their bottom line because they are not being adequately provided for because of the health care financing system in this country, it seems to me we are never going to solve the problem with the Tax Code.

Mr. MCDERMOTT. The Tax Code will not be the way we solve it. We will solve it when we have a universal health care system in this country.

Chairman THOMAS. Thank the gentleman. The gentleman from Georgia, Mr. Lewis, wish to inquire?

Mr. LEWIS OF GEORGIA. Thank you very much, Mr. Chairman. Let me thank members of the panel for being here today. Commissioner Everson, good to see you here again. I would like to know from you, have you had an opportunity in recent weeks or months, maybe you know something about the history of this, to revoke the tax exemption of any religious institution, churches, mosques, synagogues?

Mr. EVERSON. I am unaware of any we have done in recent months. We can't talk about a specific matter, but I am not sure—revocation is a rare event. As I indicated earlier, what we try to do is work with organizations to cure what we see is a defect, and that would be a rather extreme step. What I said in the testimony, what I would hope the Committee would consider is to give us better tools in the middle where we can hold an organization or its officers accountable in a way we can provoke meaningful change in the public interest because sometimes taking that step as you mentioned can be quite draconian. We are talking about hospitals today, but if you have one hospital serving a broad community, it would be a big step and the same thing would be true for other organizations you are talking about.

Mr. LEWIS OF GEORGIA. As a rule, how do you go about getting the information, data? Do you read something in the newspaper, hear something on television or see something on television or hear something on radio or do you field staff people to go out and conduct investigations?

Mr. EVERSON. There are a variety of means by which we conduct our examinations or make an inquiry. Some of it comes through information, if you are looking at say hospitals, on returns that are filed. Other information comes from allegations that are made, letters we receive or calls that we will receive. If you refer back to last summer when we talked about political intervention and that issue became quite vigorously discussed, we had leads or concerns that were written in to us and what we did was refer those to a group of career folks within the tax exempt and governmental entities unit. They assessed these and determined whether they thought they were credible or not. If they were credible, we would get in touch with the organization. There might be a written inquiry for which there would be some answers coming back, and there could be a full blown audit in some cases.

Mr. LEWIS OF GEORGIA. I know you don't want to talk about a particular case, but just a few weeks or months ago, there was a church in North Carolina where apparently the minister suggested that if people were inclined to vote in a certain direction in a particular way, maybe they should leave the church, and apparently, a group of them did leave. Anything happen or you want to say anything about that?

Mr. EVERSON. Congressman, I would not answer, and I am precluded from answering on a particular case. The law here is clear. The organization, be it a church or charity, can't be advocating for

or against a particular political candidate. Nothing wrong with talking about policy positions, but when you cross that line and you are starting to talk about a particular candidate, that is when the problems occur.

Mr. LEWIS OF GEORGIA. Can some minister stand up and say, like, God told me that a certain person shouldn't be elected? You don't try to get between the minister and God, do you?

Mr. EVERSON. I don't ever try to get between a minister and God. We are concerned if anybody who has that exempt status is advocating for or against a particular candidate; that is the law that they can't do that. So, if we have credible information that someone is doing that, we will follow up and introduce the appropriate inquiry.

Mr. LEWIS OF GEORGIA. Maybe the two of you can respond, what effect would eliminating the tax-exempt status of health care providers have on access to service for the uninsured or the underinsured?

Mr. WALKER. I think if you eliminate it across the board, it clearly would have an adverse effect. I don't think anybody here is suggesting doing that. I think what is being talked about is, what should the criteria be in determining when tax preferred status would be given—and after the criteria have been determined and properly administered, then what type of reporting mechanisms would be in place to try to make sure in fact that people are doing what they are supposed to be doing in order to maintain their tax-exempt status. Clearly, it would have a significant adverse effect if it was across the board. I don't think anybody is talking about that.

Mr. LEWIS OF GEORGIA. Mr. Chairman, I know my time is up if I could have 15 seconds?

Chairman THOMAS. Certainly.

Mr. LEWIS OF GEORGIA. Thank you, Mr. Chairman. When you look at many of these religious-based health providers, you could call names like St. Jude in Montgomery or Holy Family in Atlanta, Good Samaritan in Selma, in a certain region in the country, only service that African-Americans and minorities could receive. It was from these tax-exempt church-based health providers who many others discriminated against. If it hadn't been for St. Jude in Montgomery, Good Samaritan in Selma and others, I don't know where a whole segment of the population would be. You should keep that history and legacy in mind.

Mr. EVERSON. I appreciate that sentiment, sir. I want to say to you that no one has said to me that problems within this sector have anything to do with the religious-sponsored groups as a particular element. That is not a concern that has ever been raised to me.

Mr. LEWIS OF GEORGIA. Thank you, Mr. Chairman.

Chairman THOMAS. Gentleman from Pennsylvania, Mr. English, wish to inquire?

Mr. ENGLISH. Thank you, Mr. Chairman, I do. Mr. Everson, much of what we heard today hinges on the changes made in 1969 to eliminate the charity care standard in favor of the community benefit standard. Since 1969, other regulatory changes have been made to this standard, as I understand it, including a change in

1983. Based on activities of tax-exempt hospitals over recent years, do you feel that the basis for which the 1969 standard was established still as a practical matter serves its original purpose? In your view, are there additional regulatory updates that the IRS could make that reflect the dynamic nature of modern health systems?

Mr. EVERSON. This may get me back cross-wise with the Chairman. I think that, based on the law as it exists today, we are comfortable with that community benefit standard, because it enables us to inquire about charity care, but it also enables us to consider compensating issues about whether there may be a research facility or some other charitable purpose. It is analogous to saying, does an educational institution have a history department or a chemistry department? We don't pick between the two based on the general guidance that you give us. I do agree though that what we do rule on is whether there has been an impact on practices. If you revisit that, we will of course move forward in a different way.

Mr. ENGLISH. Seeing how the IRS clearly takes a case-by-case approach when examining whether a hospital falls under tax-exempt status or not, I realize it is difficult for you to provide an exhaustive list of factors that you look at when making a determination, but are there certain factors that would serve as an immediate red flag, and if so, what would some of those factors be?

Mr. EVERSON. I would suggest to you what we have seen here in these five general factors we have mentioned, is a convergence in areas like profits and non-profits. Both have open participation by community doctors and operate the same way regarding emergency rooms and billing. Where we have the divergence between the two is who is controlling them. Is this community board real? Or if they have a relationship with a joint venture, is the joint venture, the profit-making entity really calling the shots? That is the thing of concern to us, and also, what is happening to the money? Is the money being put back into equipment or funding the facility or new types of care or in some way going to the benefit of the directors of the hospital or maybe the doctors or whatever it would be? It is more about control. As the Comptroller General mentioned, the governance structure is a big piece of that and what is happening to the money.

Mr. ENGLISH. Mr. Walker, early in your testimony, you note that tax-exempt hospitals as charitable organizations are able to receive other financial contributions such as donations. In your closing observations, you note that a small number of non-profit hospitals accounted for substantially more of the uncompensated care burden than did others. Did you examine and can you comment on whether urban or teaching non-profit hospitals receive more income from other sources, such as donations than hospitals not accounting for the substantially higher burden of uncompensated care?

Mr. WALKER. Mr. English, with regard to the work we did for the Committee, I do not believe that we got down to that level of detail. I would be happy to go back and take a look, however. While we didn't specifically look at it by teaching hospital or by geographic area, those are factors that you would want to consider in whatever criteria you may come up with as well as such things as

whether or not public research might be conducted by these facilities as well.

Mr. ENGLISH. Thank you very much. Thank you, Mr. Chairman.

Chairman THOMAS. Thank the gentleman. The gentleman from Massachusetts wish to inquire?

Mr. NEAL. I do. Thank you, Mr. Chairman. Open this up to either of the panelists. First, I would point out that virtually all of us on this Committee as is the case with Members of Congress—and it is really pronounced in a place like Massachusetts. Hospitals are by far the biggest employers now. They give you your reputation. They entice people to live there that tend to demand good services, and in turn, they support the orchestra and the arts and libraries and museums. So, it is a great spinoff that comes from the role that hospitals play. I think one would argue, again, not only is it first-rate health care, but they drive much of our economic progress across certainly in New England in the northeast. Let me be a bit more specific. I also think you could argue that, or I certainly could argue in my constituency, most of those hospitals really are not operating on a generous margin. If these institutions were forced to relinquish their tax-exempt status and forced to pay corporate taxes, State and local taxes and even property taxes, I can assure you, most of them really would go under. Would you both share that view?

Mr. EVERSON. Dave wants me to go first here. There would be broad ramifications across a number of fronts as you so indicate. If you just lifted this entirely, of course, there would be broad ramifications. If you look for the not-for-profit health care sector, the assets that are reported this year are about $500 billion. That is the same number as the gross receipts. That gives you the scale of the whole sector. You would be talking about very significant ramifications generally, but when you get into a particular community, they could be quite pronounced, yes, sir.

Mr. NEAL. Mr. Walker?

Mr. WALKER. Obviously, the loss of tax-exempt status would have serious potential adverse effects. I don't think anybody is talking about doing away with tax-exempt hospitals. The question is that, over time, we have seen that there has not been much of a difference in certain areas between for-profit and not-for-profit hospitals. Therefore, what should the criteria be for conferring that status and how can we make sure people are meeting that criteria over time?

Mr. NEAL. I will ask you an obvious question: If these hospitals were required suddenly to pay taxes, what would they do to come up with the additional revenue? Raise health care prices? Cut uncompensated care? Scale back community health programs? In some cases, stop providing unprofitable services? The emergency room in a big city is something that we all ought to have a chance to see what happens there on a Friday or a Saturday night. The truth is, I know, again speaking to my constituency, nobody is turned away. It might not be the best health care system, but no one is turned away. The options that I have outlined really strike me as the alternative if we are to move down the road, if we are to make any dramatic changes in their status. Last, are you aware

of any good quality studies in the range of possible consequences if the tax-exempt status were revoked?

Mr. EVERSON. I am not aware of any studies that address the sector as a whole, no, sir. There may be some, but I haven't seen them. If we have them, I will get them to you.

Mr. NEAL. Mr. Walker, are you aware of any?

Mr. WALKER. I am not. I think the issue is not whether or not there should be not-for-profit hospitals; clearly, there should be. The question is, based on what criteria and how do we evaluate whether or not people are meeting those criteria over time?

Mr. NEAL. Do either of you favor a specific standard that would determine what charity care is or what the percentage would be?

Mr. WALKER. I personally believe that the Congress needs to provide additional guidance above and beyond what it has done so far. At the same point in time, I don't think it should get into micro-management.

Mr. NEAL. Congress and micro-management?

Mr. WALKER. It can happen. but there is a sensible center. Specifically, providing some criteria that IRS must consider, thereby providing the IRS the ability to provide reasonable flexibility and to recognize changes that occur over time. There is the requirement to make sure that there are performance data that people have to report back on such that you, the Congress, can oversee this area as an important area of interest to the public.

Mr. NEAL. Last, the role the teaching hospitals play in the economy across the northeast, it is astounding.

Mr. WALKER. That would be one of the factors I would suggest you would want to consider, whether or not it is a teaching hospital. There are a number of legitimate factors, I think, you would want to consider.

Mr. NEAL. Thank the Chairman.

Chairman THOMAS. Thank the gentleman. I would tell you, no matter how imperfect our effort will be, I think it is going to be a whole lot healthier saying we are trying to make health policy rather than making IRS rulings and pretending it is not. Gentleman from California, Mr. Becerra wish to inquire.

Mr. BECERRA. Thank you, Mr. Chairman. Thank you for being here. Let me ask a general question before I get into specifics. Under any comprehensive examination of the tax treatment of health care providers, would the IRS and GAO ultimately limit their audits to a particular type of health care provider? Today's hearing focuses on charity hospitals. Or would you ultimately by force end up having to review the tax treatment and the tax consequences that apply to for-profit hospitals, specialty hospitals, the various professions in health care? Because somewhere, they all touch the Tax Code, whether it is because they get certain benefits in tax deductions or tax credits. Just about any health care provider, whether it is a facility, an institution or individual has the Tax Code implicated in its or his or her work.

Mr. EVERSON. We do look across all the sectors. The IRS is organized now into four business units: One is for large and mid-sized corporations. One is small businesses, self-employed individuals. One is for bread-and-butter wage earners. The last is tax-exempt and governmental entities. What happens here is you have

seen some concentration. The Shriners, that is a big outfit. That is going to have one set of issues. If you are looking at a small hospital in New Mexico, it has revenues of $143 million. That is a different kind of audit obviously. If you are looking at an audit of a hospital that has, or charitable organization that has, these joint ventures with profit-making firms, then we will get involved. If we see a problem potentially, we will ask our people who are in that large and mid-sized business unit to look at the profit-making side of it. It all does relate, and we try to follow the string of transactions.

Mr. BECERRA. Any examination of the health care industry, it would seem that you would end up not completing the task of examining how the industry should be treated under the Tax Code if you examine only the non-profits and charity hospitals. You have all sorts of hospitals out there. You have all sorts of facilities, clinics, all sorts of professions and all these individuals or entities take advantage of or fall within certain provisions of the Tax Code. I would imagine if you are going to come and report to us, you may see a need for some change with regard to the treatment of a charity hospital. At some point, someone, whether within your shop or our shop is going to ask, did you look at what has gone on with for-profit hospitals? We have heard about some scandals, maybe abuse of the Tax Code. Have you looked at how specialty hospitals are now beginning to form and operate? Are you looking at how associations of professional doctors, medical providers are doing work under their association? Chances are you will have to report to us on all of these things if we are going to examine all of these things regarding the Tax Code.

Mr. EVERSON. I think you have to look at a series of related pieces. Some of that inquiry could be informed by things that the IRS knows, but there are many other institutions, GAO and other pieces of HHS, which certainly you would want to have as a piece of a really truly comprehensive look.

Mr. WALKER. Congressman, obviously, there are a lot of aspects of the Tax Code that affect not only not-for-profit entities, but for-profit entities. For example, today, we are talking about hospitals. My understanding is the focus today is whether or not, and if so, on what basis one would confer tax-exempt status to hospitals as compared to for-profit hospitals. That is what we are focusing on today. Ultimately, in looking at audit-type work, whether it is GAO audit work or IRS audit work, it seems to me you don't want anybody to be off the table. At the same point in time, you have to recognize you have a limited amount of resources and therefore you have to allocate those audit resources to areas based upon risk; where do you think there is the greatest risk or opportunity for abuse?

Mr. BECERRA. Let me go to that point. My understanding is that we have calculations. I think both of you have worked on this or your shops have worked on this, where we have some $300 to $350 billion of uncollected taxes on an annual basis. We find that a lot of these taxes, we know the sources. It is typically a small business that fails to fully report, underreports for whatever reason. Is there room for us to do more there to give you the resources to go after those who are underreporting or not reporting whatso-

ever and really collect some dollars before we start going after charity hospitals?

Mr. EVERSON. We recently updated our research on a big portion of the tax gap to which you refer. The gross tax gap is estimated to be between $312 and $353 billion, and we get back, through late payments or enforcement actions, some $55 billion or more of this. That leaves a net tax gap of over a quarter trillion a year. It is—80 percent of this is underreporting; 10 percent of it is by people who don't even file. Another 10 percent is people who admit to how much they owe, they just don't have the money and don't pay. The biggest piece of this is, as you indicated, in business income for people who are self-employed or smaller businesses. We are trying to do more there. We asked for more money, and we are working on the enforcement procedures. It is a priority within the administration. I think the Congress is very clearly interested in this. As I mentioned our four enforcement priorities, they all intertwine to make some progress on this.

Chairman THOMAS. Thank the gentleman. The gentleman from Wisconsin wish to inquire?

Mr. RYAN. I do, Mr. Chairman. Most of the questions I want to ask have already been asked and answered so I want to go outside the box and ask a broader question. First, let me say, I am a little puzzled at the reaction to this hearing. This is what we are supposed to be doing, we are supposed to be reviewing the Tax Code and conducting oversight on taxpayer dollars, and this is us just doing our jobs. I am a little puzzled that that is the reaction by some in this hearing. We called the part of the Tax Code where exemptions or deductions occur tax expenditures. It is a notion that I personally am not a big fan of the concept of. We expend the tax dollars back to individuals or entities based on reducing their taxes. So, we need to get a better handle of what the value or the number of this tax expenditure is. But since most of this hearing has been talking about uncompensated care, a lot of us work on this issue. Mr. McDermott, who left, talked about if we could fix all of these problems with universal health care. Mr. Cantor, Mr. Hayworth and Mr. Johnson and I recently introduced legislation to expand health savings accounts, make high-deductible health plans deductible for individuals, a refundable income tax credit for the uninsured, a tax credit for small businesses to provide care for their employees, basically virtually wiping out the uninsured of this country through the use of tax credits, a tax expenditure. The score of our bill is $125 billion over 10 years. Gleaning numbers from what I have seen from Mr. Walker's testimony and Dr. McClellan's testimony, having said I know these numbers are inaccurate. We know we have to do a better job of analyzing those numbers. Using those numbers, you could pay for this policy twice over and wipe out the uninsured problem through tax expenditure policies directly aimed at the patient, the person, the uninsured individual. Since we have so many problems with uncompensated care, people coming into the emergency room without health insurance, they are not doing preventive medicine. They are not doing disease management and don't have health insurance. Have there been any studies or analysis—and, Mr. Walker, maybe this is a question for you—has anybody analyzed the cost benefit that would

be gleaned from addressing directly the uninsured issue, and what kind of benefit that would provide to the hospitals through the uncompensated care area? Has there been any kind of analysis done comparing or contrasting? Would our dollars would be better placed in providing insurance to the uninsured, and what would that effect place upon hospitals who use this current tax expenditure to meet that need? Would the country be better off and save more money for the taxpayer by directly aiming these resources at that uninsured individual?

Mr. WALKER. Mr. Ryan, I am not aware of any study that has been done focused solely on that issue. I think what you are raising is a much broader question. The issue you are raising is the need to ultimately reexamine our entire health care system. As you properly point out, we have a lot of tax preferences out there that are not free. I mean, there is a cost associated with tax preferences, namely foregone revenues. We need to understand why we are giving it, and who benefits from it. I would respectfully suggest one of the areas that is fundamentally in need of reexamination as far as tax preferences is health care. It is number one. It is the fastest growing. It is out of control, but again, that may be another hearing.

Mr. RYAN. I thank you, and I didn't think—this is something we should do a study on this. I don't know if it would be easy to do. This is what we are supposed to do on this Committee. We are supposed to ask these questions and think outside the box. We are supposed to see if we are serving our constituents in the best possible way in protecting taxpayer dollars. It is these kinds of questions we are trying to get answers to try and acknowledge that the status quo is not sacred. We have to think about how best to achieve these goals that prior policies were designed to achieve, especially in light of the fact that those goals are not now currently being met. That is basically—I know it is more of a speech than a question. I just appreciate the witnesses. Thank you.

Mr. WALKER. Can I, Mr. Chairman, in his 25 seconds? Number one, not only is the current policy unacceptable, it is unsustainable. There is a fundamental need to reexamine the base of government, both on the spending side as well as the tax side.

Mr. EVERSON. Mr. Chairman, if I could add one point, I do welcome the inquiry on charities, because as you go into tax reform, you have to draw the right line. It doesn't get discussed a lot, but it is an important point because of the size of that sector of the economy.

Chairman THOMAS. We happen to think making health care policy belongs to us. Gentlewoman from Pennsylvania wish to inquire?

Ms. HART. Briefly, Mr. Chairman. I have been listening to a lot of the questions, and I do understand the gentleman's concern about the tone, but I have a tendency to be concerned that we not lose sight of some of the hospitals that I think would close if we didn't offer the opportunity for them to run as non-profits. I have a district full of tiny little hospitals in tiny little communities. They are not making a profit. They are not—they are barely surviving. Some of them have merged, but not for big profit coming in and setting up a deal with them. I guess my question is probably most-

ly for Mr. Everson; do you think we should further define some of the requirements or some of the expectations that we have of these not-for-profits? Is that one way we can help sort of alleviate some of the concerns that some of my colleagues have had?

Mr. EVERSON. Well, I agree with what the Comptroller general has said, and I support entirely, again, this avenue of inquiry, because it is so important within this sector. I simply suggest that we move as a nation very carefully in this sector, because it is rapidly changing and growing. We have a problem in the Tax Code generally where there is always a temptation to write another bright line into the law. That in and of itself changes behavior and people try to take advantage of that as we all know. So, I am simply suggesting that as you go into this—and I think it is timely, because the policy hasn't changed for many years—that you look at it, but we do so carefully with data.

Ms. HART. When I was a State Senator, we actually wrote the law sort of as a result of a court case that attempted to remove the status from one of our organizations, and we had a difficult time with the parameters. But we allowed for an opportunity to do this case-by-case review, and I am wondering how burdensome that would be if you look at a situation like that where we could actually have like a five-part test, which is what we ended up with as a result of a court case, that we could really go back and have each one that wants to qualify actually submit to that sort of a test.

Mr. EVERSON. We do that in the front end. Each year, there are 80,000 or 90,000 applications for tax exemption that we receive. In hospitals, we get something like 100 every year. They have their own extra page of detailed questions that you go through. They are, once again, there are considerations—they aren't automatic in terms of one answer doesn't necessarily knock you, but it says, if the answer is, no, please explain, and those factors are weighed and then a favorable determination is made, or we will work with the organization. Same thing applies in the audits. Frankly, the problem you get here is you can get drift-over time because they get accepted, and then they operate for decades if you will and never get looked at again by us, so that is a problem of how often we get in there.

Ms. HART. The sheer quantity you have to deal with.

Mr. EVERSON. We are looking at one half of 1 percent of the population every year and that is not that much.

Mr. WALKER. There is a multi-page questionnaire that is completed for applicants to grant tax-favored status. So, they are already looking at a bunch of criteria. On the other hand, Congress may say, there are five things that are most important to us. For example, you need to have at least one of these five things to a certain level. We want to encourage you to do more than that, but there are five things that are important to us. If you have one of those five at an appropriate level, you might get a safe harbor, and therefore, you are okay. We don't have that. Right now, what we have is a multiple-page questionnaire where you consider all of it, but there is no real weighting. Therefore, there can't be really consistency, and therefore, there can't be appropriate accountability.

Ms. HART. Thank you, I yield back.

Chairman THOMAS. Gentlemen yield on the time she has. Commissioner Everson, in the last 20 years, how many not-for-profit hospitals have had their tax-exempt status pulled?

Mr. EVERSON. Just a handful.

Chairman THOMAS. In the last 20 years?

Mr. EVERSON. I have to go back and check that, but in the last 5 or 10 years, it is fewer than 10. I will get you a precise number.

Chairman THOMAS. We need to get a profile to see, notwithstanding the blurriness, whether or not people have crossed so over the line so far that even despite the blurriness, you were able to make a decision.

Mr. EVERSON. It is a rare action.

Chairman THOMAS. Gentlewoman from Ohio.

Ms. TUBBS JONES. Thank you, Mr. Chairman. I come from Cleveland, Ohio, one of the largest non-profit hospitals, Cleveland clinic. I am interested in—when I was reading through something—the whole discussion about whether—not whether the fact that people who are uninsured pay higher rates than people who are insured because of this contract relationship. Are you suggesting that a way in which we might deal with the issue of the uninsured—not deal with the issue of the uninsured—are you suggesting that the cost should be the same for the same services in order to deal with the runaway cost of health care? Mr. Walker.

Mr. WALKER. I am suggesting that it is something the Congress may want to consider and/or appropriate State legislators as to whether and to what extent uninsured persons should be charged more money for the same service or charged at a certain level for comparable services.

Ms. TUBBS JONES. Why do you think we ought to do that?

Mr. WALKER. I am not proposing you do it. What I am saying is that, because of the challenges associated with our health care system, and because of the proliferation of managed care in ways that create contractual arrangements to control costs—and there are plusses and minuses to that—that in order to maximize revenues, what many providers have done—and it is not just hospitals, it is dentists, it is doctors—what many providers have done is they have a separate billing schedules.

Ms. TUBBS JONES. I love your explanations, but I don't have but 5 minutes, so get to the point, please.

Mr. WALKER. I think it bears watching as to whether or not uninsured individuals end up having to potentially pay more money merely because of the fact they are uninsured. If they are indigent, they are not going to be able to pay. However, there are middle-income individuals who may have to pay a lot more money for the same services because of billing practices.

Ms. TUBBS JONES. Let me go to something else, according to the IRS, we give non-profit status to hospitals—based on your regulations, we give non-profit status to—tax-exempt status to hospitals. One of the bases is community—what is it called, community impact?

Mr. EVERSON. Community benefit.

Ms. TUBBS JONES. In light of the fact that, across this Nation, particularly in Cleveland, hospitals are some of the largest employ-

ers in the Nation, the fact that they are, is that a community benefit?

Mr. EVERSON. I am not—if you are asking whether we look at the employment impact of having that entity operate, I don't think we consider that as a factor itself.

Ms. TUBBS JONES. Should it be a factor?

Mr. EVERSON. That is a policy call, and I think it extends beyond that definition, because you have got—the not-for-profit sector of the government is huge. That opens up a whole different avenue of inquiry, I would suggest.

Ms. TUBBS JONES. Is it an avenue we ought to pursue?

Mr. EVERSON. I think everybody would be not-for-profit by employing people if that was a factor. Maybe some of our biggest businesses, Wal-Mart and everybody else, would be not-for-profit. So, it gets you a different discussion, I would suggest.

Ms. TUBBS JONES. Wal-Mart doesn't deliver health care, so I am asking you to consider it in conjunction with the delivery of the health care not just the fact that they employ.

Mr. EVERSON. I would suggest that is taken into account indirectly. How often do we lift the exemption? Obviously, if you go to look at something as significant as lifting that exemption, if it were to be viewed as resulting in a closure, of course, we would look at impacts like that at that time.

Mr. WALKER. I would respectfully suggest that if you had a facility that was that large, that that would therefore mean there is probably demand for it to be that large, and therefore, one of the factors one would have to consider is what is the community need that created the demand for it to be that large and have that much employment. So, while it is not expressly addressed, indirectly it is probably considered.

Ms. TUBBS JONES. Finally, are you either of you familiar with payment in lieu of taxes that is happening in States across the country with regard to the fact that some non-profits do not pay taxes? You are not familiar with what they call pilots?

Mr. EVERSON. No, ma'am. If you could help me understand it, maybe——

Ms. TUBBS JONES. Unfortunately, I am out of time but I am going to have my staffer give you background information on pilots, and maybe you could give me a written response. Because of the discussion about taxes being waived for so many institutions in some States and some hospitals are making payments to the municipality to support the municipality.

Mr. EVERSON. Property and other taxes?

Ms. TUBBS JONES. Yes. I will have somebody give it to you.

Chairman THOMAS. Thank the gentlewoman. The gentleman from California wish to inquire?

Mr. THOMPSON. Thank you, Mr. Chairman, and appreciate the opportunity to ask questions and thank you for holding this hearing. I think it is important and interesting. Unfortunately, the one witness that left, I wanted to ask him a specific question. I am hopeful that the Committee can provide a means by which we can follow up on something in his statement when he referred to increased funding for community health centers——

Chairman THOMAS. Submit a written request, and we will get a written response.

Mr. THOMPSON. We need to just see some analysis as to whether or not they can accommodate anything that is missed by the non-profits. As important as this is, I don't think we can lose sight of the fact that these hospitals that we are talking about are providing a tremendous service in all of our communities. I think, Mr. Everson, you said it best when either the Chairman or Mr. Herger asked about your pulling the tax status or non-profit status from any hospitals and you said you would rather work out problems rather than revoke status because of the serious impact it would have on the community. I think that is evident probably in everyone's district. I know in my district, I have got about 19 hospitals. I think three of them are government hospitals either State or Federal government. There is one private, and the rest are all non-profit. If we did anything to disrupt this, the people that I represent would not have a hospital to rely on. One of you said that there is little difference between for-profit and not-for-profit hospitals. I would like to submit that there is one major difference that I see and that is in rural areas, such as the one I represent, all there are is non-profit hospitals. I guess the question is, has anyone done any analysis as to where these hospitals are? Are there more non-profits in rurals or is it just medically underserved areas. Can you quantify that somehow?

Mr. WALKER. I think there has been some work done on that. I would be happy to provide something to you for the record.

Mr. THOMPSON. I would like to see it. I can only talk about my district, but I do know there has been a number of attempts to bring private entities into my rural district. Each time, it hadn't been a good outcome. Generally what happens, especially in the HMO areas, they take out the easy pickings, and they close up, and they leave the people in the area without any facilities to rely on. Mr. Everson, in your testimony, you talked about your analysis of this. You said you looked at 375 health organizations, 79 of those being intense examinations. Of the 79 cases, you found tax exemption problems with about 20 of those. Are you suggesting that we extrapolate on this number for the remaining?

Mr. EVERSON. That is not what I am saying. What I am suggesting is that we make our audit selections across all IRS activities based on risk and where we think there would be potential problems. If you look at individual examinations, we end up with a no-change rate of about 15 percent or so. That is to say, 85 percent of the time, we find something. Obviously, we just don't want to go out and inquire in areas where we don't think there is a problem. So, I don't think it is fair to extrapolate simply based on the half percent of the population we are doing.

Mr. THOMPSON. Will you be doing a much more intense——

Mr. EVERSON. We want to do more, and we are dedicating increasing resources to this area. Charities include this sector in part because as I say these relations with the for-profit businesses as well.

Mr. THOMPSON. The other thing, you talked about the five ways to determine the nontax. IRS—those are your measurements, correct?

Mr. EVERSON. Those are the standards that we have developed.

Mr. THOMPSON. Should those be redone or updated?

Mr. EVERSON. Again, I think this goes back to the Chairman's question here. I am comfortable with those standards based on the law as it exists today. We will certainly update them if the Congress changes the law.

Mr. THOMPSON. It seems a little difficult to get a good read using these, and there may be some need to figure it out.

Mr. EVERSON. What we have done, sir, is we have updated this questionnaire that we talked about, the form 1023 on which you make an application. We just recently revised that to provide greater clarity on this subject.

Chairman THOMAS. Tell the gentlemen that, in the past, the IRS felt comfortable changing the regulations without a change in the Federal law. I want to thank the commissioner for which he is carrying the last 60 years of the Internal Revenue decisions on his shoulders, and he clearly has not been responsible for them. I appreciate the opportunity in which he has allowed me to illustrate some of the things that go on around here when Congress doesn't exercise its responsibility. Decisions get made anyway. With that, I want to thank both of you and would request that you be on short string, because we are going to continue this, not for the sake—and there is some misinterpretation. We are not in this for the revenue. We are in this to examine the basis in which people receive significant tax benefit paid for by someone, and can we better sharpen the tools to make sure we are getting our money's worth? We are not in it for the revenue. The Chair would then request the second panel if they would please come forward. The Chair thanks the panel's willingness to allow us to examine in some degree of fullness the testimony. John Colombo, Professor, University of Illinois College of Law. Stan Jenkins, Chairman, Champaign County Board of Review. Mr. John Thomas, Baylor Health Care System. Sister Carol KEEHAN., Sacred Heart Health System. Gerald Horwitz, University of Michigan Law School. Nancy Kane of the Harvard Business School. Chair wants to thank you for your patience. Two, more importantly thanks you for the testimony. The written testimony you have submitted for the record will be made a part of the record. The Chair will allow you in the time you have available to you to address the Committee in any way you see fit. I will tell you that, as we begin this process, we are on the verge of having the bells ring for a series of votes. The Chair would recess for that period as short a time as possible to accommodate the votes. Dr. Colombo.

STATEMENT OF JOHN D. COLOMBO, PROFESSOR, UNIVERSITY OF ILLINOIS COLLEGE OF LAW, CHAMPAIGN, ILLINOIS

Mr. COLOMBO. Thank you, Mr. Chairman and thanks to the Committee for having me here today. I think it is the first time in history that two people from Champaign County have testified before the Ways and Means Committee at the same time. For me, the debate over tax exemption for non-profit hospitals can be summarized in one word. That word is accountability or, more precisely, the lack of accountability that currently exists in our legal standards for exemption. Ever since 1969 when the IRS abandoned char-

ity care as a requirement for tax exemption for hospitals and adopted the community benefit standard for exemption, our legal tests for tax exemption have not required that non-profit hospitals demonstrate any measurable difference in behavior from for-profits. The problem with the community benefit test is that virtually anything can be a community benefit, even things that we would expect good for-profit businesses to do. The IRS itself stated in 1983 that the application of surplus to improving facilities and equipment could be community benefits. In short, under this definition, reinvesting in your own business, which for-profits certainly do, is a community benefit. So, as a legal matter, what the community benefit test really gets you is simply non-profit form with the community board. Now if you believe that non-profit form is inherently better than for-profit form for the delivery of health services, okay, then you don't need accountability for non-profits.

I would suggest that there is no good reason to believe that. Non-profits are not inherently good because they are non-profit. Both forms have their horror stories of bad behavior. In addition, the empirical evidence comparing the behavior of for profits to non-profits does not support the general proposition that non-profit form is inherently superior to for-profit form in health care. At best, this evidence shows mixed results for the non-profit sector, and the data indicates that geography, size, competitive environment and whether a hospital is a teaching hospital are all at least as important as non-profit status in influencing behavior. So, if you are like me and are skeptical of the proposition that non-profit form is inherently superior, then you probably would like to see some level of accountability built into our legal tests for exemption.

Mr. Rangel earlier asked, what are the alternatives. Okay, I will bite on that one. I will suggest two. First, we could reinstitute a charity care standard for exemption. A lot of commentators favor this approach, and it certainly helps on the accountability front. There are a lot of technical details that would have to be worked out to do this, such as how to measure charity care, how much of it would be enough to justify exemption, whether bad debt should count as charity care and so forth. It is important not to view this as a solution to health care for the uninsured poor. More charity care is better than less, but I am not sure we want a system in which the only health care alternative for the uninsured poor is to wait until they are sick so they can get free care at a hospital.

A second alternative is to try to develop a test for exemption that is more specific regarding the behavior needed to qualify for exemption, but more flexible than a strict charity care approach. One possibility here is my access test that I describe in my written statement. Require hospitals to focus on a specific access mission, whether that be charity care or providing unprofitable services or providing services to underserved communities, rural communities, whatever, or maybe a mixture of those and require hospitals to make specific plans or financial commitments to that mission and then report on how they are executing that mission.

No matter what we do, however, I think it is time to let go of the past. Hospitals long ago quit being alms houses for the poor. Today, they are multimillion or multibillion dollar businesses. We need to reconsider whether such businesses should get tax exemp-

tion at all and if so, under what circumstances. Federal and State governments give away billions in foregone tax revenues each year to non-profit hospitals, and I believe we should require accountability for those benefits. We don't have that accountability built into our current Federal exemption standards and I don't think we should be happy with that situation. Thank you very much.

[The prepared statement of Mr. Colombo follows:]

Statement of John Colombo, Professor, University of Illinois College of Law, Champaign, Illinois

Mr. Chairman, Members of the Committee:

My name is John Colombo. I am a professor of law at the University of Illinois College of Law in Urbana-Champaign, and I have taught about and written on issues of tax-exempt organizations for the past 18 years, particularly issues of tax-exemption for nonprofit hospitals. I want to give you some history and context regarding hospital tax exemption rules and perhaps suggest some alternatives to our current system.

History of Income Tax Exemption for Hospitals

Hospitals have enjoyed exemption from the federal income tax virtually since the beginning of the income tax system.[1] Prior to 1969, federal income tax exemption for hospitals (and presumably other health care providers) was tied to free care for the uninsured poor ("charity care"). The official ruling position of the Service was set forth in Rev. Rul. 56–185, which required a hospital seeking exemption under Code Section 501(c)(3) to be "operated to the extent of its financial ability for those not able to pay for the services rendered."[2] While the Service never took an official position regarding how much charity care was "enough" or even how to define charity care for these purposes, if a hospital lacked a substantial charity care program, auditing agents almost always recommended denial or revocation of exempt status.[3] This charity care standard reflected the long-held stance of the IRS (and centuries of legal precedent in the charitable trust arena) that the "relief of the poor" constituted a charitable purpose.[4]

Concurrent with Congressional consideration of the Medicare and Medicaid legislation in the mid-1960's, however, exempt hospitals began pushing the IRS for reconsideration of exemption standards.[5] The common complaint (almost hilarious, in retrospect, for its inaccuracy) was that between private medical insurance and the "new" Medicare and Medicaid programs, there simply would not be enough of a demand for charity care to satisfy the IRS, and hence exemption standards should become more flexible in order to maintain exempt status for hospitals.[6] One wonders, of course, why the most appropriate response to these arguments was not "well, if there isn't any need for charity care, then there isn't any need for exemption," but young staff attorney with the IRS, Robert Bromberg, apparently took the complaints of the hospital industry seriously and began work on a new exemption standard.[7]

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[1] Administrative rulings recognizing exemption for hospitals date back to at least 1928. See I.T. 2421, VII–2 C.B. 150 (1928).

[2] Rev. Rul. 56–185, 1956–1 C.B. 202, 203.

[3] While the ruling recognized that this test would be applied on all the facts and circumstances (and that a low charity care record would not necessarily bar exemption), IRS auditing agents often denied or revoked exempt status if a hospital's charity care was less than 5% of gross revenues. Robert S. Bromberg, *Charity and Change: Current Problems of Tax Exempt Health and Welfare Organizations in Perspective, in* Tax Problems of Nonprofit Organizations 149, 256 (1970); *see Hospital Charity Care and Tax-Exempt Status 1990: Restoring the Commitment and Fairness, Hearings Before the U.S. House of Representatives, Select Committee on Aging,* 102d Cong., 1st Sess. 58 (1990) (Statement of James J. McGovern, IRS Assistant Chief Counsel).

[4] *E.g.,* Treas. Reg. § 1.501(c)(3)-1(d)(2), listing "relief of the poor and distressed" as a charitable purpose. Historically, relief of the poor has been viewed as a charitable purpose at least since the Elizabethan Statute of Charitable Uses enacted by the English Parliament in 1601. The preamble to that statute, which is generally viewed as the "headwaters" of charitable trust law, listed "relief of aged, impotent and poor people" as an appropriate charitable purpose. See John D. Colombo and Mark A. Hall, The Charitable Tax Exemption 34 (1995).

[5] Daniel M. Fox & Daniel C. Schaffer, *Tax Administration as Health Policy: Hospitals, The Internal Revenue Service & the Courts,* 16 J. Health Pol., Pol'y & Law 251, 269–70 (1991).

[6] *Id.* at 261–62.

This new standard appeared in Rev. Rul. 69–545,[8] which quickly became known as the "community benefit" standard. This ruling abandoned charity care as the touchstone of exemption. Instead, citing the law of charitable trusts, the IRS held that the "promotion of health" for the general benefit of the community was itself a charitable purpose, even though some portion of the community, such as indigent patients, were excluded.[9] Factors that indicated that a hospital met the community benefit test included a community board, an open medical staff, treatment of Medicare and Medicaid patients, and operation of an emergency room that provided emergency treatment to charity patients.[10] Charity care other than emergency treatment, however, was not required, and in a 1983 ruling, the IRS held that even hospitals without emergency facilities could qualify for exemption under the community benefit approach.[11]

Though Rev. Rul. 69–545 implied that offering health services to all paying patients was sufficient to earn tax exemption, the IRS subsequently took the position in a series of cases dealing with HMO's that that providing health services to all paying patients (including Medicare/Medicaid patients) is insufficient to justify exemption; rather, some additional "plus" is needed, such as charity care, health education programs or health research programs. Courts have recently agreed. The most recent case on this front involved HMO's formed by Intermountain Health Care in Utah.[12] The 10th Circuit adopted this "health care plus" formula, denying exemption to an HMO whose membership was open to everyone in the community, because the HMO did not have any significant "plus" such as a charity care program, medical research program or health education program. What "plusses" will satisfy this test (and more importantly, the amount of resources that must be dedicated to the "plus") is still an open question, however.

Problems with Community Benefit

In retrospect, the community benefit standard for exemption has proven to be an unmitigated disaster both as tax law and as health care policy. As law, the main problem with the standard is that it lacks accountability; the standard simply does not require any measurable difference in behavior from a for-profit entity. Under the 1969 and 1983 rulings, a hospital is eligible for tax exemption if it has a community board, open medical staff, and treats Medicare/Medicaid patients. None of these criteria, however, focus on actual performance differences between exempt and for-profit hospitals—for example, even for-profit health care providers treat Medicaid patients.[13] This lack of substantive criteria to differentiate an exempt nonprofit hospital from a for-profit one is undoubtedly what led the IRS to litigate the meaning of the standard in HMO cases—after all, if simply treating paying patients is a charitable purpose, then any for-profit health care provider is a "charity" under this standard. Yet the recent "health care plus" formulation of the 10th Circuit doesn't really add much to what we already knew. Perhaps it is now clear from the *IHC* case that simply treating paying patients isn't enough to get exemption, but even in 1983 the IRS opined that "the application of any surplus to improving facilities, equipment, patient care, and medical training, education, and research, indicate

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[7] *Id.* Bromberg was not the only lawyer taken with the circular reasoning advocated by the hospitals (the circularity being that if hospitals could no longer meet charity care standards of exemption, those standards needed to change in order to keep hospitals from losing exemption). The D.C. Circuit Court of Appeals was equally duped. In Eastern Kentucky Welfare Rights Organization v. Simon, 506 F.2d 1278 (D.C. Cir. 1974), the Court opined that exemption standards needed to be more flexible because "the rationale upon which the limited definition of 'charitable' was predicated has largely disappeared." It apparently never occurred to the court that exemption ought to disappear, as well, "Gone with the Wind" of charity care.

[8] 1969–2 C.B. 117.

[9] *Id.* at 118.

[10] *Id.*

[11] Rev. Rul. 83–157, 1983–2 C.B. 94. This ruling noted that specialty hospitals, such as cancer treatment hospitals, generally could qualify for exemption under the community benefit approach even though they did not operate emergency facilities as long as there were other indicia of community benefit "including a broad of directors drawn from the community, an open medical staff policy, treatment of persons paying their bills with the aid of public programs like Medicare and Medicaid, and the application of any surplus to improving facilities, equipment, patient care, and medical training, education, and research, indicate that the hospital is operating exclusively to benefit the community."

[12] IHC Health Plans, Inc. v. Comm'r, 325 F.3d 1188 (10th Cir. 2003).

[13] *See, e.g.,* General Accounting Office Study 04–167, Report On Specialty Hospitals to the Honorable Bill Thomas, Chairman, Committee on Ways and Means, House of Representatives, and the Honorable Jerry Kleczka, House of Representatives, available on-line at http://www.gao.gov/atext/d04167.txt (last viewed 6/14/2004). This study reported that for-profit spe-

that the hospital is operating exclusively to benefit the community."[14] In short, virtually anything a nonprofit hospital does with surplus funds might be a community benefit, and even supporters of the community benefit standard have admitted that definitions of community benefit remain "inconsistent, narrow, fragmented and only loosely related to the ways in which communities actually affect the health of their residents."[15]

What we do know is that many of the behaviors touted by the nonprofit hospitals community as "community benefits" are really nothing more than what any good business would do to lure paying customers or stay in tune with their customer base. Hospitals, for example, claim that community needs assessments and community health education programs are "community benefits." But a community-needs assessment is analogous to market research regarding what services are in most demand; if a local automobile dealer did a "community needs assessment" for transportation services, we'd call this a marketing study. Similarly, many health education and screening programs, such as a pre-natal care program, are also good business—women who enroll in a particular hospital's pre-natal education program are very likely to choose that hospital for delivery services—which the hospital will make money on.

Finally, the community benefit standard ignores the fact that taxes paid by for-profit hospitals themselves constitute a major community benefit. In fact, one academic study noted that if we included the taxes paid by for-profit hospitals as a community benefit, for-profit hospitals actually provide *more* community benefits than their nonprofit counterparts.[16]

So we are entitled to ask, I think, "What are we getting for the billions per year that we lose in tax revenues as a result of exemption?"[17] The answer to this is that as a legal matter, we are getting nothing specific other than nonprofit form and a community board. Community benefit does not provide us with a benchmark against which we can hold nonprofits accountable for their performance; instead we simply trust nonprofits to do a better job by virtue of their form.

Now we might be happy with this "trust us" approach if we really believed that nonprofit form was inherently superior to for-profit form for the delivery of health services, so that no accountability was needed. If we believed this, we might simply say that tax-exemption is a way to "buy" the superior nonprofit form. But there is no reason to believe that is the case. Empirical studies on quality of care, costs of care, and free care for the poor show decidedly mixed results, with some studies finding in favor of nonprofits and others finding in favor of for-profits.[18] These studies certainly do not prove that nonprofit form is better than for-profit form; at best, all we can conclude is that nonprofits in some markets in some measures out-

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[14] Rev. Rul. 83–157, 1983–2 C.B. 94.

[15] Mark Schlesinger & Bradford Gray, *A Broader Vision for Managed Care, Part 1: Measure the Benefit to Communities,* 17 Health Affairs 152, 155 (1998).

[16] Gary Claxton, et. al., *Public Policy Issues in Nonprofit Conversions: An Overview,* Health Affairs, Mar.-Apr. 1997 at 18.

[17] Estimates of the revenue loss from tax exemption for nonprofit hospitals vary somewhat. James Copland and Gabriel Rudney estimated aggregate tax subsidies to nonprofit hospitals at $8.5 billion annually in 1990. James Copland & Gabriel Rudney, *Federal Tax Subsidies for Not-for-Profit Hospitals,* 26 Tax Notes 1559 (1990). These estimates include not only federal income tax revenues, but also state income and property tax revenues. In the mid-1990's William Gentry and John Penrod estimated the value of tax subsidies for nonprofit hospitals at close to $8 billion. William M. Gentry & John R. Penrod, *The Tax Benefits of Not-for-profit Hospitals,* in The Changing Hospital Industry: Comparing Not-for-Profit and For-Profit Institutions 286 (David M. Culter, ed., 2000).

[18] One recent summary of the empirical studies is Jack Needleman, *The Role of Nonprofits in Health Care,* 26 J. Health Politics, Policy & Law 1113 (2001). Recent empirical work by Professor Jill Horwitz at Michigan suggests that nonprofit hospitals are more likely to provide unprofitable services, such as burn centers or AIDS treatment centers. Jill R. Horwitz, *Why we need the Independent Sector: The Behavior, Law and Ethics of Not-for-Profit Hospitals,* 50 UCLA L. Rev. 1345 (2003). Professor Horwitz admits, however, that she cannot draw a causal connection between tax exemption and the observed behavior; it is possible, for example, that her results reflect the historical fact that hospitals were dominated by the nonprofit form, so that historically all services were provided in that form. In fact, some empirical work on nonprofit conversions (e.g., transactions in which nonprofit hospitals convert to for-profit form) suggest that ownership form is not the controlling factor in service mix, since service mixes remain stable (e.g., no decline in unprofitable services) post-conversion. *See, e.g.,* Duke University Center for Health Policy, Law and Management, A Guide for Communities Considering Hospital Conversion in the Carolinas (May 1998) at 19. Moreover, Prof. Horwitz's report of data in this article does not indicate what percentage of unprofitable services are offered by private nonprofit academic medical centers, which would be exempt as educational institutions even if the community benefit test were repealed. If this percentage is significant, it would suggest that a primary mission of teaching/research is a more important factor than ownership form in determining service mix.

perform for-profits, and that in other markets on other measures, for-profits outperform nonprofits. It is far more likely that geography, size and market competition affect behavior than simply nonprofit form. So if we are looking to empirical evidence to justify the "trust me" approach of community benefit, the evidence simply isn't there.

As health policy, this lack of accountability also leads to the inevitable horror stories. In my own back yard, the Illinois Department of Revenue recently revoked state property tax exemption for Provena-Covenant Hospital in Urbana, Illinois. The reason was that for some period of time, Provena essentially hid its charity care program from patients; instead, it had a policy of billing all patients for services rendered, instituting bill collection proceedings against them (which in Illinois, permitted the use of "body attachments"—arresting people if they missed a court date on an uncollected debt), and then, after all that, if collection efforts were exhausted and the person still couldn't pay, the hospital would write off the bill and call it "charity care." The most distressing thing about Provena-Covenant for me as an expert on federal tax exemption is that throughout this entire ordeal, Provena kept touting in the press reports that even though the State of Illinois had revoked its property tax exemption, *it still met the standards for exemption under federal tax law—and Provena's statement on this point was absolutely correct.* From a federal tax perspective, I think we should be both embarrassed and horrified that an organization operating the way Provena did nevertheless could legitimately claim it had met federal exemption standards under the community benefit test.

Alternatives to Community Benefit

If community benefit isn't the answer, then the next question concerns what alternatives are available. I think there are three possibilities, each of which admittedly carry some drawbacks but any of which are better than our current law.

A. A Strict Charity Care Standard

One alternative to the community benefit standard is to return to a charity care formula for hospital tax exemption. At least one state, Texas, has enacted specific charity care standards for exempt hospitals. A strict charity care approach certainly would provide an administrable standard of accountability for nonprofit hospitals. In crafting such a standard, however, a number of practical issues would have to be resolved. These issues include whether to measure charity care on the basis of costs or charges, and if on costs, whether to use marginal or average costs;[19] what the minimum level of charity care would be to justify exemption; whether that minimum level would have to be in excess of what for-profits write off each year in bad debt (since presumably this is the baseline of "free care" that is being provided by the for-profit providers without tax exemption); and whether nonprofits should have to separate "true" charity care from bad debt in making a charity care measurement (e.g., whether the measurement should be total uncompensated care or a more narrow subset of uncompensated care involving up-front decisions that a patient is a "charity" patient and will not be charged for service).[20] These issues are simply matters of policy choices and certainly can be resolved, but they in fact must be resolved in order for a charity care standard to work.

In addition, there are some more general policy questions with respect to a charity care approach. First, since free care has to be provided by reallocating revenues from other sources, some commentators argue that this essentially involves a "hidden tax" on paying patients and 3d-party and government insurers. Moreover, this "tax" is being assessed by private actors (hospitals) instead of through normal democratic processes.[21]

Second, whether charity care is available and how much is available will be dictated by the local market and the success (or lack thereof) of hospitals in that mar-

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[19] *See generally,* John D. Colombo and Mark A. Hall, The Charitable Tax Exemption 55–56 (1995). Compare Gary Claxton, et. al., supra note 16, at 16 (arguing for average costs) with David A. Hyman, *The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals,* 16 Am. J. L. & Med. 327, 361 (1990) (arguing for marginal costs). Using charges as a measure of charity care is patently ridiculous, since hospitals can simply raise their "rack rate" for hospital services in order to increase their charity care numbers, knowing that virtually no one would ever pay that rate given the discount arrangements with insurers.

[20] Several academics point out that while some bad debt may not be related to the economic inability of the patient to pay their bills, some certainly is so related. Gary Claxton, et. al., *supra* note 16; Nancy M. Kane & William H Wubbenhorst, *Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption,* 78 Milbank Quarterly 185, 190 (2000). At least some bad debt, therefore, probably should be included in charity care measurements but how much is open to debate.

[21] M. Gregg Bloche, *Health Care Below the Waterline,* 80 Minn L. Rev. 299 (1995).

ket in reallocating revenues from other sources. Thus availability of care may vary enormously depending on geographic location.

Third, while a strict charity care standard is a viable solution to the accountability problem with tax exemption, it should not be viewed as a total solution to health care for the uninsured poor. Standing alone, a charity care system administered at the hospital level virtually assures that the uninsured will not engage in much, if any, preventive care, and instead will wait until a serious illness compels hospitalization which then would be "free" under this system.[22] This behavior would be exactly contrary to the emphasis put on preventive care by most (if not all) health policy experts. Certainly, having more charity care is better than having less, but it is not a complete solution to health care for the uninsured.

B. Replacing Community Benefit with a More Accountable Standard

A second possibility is to replace the community benefit standard with something more flexible than the strict charity care approach, but which has more specific behavioral guidelines that would provide more accountability than the community benefit standard. For example, the Catholic Hospital Association once promulgated guidelines for its members limiting "community benefits" to behavior that would not duplicated by the for-profit sector.[23] Another approach along these lines is my recent suggestion that we require exempt hospitals to focus on a mission of "enhancing access."[24] This test would permit exemption when individual health care entities develop a specific plan for enhancing access to services and demonstrate actual financial commitment to and execution of such a plan. "Enhancing access" would encompass not just free or expanded care for the poor, but could also involve providing usual health services to a medically-underserved population (e.g., an HMO formed to bring health services to a medically-underserved area) or providing services to the general population that were previously unavailable or under-provided. Thus a particular entity that formulated a plan to provide expanded AIDS treatment (a service identified in empirical work as unprofitable and hence under-provided) and met minimum financial commitments to such treatment might be rewarded with exemption. The downside of this approach is that it provides less clarity and therefore less stringent accountability than a strict charity care standard. In effect it introduces some "fuzziness" as compared to a strict charity care standard in order to achieve more flexibility.

C. Repeal the Community Benefit Standard

The final possibility would be to repeal the community benefit test. Under this alternative, a few hospitals that met other traditional standards of charity could remain exempt—for example, academic medical centers would remain exempt as an educational institutions under Code Section 501(c)(3); and a few organizations such as the Mayo Clinic might be able to make the case that they are primarily engaged in medical (scientific) research and hence would be exempt for that purpose. Similarly, a clinic whose primary purpose was to serve the poor would be exempt as a poor relief charity. Most private nonprofit hospitals, however, would lose exemption under this approach, because their primary purpose would not be education, research or poor relief (rather, their primary purpose is to provide health services for a fee), but that is not necessarily a bad thing. A number of commentators argue that our health care system would be better served by taking the money saved from tax exemption and using it for entity-neutral, direct financial incentives for certain behavior.[25] For example, if the problem is health care access for the uninsured poor, the system might be better off eliminating exemption and taking the revenues resulting from that decision to expand Medicaid. Or if we believe there is a problem of access to unprofitable services, we could use the money to provide direct incentives to all hospitals to provide more such services.

Of course, the downside of such entity-neutral incentives is that such incentives would be complicated to enact and administer, requiring agreement by Congress or

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[22] Bloche, *supra* note 21; Peter Schuck, *Designing Hospital Care Subsidies for the Poor,* in Uncompensated Hospital Care: Rights and Responsibilities (Frank A. Sloan, et. al., eds. 1986).

[23] The CHA developed five criteria for these kinds of community benefits. These criteria were (1) they must be financed through philanthropic contributions, volunteer efforts or endowment; (2) they must respond to a particular or unique health problem in the community; (3) they generate low or negative margin; (4) they respond to the needs of special populations, such as minorities, the poor, the elderly, the disabled, those with AIDS, etc.; and (5) the service or program likely would be discontinued if the decision were made on a purely financial basis. See Kane & Wubbenhorst, *supra* note 20, at 196.

[24] John D. Colombo, *The Role of Access in Charitable Tax Exemption,* 82 Wash. U.L.Q. 343 (2005).

[25] See, Robert C. Clark, *Does the Nonprofit Form Fit the Hospital Industry?,* 93 Harv. L. Rev. 1416, 1418; Hyman, *supra* note 19, at 380.

a duly-delegated agency on the exact policy initiatives that this approach would subsidize. Because of the need for national political agreement, the direct incentives approach in the long run may be less desirable than an approach focused on more specific local community needs—for example, a particular community might need charity care more than it needs a burn unit.

Summary

One of the hardest things for human beings to do is to let go of the past. Prior to WWII, hospitals were essentially homeless shelters for the poor, often run by religious orders and staffed with volunteers. Today they are multi-million or in many cases multi-billion-dollar fee-for-service businesses. The reasons that justified exemption for hospitals in 1928 simply don't exist any more, and I think that this Committee should carefully reconsider whether multi-billion-dollar fee-for-service businesses should be eligible for tax exemption at all. At the very least, shouldn't we replace community benefit with some specific behavioral standard that will provide accountability and enable us to answer with certainty the question posed earlier, "What are we getting for our money?"

Chairman THOMAS. Thank you, Professor Colombo. Mr. Jenkins.

STATEMENT OF STAN JENKINS, CHAIRMAN, CHAMPAIGN COUNTY BOARD OF REVIEW, URBANA, ILLINOIS

Mr. JENKINS. Thank you, Mr. Chairman. I appreciate the opportunity to be here and your staff has been most gracious in welcoming us. Like most local boards of review around the United States, we consider the exemption from property taxes to be a privilege conferred by State law. It is not an inherent right just because an organization is a hospital or because it is tax exempt under Federal law. The burden of proof is always on a hospital to demonstrate that it deserves exemption for paying taxes by virtue of the charitable benefits it returns to a community.

In our opinion, not only did our two local hospitals in Champaign County not meet this burden of proof, in many aspects, they fell far short. A few particular areas stood out. The hospitals were charging uninsured patients higher prices than they were charging anyone else for exactly the same care or service. An uninsured person could be charged two to five times as much as an insured person for the very same Band-Aid, same aspirin and the same hospital room. People who are without insurance are usually in that situation because they can't afford to have insurance in the first place. It is not by choice. To then force these very same people to pay higher prices than anyone else has to pay is not befitting a charitable institution and, in my mind, is just plain wrong.

Too often, instead of working on reasonable payment plans with uninsured patients, the hospitals were using onerous collection practices including suing hundreds of their own patients. We considered these practices to be contrary to what a charitable organization should be doing. In one case, the level of actual charity care provided was less than one half of 1 percent of total revenues, and this was at a time that this institution posted a $32 million profit. In our opinion, that was no where near the legal level required under Illinois law.

Finally, we found that both of these not-for-profit institutions had intimate business relationships with for-profit entities directly related to their own corporate organizations. This included, but

was not limited to, the transfer of millions of dollars from a not-for-profit hospital to a for-profit subsidiary and then still claiming the hospital to be not-for-profit. This just didn't make sense to us. In following other hospitals' practices across the United States, we have learned that these practices of our two hospitals in relation to pricing, collections and charity care are very common.

Common practice does not make something right and it certainly does not make these hospitals charitable as defined by law. In my opinion, many of the these hospital practices simply do not make sense from the standpoint of their own financial interest. James Unland of from the Health Capital Group recently surveyed several hundred patient account representatives across the United States. He concluded that the hospitals could actually increase their revenue from uninsured patients through fair pricing and fair payment terms. I would have to agree. This should come as no surprise to anyone. Fair pricing and fair payment terms are good business practices in any business.

From a public policy standpoint, we are beginning to see a class of citizens who are afraid to go to hospitals for being charged prices they can't afford to pay in the first place and then being hounded for that payment through the court system. I consider this dangerous for hospitals and society. People who stay away from hospitals until what otherwise might be a relatively low cost ER visit becomes a life threatening extremely high cost medical episode. Having the uninsured afraid of their own hospitals helps no one.

I believe there are some constructive steps that could be taken at the Federal level to address these practices before the situation worsens. First, I would suggest established pricing payment and collection standards with respect to the uninsured and underinsured, require all tax-exempt hospitals to provide charity care within their respective financial means, review the proliferation of for profit businesses in an industry that is dominated by 501(c)3 organizations and finally compel hospital executives and boards to be accountable to their missions as the charitable organizations they profess to be.

In closing, I would like to make one other comment. Locally, Provena covenant hospital in Urbana, Illinois, we looked at their activities for the 2002 tax year. In 2003, they had a new chief executive officer come on board and also had a new CFO come on board. Prior to the new administration coming in under Mark Wiener, Provena covenant had been suing hundreds of patients. Last year under his leadership in 2004, there was one lawsuit filed against a patient. Change can be made by these administrators if they choose to make them, and he is a prime example of that happening. Thank you very much. I appreciate the time. Again, I appreciate the welcome we received from your staff and from your Committee.

[The prepared statement of Mr. Jenkins follows:]

Statement of Stan Jenkins, Chairman, Champaign County Board of Review, Urbana, Illinois

I am the Chairman of the Champaign County, Illinois Board of Review. In Illinois, local boards of review are charged with the responsibility to review applications for exemptions from property taxes, including applications filed by not-for-profit 'charitable' hospitals.

In 2001 both hospitals in Champaign County, Illinois were exempt from paying property tax. Today both are on the tax rolls. In each case the Champaign County Board of Review recommended to the Illinois Department of Revenue that tax-exempt status be denied.

THE LEGAL BASIS FOR TAX-EXEMPTION

In Illinois (as well as in many other states) a property must be in "exempt ownership" and "exempt use" to be exempt from property tax.

The Illinois constitution, the statutes, and Illinois case law going back nearly a hundred years address what qualifies as a "charitable" institution. The constitution states that an institution must be "exclusively" used for charitable purposes to be exempt from property tax. The statues go on to say that the property cannot be "leased or otherwise used with a view to profit".

Again and again case law has upheld the standard that "exclusively used" means the primary purpose for which the property is used be charitable and "not by any secondary or incidental purpose." As recently as December of 2004 the Illinois Supreme Court affirmed this standard.

THE TAX-EXEMPTION APPLICATION PROCESS

The burden of proof to receive a determination of exempt status is always on the applicant, in that exempt status is not automatically conferred just by virtue of the fact that a hospital, for example, may be a federally qualified 501(c)(3) organization. Any institution seeking exemption from property tax must submit an application to the local Board of Review. The Board of Review has a statutory obligation to make "a full and complete statement of all the facts in the case"—including submitting appropriate interrogatories to the applicant—and to send a "recommendation" to the Department of Revenue. The Department of Revenue then grants or denies that exempt status.

THE BASIS FOR THE RECOMMENDATION

The issue of how exempt organizations treat those they serve is crucial to whether or not they deserve exempt status. Prior to our beginning to review the hospitals' exempt status, in a completely unrelated matter, an official at the Illinois Department of Revenue told me in relation to a housing project, "if the organization evicts people it is not charitable, if they sue people they're not charitable."

The issue of these two hospitals suing patients was common knowledge, due in part to the work of a very active community group. A related issue was the issue of hospitals charging their highest 'list prices' to the uninsured.

When the hospitals applied for property tax-exemption is where the long journey began that culminates in my appearance here today. We did not enter into this lightly. We knew we would likely ruffle some very well placed feathers in our community. We spent countless hours researching the law. We sifted through hundreds of court records. We dug into numerous public records, newspaper articles and Internet documents. To characterize that what we discovered as appalling would be an understatement.

First, let me address "exempt ownership". A determination must be made if the institution is "charitable" as defined by the law.

Three main issues clearly emerged from our research:

1. Pricing to the Uninsured
2. Billing and Collection Practices
3. Availability of Charity Care

Pricing to the Uninsured And Billing/Collection Practices

As we sit here today, it is a common practice in the hospital industry to charge an uninsured patient higher prices for the same care or procedure than an insured patient. If you and I both go into the hospital for exactly the same thing and you have insurance and I don't have insurance, I will be charged two to five times more for exactly the same thing. Insurance companies and government payers have the luxury of negotiating lower rates. The uninsured has no one as an advocate.

It is safe to say that people who do not have insurance have not made a willful decision to forego insurance coverage. It's because they can't afford it. They are the poorest among us. Yet these same people are charged higher prices than anyone else and when they are unable to pay these inflated prices they are sued.

This is discriminatory pricing; it is fundamentally wrong; it is indefensible and it is particularly egregious when practiced by a "charitable" institution. More than that, as at least one leading hospital industry insider has concluded: unfair pricing is just bad business in that hospitals will actually collect more money if people feel their hospital pricing is fair.

Here are but a few examples of what we found in court records:

- One patient who was taken to court had "medical disabilities" and was later admitted to "a facility in Chicago due to a break down." The defendant's husband was then added as a co-defendant. Ultimately the defendant filed for bankruptcy.
- Another defendant was "ordered to be incarcerated immediately."
- One judgment against a patient was for an amount of $140,626.32. Another judgment against a patient was for $10.00. No amount seemed to be too small or too large to be pursued through the legal system.
- One defendant was ordered "not to disburse or spend any money he may receive from said tax returns." The defendant was also threatened with incarceration. There was also a "body attachment" (arrest warrant) was issued with bond set at $5000.00.
- Yet another patient "appears personally and represents to the Court he is undergoing cancer treatment and he works as a hired person."
- Another judgment in favor of the hospital and against the patient was in the amount of $578.62. Yet there was an "immediate body attachment (arrest warrant) ordered to issue with bond set in the amount of $2,500.00."

The list goes on and on. Wages were garnished, mental health records were ordered for inspection, interpreters were required.

These examples are not isolated. Our Board of Review did not and does not believe these are the acts of a charitable institution.

The Availability of Charity Care

I would also like to address the availability and amount of actual charity care provided. In 2003 Carle Foundation Hospital (using its own figures) provided approximately $1.3 million in "charity care". However, when this is compared to total assets, total revenues or total patient revenues that amount is in fact less than one half of one percent (

Looking at "exclusively" used for charitable purposes on one end of the spectrum and "secondary or incidental" charitable use on the other end of the spectrum, its obvious that less than one half of one percent (

Countless thousands of for-profit businesses across this nation contribute more than one half of one percent to various charities every year. They do so out of a sense of community obligation and good citizenship. However, they neither expect nor receive the benefits of tax-exemption.

Tax-exemption is a gift bestowed upon certain institutions in exchange for the benefits returned to our society and our communities. From property tax alone, on just five parcels of property, Carle Foundation benefits to the tune of $2,000,000. However, exemption from sales tax, federal and state income tax saves them many more millions of dollars. The $1.3 million in actual charity care provided isn't even a dollar for dollar trade off.

Our Board of Review asked the logical question: "What is our society getting in return for extending the privilege of tax-exemption?"

Now for a moment let's examine the issue of "exempt use". The standard has been established and upheld; the property cannot be "leased or otherwise used with a view to profit."

It is common practice in the hospital industry today to employ outside service providers and physicians groups to fulfill certain functions within a hospital. These groups are for-profit entities with leases and/or agreements with the hospitals.

In the case of Provena Covenant Hospital there were thirteen such entities functioning inside a tax-exempt hospital.

Carle Foundation Hospital is somewhat different. Carle Foundation Hospital is a not-for profit institution and Carle Clinic Association is a for-profit entity. By lease agreement Carle "Clinic and its staff are to have access to all of Foundation's hospital, accessory buildings, property and facilities, including full rights of ingress and egress to the Clinic, its staff, employees, patrons, visitors and persons furnishing services to Clinic."

Carle Clinic provides all radiology and laboratory services and equipment in Carle Hospital. Carle Hospital "leases" hospitalists (doctors) from the Clinic through Carle Foundation Physician Services, LLC, which is comprised entirely of Carle Clinic doctors.

Patients go to Carle Foundation Hospital, a tax-exempt, charitable, not-for profit hospital, only to be assigned a Carle Clinic Number, treated by Carle Clinic doctors and x-rayed by Carle Clinic equipment. Those x-rays are read by Carle Clinic radiologists, tests run in the Carle Clinic Lab and then the patient is separately billed by Carle Clinic Association, a for profit company that has no charity care policy or

any obligation to provide any charity care whatsoever. And, Carle Clinic has its own history of suing patients over medical debt.

There is a glaring juxtaposition of a "charitable" hospital allowing doctors complete, unfettered access to and use of their "exempt" facilities to pursue private gain while this same "charitable" hospital continues an unfair policy of overpricing and suing the uninsured. This juxtaposition can not be ignored, and it violates one's sense of fairness and what is right. It is my view that any institution that permits these unfair practices to exist can not be considered "charitable" or tax-exempt.

I want to be very clear . . . like any other business, a hospital deserves to be paid for its goods and services. A hospital has every legal right to pursue collections through the court system like any other business. But they can't have it both ways. They can't *act* like any other business yet expect to enjoy tax-exempt status *unlike* any other business, especially if they hold themselves out to be 'charitable' organizations under either federal or state law.

OTHER ISSUES

While compiling information regarding Provena Covenant's Tax-exemption Application, more questionable practices were discovered. Provena Covenant is comprised of both for-profit entities and not-for profit entities. In a two year period of time Provena Hospitals and Provena Senior Services (both not-for profit entities) transferred $159.7 million to the parent corporation, Provena Health. Provena Health, in turn, transferred $23.1 million to Provena Ventures, a for-profit affiliate.

The Board of Review viewed this as little more than a corporate "shell game" that raised serious questions regarding the not-for profit status of ProvenaHospitals and Provena Senior Services.

At the time of our review, Provena Covenant Medical Center patients were provided with very few payment options. The patient could agree to pay in full at the time of discharge, pay with insurance, pay Provena Covenant Medical Center 10% of the total balance on a monthly basis or agree to get a loan through a lending company and then repay the lending company, with interest.

Capstone Bank was the lending company that Provena Covenant Medical Center patients were referred to. A patient using Capstone's financing plan, agreed to pay a minimum of $40 per month and finance charges of 12.9% interest on their outstanding balance. When a "credit line" was established by the patient, funds borrowed against that credit line were subject to "APPROVAL BY PROVENA HOSPITALS . . ." and could ONLY be used to pay Provena.

Under federal statute it is unlawful to charge Medicare patients interest on their Medicare-related health care bills. By encouraging patients (including Medicare patients) to obtain loans from Capstone, Bank, Provena was, in effect encouraging Medicare patients to incur those same finance charges on Medicare related bills, only payable to a different entity.

Executive compensation is another area deserving serious scrutiny. Minnesota Attorney General Mike Hatch recently testified before the Senate Finance Committee regarding this issue. He cited abuses that are not unique to the State of Minnesota.

In reviewing Carle Foundation Hospital's 990 Form for 2002, it appears that approximately $40 million of investments are cited. All but approximately $400,000 is for deferred compensation.

The Board of Review was also informed that executive bonuses were paid based on the financial performance of the hospital. If this is the case, it would prove to be a direct conflict of interest in light of the charity care actually dispensed to those in need of it.

REASONS FOR OVERSIGHT

Since the time the Board of Review began reviewing these hospitals' tax-exemption applications it has become increasingly clear that local officials and county governments are ill equipped to adequately deal with these matters.

Typically a hospital is one of the largest employers in the area. They often have access to greater financial resources than does a municipal or county government. The typical response to inquiries or scrutiny of any kind is to immediately "lawyer up."

The issues at hand are complex. In most cases there simply is not enough time, resources or technical knowledge to mount a challenge to the inappropriate conduct of some of these institutions.

Many local officials are simply too intimidated to take on such tasks.

I recently addressed a meeting of Illinois Assessment Officers regarding these charitable institutions. After that meeting, in a private setting, several of these officials made comments to me, such as, "You may be right. But I have three years until I retire and I'm not going to touch this." Others simply said they were worried

they would not be reappointed or reelected if they challenged a local hospital, regardless of the conduct of that hospital.

The Champaign County Board of Review, while conducting our research, requested that the hospitals provide us with certain information to enable us to carry out our statutory obligation to make "a full and complete statement of all the facts in the case." In each case the hospitals simply refused.

Both hospitals made a unilateral decision that they simply would not respond to the legitimate, lawful requests of local authorities.

It's now clear that many of our nation's hospitals and their attorneys have doggedly clung to the notion that they have the inalienable legal right to overcharge uninsured patients, who most often are the poorest citizens among us. When these same people are unable to pay the inflated prices (prices that no one else is required to pay), they are then hounded through the court system. Needless to say, these patients are least able to afford legal advice and are left to fend for themselves in the face of the hospitals' attorneys and a legal system they are unfamiliar with.

Moreover, the behavior of the many hospitals, as one leading industry analyst has pointed out, is contrary to their own best financial interests. After interviewing several hundred patient account representatives at hospitals, he concluded that the patient account people are convinced that fair pricing is good business. People who believe they are treated fairly will actually take their hospital bills more seriously and, if given fair repayment terms, will pay more money into hospitals.

This principle of fair pricing being good business should not surprise anyone in any business.

HOW CONGRESS CAN HELP

Here are some thoughts on possible federal legislation that would be fair to both hospitals and consumers:

- Require in a national standard that hospitals price their services to the uninsured at a level no higher than their 'most favored commercial payor' pays, similar to what the Minnesota Attorney General persuaded the large hospital systems there to do. However, make it known to the private insurance industry that such repricing is not a pretext for throwing out and renegotiating private payor contracts.
- Require that each hospital provide a level of charity care commensurate with its financial ability to do so, without in turn jeopardizing its financial viability or ability to obtain credit.
- Require that form 990s be redesigned to encompass individual hospitals' information in the case of hospital systems. It is almost impossible to discern information from some form 990s at the individual community hospital level in the case of multi-hospital systems.
- Require that hospitals set up reasonable medical debt repayment plans with repayment structured correspondingly to the individual's income level and credit situation. In this regard, hospitals should be required to take all reasonable steps before sending any patient account to collection agencies.
- Require that hospital executives and board members establish judicious ground rules on the use of collection agencies, that those collection agents abide by very specific standards and that the top executives of the hospitals know exactly what accounts the collectors are pursuing and why.
- Conduct an explicit, separate review of the proliferation of for-profit businesses that are affiliated with not-for-profit hospitals and pose the question: are all these spin-off businesses necessary, are they truly part of the core hospital business and, if so, why can't they be not-for-profit?
- Review the possibilities in regards to the IRS assisting hospitals to verify adjusted gross income and number of dependents pursuant to those patients applying for charity care assistance. The so-called 'charity care applications' are often highly burdensome on patients and not accurate from the point of view of hospitals.

Chairman THOMAS. Thank you very much, Mr. Jenkins. Is the board of review an elected or an appointed position?

Mr. JENKINS. We are appointed part-time county employees.

Chairman THOMAS. I was curious because many of us are accused of being amateur hot air balloonists. I notice that you are a commercial hot air balloon pilot.

Mr. JENKINS. That was in a previous life.

Chairman THOMAS. I appreciate professionalism in any area. Gentleman from Baylor, welcome back, Mr. Thomas.

STATEMENT OF JOHN THOMAS, SENIOR VICE PRESIDENT AND GENERAL COUNSEL, BAYLOR HEALTH CARE SYSTEM, DALLAS, TEXAS

Mr. THOMAS. Thank you, Mr. Chairman. My name is John Thomas, senior Vice President and general counsel of Baylor Health Care System. It is my pleasure to be with you to describe the Texas non-profit hospital community benefits law. Baylor is experienced with that law and the impact that law has had on the provision of indigent and other health care in the State of Texas. In sum, Baylor and Texas non-profit hospitals are accountable. Baylor is a faith-based institution with strong ties to the Baptist general convention of Texas. We are more than a century old with a history rich in innovation. Last fiscal year, we provided more than $240 million in community benefits by a very specific definition. We are a leading medical education facility and conduct some of the world's cutting edge research. Baylor Health Care System is the corporate sponsor of 13 non-profit hospitals with our flagship Baylor University Medical Center located in downtown Dallas. Baylor University Medical Center is a 1,000-bed teaching hospital with a level one trauma center that provides more care to penetrating trauma victims than Dallas County's tax-supported Parkland hospital.

More than 35 percent of the patients who come to our trauma center have no ability to pay for their care. Baylor has the largest neonatal ICU in the southwest and one of the five largest organ transplant programs in the country. Charity care is provided under the most generous charity care financial assistance policy among all Dallas Fort worth hospitals including Parkland. Operating income and philanthropy have funded bench research that has produced a vaccine that has cured melanoma in early clinical trials. We train over 185 post graduate physicians each year in almost every specialty. Since 1993, Texas has had a formalized mechanism for non-profit hospitals to demonstrate their commitment to the mission. Hospitals supported the 1993 effort and acknowledged that the Texas legislature did a good thing in raising public awareness to the many contributions non-profit hospitals make to their communities and in formalizing that process.

Baylor and Texas non-profit hospitals consistently have complied with and frequently far exceeded the requirements despite a dramatic change in the health care environment. Today, approximately 30 percent of the State's population is uninsured. Under the Texas law, Texas non-profit hospitals are required to meet one of three standards. By providing charity care and government sponsored indigent health care and other community benefits. Baylor and most non-profit hospitals report under the requirement to provide charity care and government-sponsored indigent health care and other benefits equal to at least 5 percent of the hospital's net patient revenues with charity care and government-sponsored indigent health care equal to at least 4 percent of the hospital's net patient revenues. Last year as I mentioned, Baylor provided over

$240 million in total community benefits over 15 percent of our net patient revenue. Hospitals that do not meet the requirement risk having their State capital, property and sales tax exemptions revoked, but are given the opportunity to remedy their shortfall in the following year and/or make contributions to charitable institutions to satisfy that obligation.

Charity care is strictly defined generally as the unreimbursed costs to providing health care services to the poor, financially indigent and medically indigent. People with incomes with less than 200 percent of the Federal poverty level are considered pure charity care under this law. For example, at Baylor, an individual at the 200 percent of Federal poverty level gets free care, period. Government-sponsored indigent health care means the unreimbursed cost of the hospital providing health care service to recipients of Medicaid and other Federal benefits—Federal indigent health care benefits. Costs for these purposes are defined by GAAP. Bad debt is not considered unreimbursed care for these purposes. To our knowledge, all of the States' non-profit hospitals have been in compliance with this law for most reported years. The amount of charity care being provided by nonprofit hospitals has increased over time, as reflected in the chart that is in my written testimony.

But, to summarize, in 1994, the first year of that law, there was over $573 million of charity care reported, about 6.4 percent of the net patient revenue reported by the State's nonprofit hospitals. By 2003, the amount of charity care had tripled to $1.6 billion, 9.65 percent of charity care provided of net patient revenue of the nonprofit hospitals in Texas. While net patient revenue during that period of time only doubled, charity care tripled. In conclusion, the Texas community benefit law provides an objective tool for determining whether nonprofit hospitals are satisfying the respective obligations to the communities they serve. Baylor has found the Texas community benefit law to be a fair and helpful measure to ensure nonprofit hospitals in the communities we serve are meeting, at a minimum, the required level of community benefits and charity care. Mr. Chairman, may I have 15 more seconds?

Chairman THOMAS. Sure.

Mr. THOMAS. Finally, there is a huge difference between the community benefit of Baylor and the for-profit hospitals in our community. In 2003, Baylor University Medical Center provided more charity care alone than HCA's Medical City Hospital, its charity and bad debt combined. Medical City has a cost-to-charge ratio of 25 percent, compared to Baylor's 50 percent; and that same year they had net income of $158 million, a 52 percent margin, compared to Baylor University Medical Center's 10 percent margin, which produced $65 million of income to roll back into the inner city level one trauma center, charity care, medical education and research. We do not begrudge HCA. We will compete with them on quality patient service, patient satisfaction and cost all day long. But there is a clear difference in the nonprofit service and commitment, and their for-profit purpose. Thank you, sir.

[The prepared statement of Mr. Thomas follows:]

Statement of John T. Thomas, Senior Vice President and General Counsel, Baylor Health Care System, Dallas-Fort Worth, Texas

Mr. Chairman, Ranking Member Rangel, Mr. Johnson, members of the Committee, my name is John T. Thomas, Sr. Vice President, General Counsel, Baylor Health Care System, Dallas-Fort Worth, Texas. It is my pleasure to be with you today, to describe the Texas Nonprofit Hospital Community Benefits Law, Baylor's experience with that law, and the impact that law has had on the provision of indigent and other health care in the state of Texas.

Baylor is a faith based institution, with strong ties to the Baptist General Convention of Texas. We are more than a century old, with a history rich in innovation, quality care, and providing charitable services. Last fiscal year we provided more than $240 million in Community Benefits (15% of net patient revenue). We are a leading medical education facility and conduct some of the world's cutting edge research.

Baylor Health Care System is the corporate sponsor of 13 non-profit hospitals, with our flagship—Baylor University Medical Center—located in downtown Dallas. BUMC is a 1,000 bed quadenary teaching hospital, with a Level I trauma center that provides care to more penetrating trauma victims than Dallas County's tax-supported Parkland hospital. BUMC has the largest Neonatal ICU in the Southwest, and one of the five largest organ transplant programs in the Country. Baylor Health Care System is deeply committed to its mission as a non-profit hospital. Charity care is provided under the most generous Charity Care/Financial Assistance policy among all Dallas-Fort Worth hospitals, including Parkland.

Texas Nonprofit Hospital Community Benefits Law (Texas Health and Safety Code Sections 311.041 et. Seq.)

Since 1993, Texas has had a formalized mechanism for nonprofit hospitals to demonstrate their commitment to mission through the reporting of charity care and community benefits. By conducting formal community needs assessments and submitting annual reports detailing the amounts of charity care and community benefits provided, nonprofit hospitals became more accountable to their communities. The Texas Attorney General was given broad power to enforce the charity care statute, and has the appropriate authority to audit any nonprofit hospital to ensure compliance with the law.

Hospitals supported the 1993 effort, and acknowledge that the Texas Legislature did the right thing in raising public awareness of the many contributions nonprofit hospitals make to their communities, and in formalizing the process by which local communities and hospital governing boards determine community health priorities and set goals to achieve them.

Baylor and Texas' nonprofit hospitals consistently have complied with—and frequently have exceeded—the requirements, despite a dramatic change in the health care environment. Today, approximately 30 percent of the state's population is uninsured.

Charity Care Requirements Under Texas Law

Under the Texas law, Texas nonprofit hospitals are required to meet one of three standards, by providing:

- Charity care and government-sponsored indigent health care at a reasonable level in relation to community needs, available resources and the tax-exempt benefits received by the hospital (the **"Reasonableness Standard"**), or
- Charity care and government-sponsored indigent health care equal to 100 percent of the hospital's tax-exempt benefits, excluding federal income tax (the **"100% of Tax-exempt Benefits Standard"**), or
- Charity care and community benefits equal to at least 5 percent of the hospital's net patient revenues, with charity care and government sponsored indigent health care equal to at least 4 percent of the hospital's net patient revenues, and at least 1 percent in other community benefits (the **"Charity Care and Community Benefits Mix"**).

Nonprofit hospitals that are "disproportionate share" Medicaid hospitals, as determined by the Texas Medicaid program are deemed to satisfy the requirements of this law.

The law also requires nonprofit hospitals to conduct a community needs assessment, and based on the assessed needs, develop a plan and budget for addressing the charity care and other community benefit needs.

Hospitals that do not meet their requirement risk having their state capital, property and sales tax exemptions revoked, but are given an opportunity to remedy their

short-fall in the following year and/or make payments to other charitable institutions.

How Charity Care is Calculated

- "Charity care" means the unreimbursed costs to the hospital of providing, funding or otherwise financially supporting health care services to the financially or medically indigent. Hospitals may establish eligibility criteria for their applicable charity care policies, but "financially indigent" criteria may not exceed 200% of the federal poverty law, for consideration as "charity care" for purposes of calculating compliance with the law.
- "Government-sponsored indigent health care" means 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.
- Originally, "cost" was calculated using the Medicare cost report. In 1995, the Texas legislature recognized the Medicare cost report calculation was not a complete reflection of a hospital's "cost" so they changed the formula to reflect "unreimbursed costs" as determined under generally accepted accounting principles (GAAP). GAAP is standardized, has a broader focus, and reflects more accurately costs and expenses on all types of patients.
- Bad debt is not considered "unreimbursed care" for the purposes of determining the amount of Community Benefit, but it is considered an expense when calculating the cost to charge ratio of the hospital under GAAP.

Other important defined terms include:

"Community Benefit" generally means unreimbursed cost to a hospital of providing charity care, government-sponsored indigent health care, donations, education, research and subsidized health services. It does not include any taxes or government assessments paid by the hospital.

"Net Patient Revenue" is an accounting term calculated in accordance with GAAP for hospitals. Essentially Gross Revenue less contractual adjustments.

Baylor and Texas Hospitals Meet or Exceed Requirements

Under the law, ***all*** of the state's nonprofit hospitals were in compliance with one of the three alternative requirements for 2003, the most recently available data.

- The amount of charity care being provided by nonprofit hospitals has increased over time, as reflected in the Chart below (which includes only Texas Nonprofit Hospitals)
- Baylor Health Care System files three separate reports each year—one each for Baylor University Medical Center and Our Children's House at Baylor, two facilities that satisfy the requirement as a result of their heavy Medicaid "disproportionate share" utilization. The third, is a "consolidated" report for the other Baylor hospitals, who report on a consolidated basis. In 2003, Baylor Health Care System's Total Community Benefit was $190 million, which grew to $240 million in 2004.

Year	Net Patient Revenue	Bad Debt	Bad Debt as % of Net Patient Revenue	Charity	Charity as % of Net Patient Revenue
1994	9,500,347,808	502,527,431	5.29%	573,760,164	6.04%
1995	9,504,914,516	503,355,365	5.30%	631,950,218	6.65%
1996	9,944,720,361	576,725,934	5.80%	702,196,293	7.06%
1997	10,467,197,285	671,766,095	6.42%	764,662,344	7.31%
1998	11,195,490,162	761,715,643	6.80%	943,564,737	8.43%
1999	11,691,125,703	892,525,552	7.63%	897,514,122	7.68%
2000	12,570,707,023	1,097,354,780	8.73%	1,015,280,788	8.08%
2001	14,232,736,653	1,156,159,672	8.12%	1,189,049,039	8.35%

Year	Net Patient Revenue	Bad Debt	Bad Debt as % of Net Patient Revenue	Charity	Charity as % of Net Patient Revenue
2002	16,309,834,839	1,351,918,193	8.29%	1,455,199,704	8.92%
2003	17,068,038,721	1,416,284,606	8.30%	1,647,681,372	9.65%

Conclusion

In conclusion, the Texas Charity Care Law provides an objective tool for determining whether nonprofit hospitals are satisfying their respective obligation to the communities they serve. Baylor has found the Texas Charity Care Law to be fair, and a helpful measure to ensure the nonprofit hospitals in the communities we serve are meeting, at a minimum, the required level of Community Benefits and Charity Care.

I have attached to my written testimony, a copy of the Law and supplemental information about the Texas Charity Care Law.

Thank you.

Chairman THOMAS. Thank the gentlemen. The Chair will consider the extra minute twang time. Sister Keehan.

STATEMENT OF SISTER CAROL KEEHAN, BOARD CHAIR, SACRED HEART HEALTH SYSTEM, PENSACOLA FLORIDA; AND CHAIRPERSON, BOARD OF TRUSTEES, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

Sister KEEHAN. Thank you, Mr. Chairman. Good afternoon to you and the members of the Committee. I am pleased to be with you today as the Chairperson of the Catholic Health Association of the United States. Today, while contemporary Catholic health care and other not-for-profit health care institutions excel in quality, innovation, and technology, they remain community benefit organizations, founded and sustained because of community need. Some of our community benefit activities include our outreach to low-income and other vulnerable persons, charity care for people unable to afford services, health education, illness prevention, free or low-cost clinics, training for physicians and nurses, subsidizing under or unreimbursed services such as palliative care teams and pastoral care.

Let me give you one example that you can see from the windows of this beautiful building. In a few blocks from here is the neighborhood in Washington known as Northwest #1. You may have read about it in the Washington Post, the drug deals, the murders there. The Post contended in one of its articles that even the police were afraid to go into this neighborhood. If you looked at the health indices of this neighborhood, you would think you were looking at the Third World. The neighbors asked Providence Hospital here in Washington to please give them a clinic, and today some of the finest health professionals in our community go into that neighborhood to provide over 12,000 health care visits a year.

I would like to emphasize that Catholic hospitals do not provide these services to justify continued tax exemption. We provide them because serving our communities in this way is integral to our history, our identity, and our mission. It is what we have always done. I am pleased to report that community benefit activities in not-for-

profit health care organizations are provided in an organized, deliberate way. This was first described nearly 20 years ago in CHA's social accountability budget, which presented guidelines to plan, monitor, report and evaluate community benefit activities and services. They have since been revised, updated and strengthened with the input of others.

Over the past years, to achieve greater standardization in reporting community benefits, we have published with the VHA. This community benefit reporting, updated, contains guidelines and standard definitions. With the American Hospital Association, we are encouraging wide use of these guidelines so that not-for-profit hospitals throughout the Nation are reporting how they serve their communities in a more standardized way. We are often asked how much charity care and community benefit not-for-profit organizations should provide, and we have concluded that at least nationally there is no common benchmark. However, many Catholic and other not-for-profit health care organizations set benchmarks specific to their communities and carefully examine their contributions to the same.

My organization, Sacred Heart Health System, reported that, in 2004, $2 were spent on charity care and community benefit for every dollar in terms of operating income. A large Catholic system that I am familiar with has determined that, on average, the community's return on investment in exchange for the tax-exempt status they enjoy is, on average, $1.76 for every dollar they would have paid in taxes. I understand that one of the purposes of this hearing is to examine whether there is a difference between the behavior of for-profit investor-owned and not-for-profit health care organizations. I believe the fundamental distinction between the not-for-profit and for-profit health care sectors is their essential purpose, their mission. I realize that most for-profit health care facilities provide excellent quality of care, but the ultimate purpose of for-profit health care is to be profitable. The purpose of the not-for-profit facility is healing, teaching, research and committing all its resources to its community. In essence, our stakeholders are not individual investors but the community as a whole.

Continued tax exemption is vital in allowing and encouraging our service to these communities. It allows hospitals the ability to access tax-exempt financing for new technology and equipment, as well as providing exemption from certain Federal and State taxes on supplies and drugs we purchase and access to government grant programs. Without tax exemption, the philanthropic activity that is essential for not-for-profit hospitals would be severely curtailed. We are committed to our mission of service even without tax exemption. But, without it, communities would experience increased costs, there would likely be fewer investments in new technology, and there would be increased reliance on the already over burdened public hospitals.

In conclusion, Mr. Chairman, the community benefit tradition in Catholic and other not-for-profit health care organizations is thriving and being reinforced by efforts to better account for these activities and to evaluate their effectiveness. Our long-term commitment to the people in our communities is being demonstrated every day. But we strive to do better. We believe that the not-for-profit

health care sector and the communities we serve continue to deserve tax exemption and that it is the responsibility of our organizations to demonstrate this to you and to the communities we serve. Over a decade ago, Senator Daniel Moynihan said, a distinguishing feature of American society is the singular degree to which we maintain an independent sector, private institutions and public service. This is no longer true in most of the democratic world. It never was so in the rest. It is a treasure, a distinguishing feature of American democracy. It is important to us in Catholic health care that we continue that tradition of service. That is our mission. That is our commitment to you and, most importantly, to the communities we serve. Thank you.

[The prepared statement of Sister Keehan follows:]

Statement of Sr. Carol Keehan, Board Chair, Sacred Heart Health System, Pensacola, Florida, and Chairperson, Board of Trustees Catholic Health Association of the United States

Good morning, Mr. Chairman and Members of the Committee, I am Sr. Carol Keehan, a Daughter of Charity and chair of the board of Sacred Heart Health System in Pensacola, Florida. I am pleased to be here with you today as chairperson of the Catholic Health Association of the United States (CHA). I would like to discuss the community benefit role of Catholic health care and other not-for-profit health care organizations.

Catholic health care began a tradition of community service in this country in 1727, when 12 Ursuline sisters arrived in New Orleans from France to nurse the sick, care for orphans, teach school, and open a hospital in the territory that would later become the United States. Our tradition of service continued as America's newly formed communities invited religious sisters to establish health care facilities, wanting the values the women religious represented to flourish in their towns: compassion, dedication to service, and concern for persons who are poor or sick. Providence Hospital, here in Washington, DC, where I served as chief executive officer until last year, was established at the request of President Abraham Lincoln to care for wounded from both sides of the Civil War.

Today, while contemporary Catholic health care and other not-for profit health care institutions excel in quality, innovation and technology, they remain community benefit organizations, founded and sustained because of community need. Our doors are open to everyone regardless of faith, ethnic background or ability to pay. We treat all patients—uninsured and insured—with the same dignity, respect, and compassion.

Community Benefit Mission

We provide benefit to communities because it is our mission to serve our communities. As Catholic health care institutions, we are a healing ministry of the church. Our mission includes special attention to low-income and minority populations, and we reach out to fill the void that exists for many of our disabled, elderly, and chronically ill neighbors.

Our facilities also are committed to pursuing the common good. Therefore we pay particular attention to promoting health and preventive care for all who reside in our communities.

The essence of our community benefit role and that of other not-for-profit community benefit organizations is providing services to disadvantaged persons and improving the health of all. By utilizing our resources to provide programs, staff, and equipment for our communities, we help to make them healthy places to live, work, and raise families.

Community benefit activities include outreach to low-income and other vulnerable persons; charity care for people unable to afford services; health education and illness prevention; special health care initiatives for at-risk school children; free or low-cost clinics; training for physicians and nurses, and efforts to improve and revitalize our communities. These activities are very often provided in collaboration with community members and other community organizations. In fact, in many cases, not-for-profit hospitals are able to be catalysts in helping to organize community health resources to improve access to health care and improve community health.

Another type of community benefit is subsidizing services such as mental health and hospice programs, and trauma units that are truly needed but are high cost and provide low reimbursement. Our organizations routinely open or sustain these needed services, even if they result in a financial loss.

The categories of community benefit include:

- **Community Health Services:** clinics, support groups, support services, and health prevention and promotion activities.
- **Health Professional Education:** training for physicians, nurses, and other health professionals to address unmet community needs.
- **Subsidized Services:** trauma services, hospice and palliative care programs, and behavioral health.
- **Health Research:** clinical research, and studies on community health and health care delivery.
- **Donations:** cash, grants, and in-kind services.
- **Community-Building Activities:** neighborhood improvements, housing programs, coalition building, and advocacy for community health improvement.[1]

Let me give you one example that is happening just a few blocks from here. In sight of this very building there is a Washington, DC neighborhood known as Northwest #1. You may have read about the drug trafficking and murders there in the *Washington Post.* In the Post article, it was claimed that even the police are reluctant to go into that neighborhood. The health indices for residents of the area look like the third world. The neighborhood asked Providence Hospital to provide them with care, and every day some of the finest health care practitioners go into that community to provide over 12,000 visits a year. Because we made a commitment to anchor a health facility in a historic building that was the first African American high school in the District following the Emancipation Proclamation, it has become a vibrant community center. A nursery school, job and computer training programs, dance and karate classes are among the many services now available in the heart of the neighborhood. I am sure you can appreciate how helpful it is for the low-income, working mothers of that neighborhood to have a day care center in the same building with the pediatrician.

I would like to emphasize that Catholic hospitals do not provide these services to justify continued tax exemption. We provide them because serving our communities in this way is integral to our history, our identity, and our mission—it is what we always have done.

It also is important for you to understand the broad scope of community benefit. It is more than providing charity care, although for members of our communities unable to afford needed services, free and discounted care (especially emergency care) is indeed important. We look beyond charity care to even more important community benefit programs. Often some of the most efficient programs cost little but can make a huge difference for persons in our communities. For example, relatively low-cost programs supporting pregnant teenagers can make huge differences in the health and well-being of these mothers and their babies, and save potential costly services related to premature birth or developmental disability. Often our very presence, collaborating with others and acting as facilitators for community-wide activity, can have far reaching effects that cannot be measured completely or accurately just in dollars. Yet none of these community benefits are included when we look only at uncompensated care.

How our Organizations Provide Community Benefits

Community benefit activities in not-for-profit hospitals and other health care organizations are provided in an organized, deliberate way. Since the last time this committee examined health care tax exemption, and in part because of the work of the committee, not-for-profit hospitals have improved the way they plan and report community benefit programs.

In the late 1980's and early 90's, with the growth of for-profit hospitals, Congress and state legislatures embarked on examinations of whether there was a difference between for-profit and not-for-profit health care, and whether not-for-profit health care organizations continued to deserve the privilege of tax exemption. Interestingly, women religious who sponsor Catholic organizations were asking similar questions: they wanted to know if their health care organizations continued to be mission-driven, dedicated to serving the poor and improving health in our communities.

[1] For additional information see *Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability* Catholic Health Association, St. Louis, 2004.

As a result of these discussions the Catholic health ministry developed a systematic approach to plan, monitor, report, and evaluate the community benefit activities and services they provide to their communities in order to reinforce our community benefit role and to document that we are, indeed, community benefit organizations.

This systematic approach was first described in CHA's *Social Accountability Budget,* which has been revised, updated, and adapted for use by non-Catholic facilities as well. Hundreds of Catholic and other health care organizations throughout the country use these resources.

The steps involved in the social accountability community benefit process include:

- ***Reaffirming the commitment:*** assuring that governing boards, managers and all staff understand and act upon the organization's mission, and affirming that policies and procedures support that mission.
- ***Planning and budgeting for community benefit programs:*** partnering with the community to assess needs and available assets to determine community priorities, and developing a comprehensive community benefit plan; and establishing a detailed community benefit budget.
- ***Monitoring services and outcomes:*** tracking various community benefit programs and activities and assuring that they are addressing identified needs and priorities. Over 800 health organizations track their community benefit programs using a software program, designed to complement the book, The Community Benefit Inventory for Social Accountability (CBISA).
- ***Reporting community benefits:*** showing accountability to the communities served and to others, and demonstrating that we continue to fulfill our charitable mission.
- ***Evaluating community benefits:*** determining if the right steps are being taken to serve an identified community need and provide maximum value; adjusting programs accordingly to ensure that they reflect a high standard of quality; and carefully monitoring results to accurately report the community impact.

Over the past year, we have accelerated efforts to achieve greater standardization in reporting community benefits. With VHA, we published *Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability.* This comprehensive document spells out what should and should not be considered community benefits. It directs community benefit programs to measure benefits in terms of cost, not charges; not to include bad debt; and recommends not including the shortfall from Medicare.

With the American Hospital Association, we are advocating widespread use of these guidelines so that not-for-profit hospitals throughout the nation are reporting how they serve their communities in a more standardized way. We also are working with our organizations' chief financial officers, the Healthcare Financing Management Association, and the American Institute of Certified Public Accountants to develop accounting guidelines for more consistent reporting of community benefits.

Budgeting is an important part of this social accountability process. We discovered early on that, in times of fiscal constraint, community benefit services must be proactively assigned a budget, to ensure they are not vulnerable to being reduced or eliminated. We, like every household, must work within a budget that covers expenses, maintenance, and future plans. So, like a typical family having many competing needs, unless they plan in advance to donate to charities important to them, there will be nothing left over at the end of the year. Therefore, as we develop our operational plans and budgets, our facilities assess community need and determine the budget amounts that must be allocated to respond to those needs. The resources for budgets come from various sources. While we are able to raise some funds through foundations and other philanthropic efforts, community benefit is provided to a great extent by utilizing the resources of the organization.

Benchmarks

We are often asked how much charity care and community benefit not-for-profit organizations should provide. Our facilities, systems and national association struggle with this issue and we have concluded that at least nationally, there is no common benchmark. The key issue is that all our resources are earmarked for the community. Some are in charity care, some in community programs, some in technology, and some held in reserve as prudent stewards of a major community asset.

Community need differs from state to state and from community to community. What is sufficient community benefit in one area may be insufficient in another. In states where the Medicaid programs cover most low-income people there may be minimal need for charity care, but hospitals must make up the difference between what Medicaid pays and the cost of care. In other states where low-income families

and persons may not be covered through Medicaid, there will be a large need for charity care.

Another reason we are unable to come up with a benchmark is that we believe asking how much is spent on community benefits is in many cases the wrong question. As I mentioned earlier, low-cost programs often can have more far reaching impact than higher cost programs. Increasingly, our facilities are looking at how they can improve the health of uninsured persons and avoid high-cost charity care in their emergency rooms and their hospitals by reaching out to them before their conditions reach a dangerous stage, managing chronic illness, and preventing episodes or acute illness. For example, teaching children and their parents how to deal with asthma and ensuring that the child's asthma is being well managed can prevent expensive trips to the emergency room and emergency hospitalizations. A numeric benchmark looking only at how much is being spent would not capture this cost saving, let alone the improved health and quality of life for the parents and child.

A better question to ask is: what is the value we are providing to our communities? This is the most pressing issue for community benefit professionals today. They are expending considerable effort to assess the return on investment from community benefit activities and to evaluate the impact their services are having.

A final reason why benchmarks cannot be assigned is that, despite efforts to improve standardization in reporting community benefits, there are still major challenges in how health care organizations account for and report community benefits. This is due in part to competing requirements from state governments and other agencies. Our social accountability materials advise organizations to report only those services that meet specific requirements. We recommend, for example, separating bad debt from charity care, although we realize much bad debt represents care given to persons who cannot afford to pay. In most situations we do not consider the shortfall from Medicare, which can be considerable, to be counted as community benefit. So when an organization following our guidelines is compared with another that counts activities that we do not count, including bad debt and the Medicare shortfalls, the comparison is neither fair nor instructive. Therefore, we are pleased that there are major efforts under way in the hospital and accounting industries to improve reporting standards.

Still, we firmly believe that our organizations should be accountable for the community benefit services they provide. We recommend that the executive and governing leadership of our organizations ask:

- Are we maximizing the use of resources consistent with the community needs we have identified?
- Are we providing our share of community benefit consistent with the resources available to us?
- How does it compare with past levels and capacities?
- Does our spending on community benefit exceed the value of our tax exemption?

There are several indications that these guideposts are being widely and successfully used. An informal survey of CHA and VHA members indicates that over the past four years, despite fiscal pressures, the amount of community benefit being provided increased. Furthermore, witnesses at the Committee's last hearing agreed that most hospital community benefit spending exceeds the value of their tax exemption.

Many Catholic and other not-for-profit health care organizations set benchmarks and carefully examine their contribution to the community. My organization, the Sacred Heart Health System, reports that in 2004 two dollars was spent on charity care and community benefit for every dollar made in terms of operating income.

In the summer of 2004, a large multi-hospital Catholic system in the mid-west undertook to estimate the value of its tax exemption, to determine if it could validate a favorable community benefit being provided for the tax exemption received. The system discovered that there is no established or agreed-upon methodology or formula for making such an estimate. Additionally, many community benefit programs are difficult to value precisely, as intangible and social health and community benefits are often difficult to quantify.

They reviewed the methodology and components of the approach to estimate the value of their tax-exemption with their independent auditors. The auditors provided comments that were incorporated to the extent it was feasible to do so. The system has created an estimate that is reasonably believed to be as accurate as is presently possible.

The components of tax exemptions that were included in their estimate are:

- Reduced interest paid from tax-exempt financings

- Reduced federal/state unemployment taxes
- State and local sales taxes on all purchases of supplies and equipment
- Real estate taxes
- Personal property taxes
- Corporate franchise taxes
- City, state and federal income taxes

Estimated value of 2003 tax exemption as compared to 2003 Community Benefit[2] or care for the Poor[3]

	Health System	Representative Hospital Region
Care for the Poor	$137M	$ 9.2M
Community Benefit (includes Care for the Poor + benefits to the broader community)	$202M	$13.5M
Value of Tax Exemption	$115M (est.)	$ 6.0M (est.)
Estimated ratio of return to the community of the value of Community Benefit compared to the value of tax exemption	1.76:1	2.25:1
Estimated ratio of return to the community of the value of Care for the Poor compared to the value of tax exemption	1.19:1	1.53:1

Note: The Health System ratios are aggregates for a 29 hospital system. The ratios for hospital regions vary considerably, due to the many unique factors in individual communities, but in all instances, the Community Benefit provided exceeded the value of tax exemptions received.

[2] Community Benefit includes Care for the Poor, plus the unreimbursed cost of health professional education, unreimbursed cost of research, and the cost of programs that benefit the health of the broader community (*e.g.,* stop smoking groups, nutrition classes, etc.) It does not include bad debt expenses or losses on the cost of providing Medicare services.

[3] Care for the Poor includes the cost of charity care, the unreimbursed cost of Medicaid and the costs of programs that specifically focus on the poor (*e.g.,* free immunization programs).

Standards for Community Benefit

For almost twenty years, CHA has worked to improve the standard of planning and reporting of community benefit. In 1992, we established a set of community benefit standards. These call for Catholic health care organizations to ensure that:

- Mission statements reflect a commitment to community benefit;
- Governing bodies adopt, make public, and implement a community benefit plan;
- Community benefit services provided to the materially poor and broader community are designed to improve health status in the community and access to health care services; and
- Annual community benefit reports describe the scope of services and collaboration with others.

Health Care and Not-for-Profit Organizations

I understand that one of the purposes of this hearing is to examine whether there is a difference between the behavior of for-profit, investor-owned, and not-for profit health care organizations. I believe there are clear similarities and clear differences between the two. To understand the not-for-profit sector and how it differs from the for-profit sector, the committee cannot rely on a single, one dimensional measurement such as uncompensated care. Rather, it is important to look at the organization as a whole and the benefits it provides to the community.

The fundamental distinction between the not-for-profit and for-profit health care sectors is their essential purpose, their mission. I realize that most for-profit health care facilities provide excellent quality of care, but the ultimate purpose of for-profit health care is to be profitable. The purpose of the not-for-profit sector is healing, teaching, research, and community service.

Our institutions are not "for-profit" in the sense that revenue surpluses may not enrich any individual. Rather, the not-for-profit sector health care provider uses surpluses to expand health care services, meet future capital needs, invest in technology and innovation, cover future deficits, and to provide community services. Not-for-profit organizations must earn a surplus when circumstances permit because

failure to do so would result in at least a gradual degradation in the quality and a decline in services.

Not-for-profit health care providers also are less market sensitive and more likely to remain within a community and to continue necessary clinical programs in times of economic distress. That long-term commitment to our communities, and our efforts to remain in them through good times and bad, also distinguishes not-for-profit health care.

In 1995, Cardinal Joseph Bernardin in a speech before the Harvard Business School Club of Chicago said, "The not-for-profit structure is better aligned with the essential mission of health care delivery than is the investor-owned." He argued that health care's purpose is to serve human need, not to promote economic ends. This primarily non-economic goal, he said, is best advanced in the not-for-profit health care system because that structure is best suited to promoting access, a patient-first professional ethic, and attention to community-wide needs.

Community Benefit and Tax Exemption

The Catholic Health Association commends the Committee for reexamining the tax exemption for all types of federally tax-exempt organizations and asking whether the community benefit standard, now 36 years old, continues to be the appropriate standard for the Internal Revenue Service to apply in determining a health care facility's entitlement to exemption. Although Catholic hospitals and other not-for-profit health care providers are motivated by far more than just IRS expectations in serving their communities, it is also true that continued tax exemption is vital in allowing or encouraging our community service role.

Tax-exempt hospitals would lose the ability to access tax-exempt bond financing for new facilities and equipment in the event they were no longer exempt. While taxable debt and equity capital may be available for investment in hospital activities during favorable times of the nation's economy, that is not always so. Moreover, the ability to use tax-exempt financing allows facilities to borrow at lower costs, thereby allowing them to make the necessary capital investments to replace or update the facilities and equipment to fulfill their mission. That ability to update facilities and technology in health care is closely tied to quality and healthy outcomes.

Other benefits of continued exemption include not having to pay federal income tax on net income or federal unemployment tax; state and local tax exemptions on income, sales and use, and real property; access to favorable pricing on drugs and medical supplies and mailing rates; and access to certain government grant programs.

The value of tax exemption varies from facility to facility, depending on its net income, the value of its property and local tax rates, and the value of its outstanding tax exempt bonds. A recent study by PricewaterhouseCoopers' Health Research Institute estimates that the total tax benefit of exemption (federal, state, and local) for a 300-bed average community hospital equals about $6.5 million annually. This amount is twice the hospital's surplus, and would take the hospital from a small positive margin to a loss if the facility had to pay all taxes.

While we agree that a review of the standards for exemption and the charity care and community benefit activities of hospitals is valuable, we also want the Committee to be aware that Catholic hospitals and other not-for-profit providers are already themselves reevaluating their charity care policies and reexamining their pricing and the availability of discounts for the uninsured. The PricewaterhouseCooopers study points out that 70 percent of hospitals reported a voluntary revision of charity care and pricing policies for the uninsured over the last year.

Sponsors, governing boards, and executive leaders continue working to assure ready access to charity care by simplifying and strengthening charity care policies and procedures. One advantage of the flexibility of the current IRS community benefit standard is that hospitals can make needed changes to their policies and practices that reflect the unique characteristics of the communities they serve and adjust them according to experience within that standard.

Conclusion

In conclusion, Mr. Chairman, the community benefit tradition in Catholic and other not-for-profit health care organizations is thriving and being reinforced by efforts to better account for these activities and to evaluate their effectiveness. Our long-term commitment to the people in our communities is being demonstrated every day, but we strive to do better. We believe that the not-for-profit health care sector and the communities we serve continue to deserve tax exemption, and that it is the responsibility of our organizations to demonstrate this to their governing bodies, staff and communities.

Over a decade ago, Senator Daniel Moynihan said, "A distinguishing feature of American Society is the singular degree to which we maintain an independent sector—private institutions in the public service. This is no longer true in most of the democratic world; it was never so in the rest. It is a treasure, a distinguishing feature of the American democracy." It is important to us in Catholic health care that we continue that tradition of service. That is our mission. That is our commitment to you and to the communities we serve.

Chairman THOMAS. Thank you, Sister. Dr. Horwitz.

STATEMENT OF JILL R. HORWITZ, PH.D., ASSISTANT PROFESSOR, UNIVERSITY OF MICHIGAN LAW SCHOOL, ANN ARBOR, MICHIGAN; AND FACULTY RESEARCH FELLOW, NATIONAL BUREAU OF ECONOMIC RESEARCH, CAMBRIDGE, MASSACHUSETTS

Dr. HORWITZ. Mr. Chairman, Mr. Rangel, members of the Committee, in its review of the tax-exempt sector, this Committee is considering questions that are particularly important for the hospital industry, where nonprofit, for-profit, and government institutions operate side by side. In my written testimony, I discussed two questions about the implications of the mix of hospital types: first, do hospitals act differently; and, second, are there significant competitive issues raised by having different hospital types competing in the same markets together? I confine my oral remarks to the first question. There is good reason to expect nonprofits and for-profits to behave alike. They are all hospitals. They treat sick people with the same doctors, nurses and medical equipment. Superficially, as Chairman Thomas mentioned earlier, they resemble each other so much that a patient admitted to a hospital is unlikely to be able to tell whether it is a for-profit or a nonprofit, even with the blindfold off. However, whether you find differences depends on where you look. Most research on hospital ownership has found little difference by looking at financial measures such as costs, margins, capital sources and non chief executive officer salaries. These financial measures, however, provide an incomplete picture of a hospital. Because they are first and foremost providers of care for the sick and the injured, to evaluate whether nonprofit hospitals earn their keep we must also know how they differ in terms of the medical care they provide.

In my research on medical services, I have found large, systematic and longstanding differences among hospital types. For-profit hospitals are more likely than their nonprofit counterparts to offer the most profitable services and less likely than either nonprofits or government hospitals to offer unprofitable services, some of which are valuable, even essential. Let me offer a few examples. Psychiatric emergency care is considered an extremely unprofitable service, both because of low reimbursement and because patients tend to be poor and uninsured. It is easiest to see how much service provision depends on ownership on a chart. Comparing hospitals that are similar in terms of size, teaching status, markets, and location, for-profits are 7 percentage points less likely than nonprofits and 15 percentage points less likely than government hospitals to offer this kind of care. Compare these results to open heart surgery, a service that is so profitable it is often referred to

as the hospital's revenue center. For-profits are predicted on average to be 7 percentage points more likely than similar nonprofit hospitals and 13 percent percentage points more likely than government hospitals to provide open heart surgery. Perhaps what is most striking is how large and quick the for-profit response is. Post-acute services like home health care, whose profitability changed sharply over time, offer the best illustration of this. While profitability potential increased, for-profit entry more than tripled. Other types increased their investment, but they did so at a much lower rate. When these services became unprofitable in 1997, for-profits were also quick to exit the market, roughly five times quicker than nonprofits.

In sum, for-profit and nonprofit hospitals act quite differently in service provision. For-profits are considerably more responsive to financial incentives, not just in service provision decisions but also in their willingness to operate at all. When they come under financial pressure, for-profit hospitals are more likely to close or restructure than are nonprofits. In addition, nonprofits are more willing than for-profits to offer services even though they happen to be unprofitable—not just psychiatric emergency care but also child and adolescent psychiatric care, AIDS treatment, alcohol and drug treatment, emergency rooms, trauma services, and obstetric care. There are a few clear implications of these findings for whether nonprofits provide valuable benefits for society. First, if the mix of medical services available in a community is strongly determined by the profitability of those services, this is potentially worrisome for all patients, rich and poor, insured and uninsured. Patients need what they need depending on their medical condition, not on how much the service pays. Second, extreme responsiveness to financial incentives can be quite costly to the government. For example, during that period of ramped-up provision of home health services, visits per Medicare beneficiary increased by nearly a factor of seven, and payment for those services ballooned. It wasn't that patients were getting better care but that hospitals were double-dipping in terms of payments.

This responsiveness has even lead to fraudulent billing through a practice known as "up-coding," which occurs when a hospital shifts a patient's diagnosis to a higher reimbursement group. For example, a hospital may identify a case of pneumonia as a case of pneumonia with complications and get about $2,000 extra on a patient treatment. For-profit hospitals have been found to do this more than nonprofits. In conclusion, what you find depends on where you look; and looking only at charity care provision or other financial measures does not give a complete picture of differences among hospital types. If you look at medical treatment, you will find some striking differences of the sort that need to be included in any thorough discussion of nonprofit benefits. Thank you.

[The prepared statement of Dr. Horwitz follows:]

Statement of Jill R. Horwitz, Ph.D., Assistant Professor, University of Michigan Law School, Ann Arbor, Michigan; and Faculty Research Fellow, National Bureau of Economic Research, Cambridge, Massachusetts

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, thank you for the opportunity to speak with you today. My name is Jill Horwitz. I am an Assistant Professor of Law at the University of Michigan and a Faculty Research Fellow at the

National Bureau of Economic Research, although the opinions I offer today are my own.

Mr. Chairman, in its review of the tax-exempt sector, this Committee has heard many distinguished witnesses discuss the legal requirements governing nonprofit organizations, the advantages that come with nonprofit status, and whether nonprofit organizations provide sufficient public benefits to justify these advantages. These are particularly important questions for the hospital industry, where for-profit, nonprofit, and government hospitals operate side by side.

In my testimony, I will discuss two questions about the implications of the mix of hospital types: First, do different types of hospital act differently? Second, are there significant competitive issues raised by having different hospital types competing in the same market together?

Medical Service Provision

Underlying many of the policy questions about the legal treatment of nonprofit hospitals is one basic issue: do they act the same as for-profit hospitals—and if not, what are the differences and are they big enough to matter?

There are good reasons to expect hospitals of different ownership status to act alike. They all share common goals of treating sick people; they all employ large numbers of doctors and nurses, using medical technology; they contract with the same employers and insurance companies, and are subject to the same health care regulations. Superficially, they resemble each other so much that a patient admitted to a hospital is unlikely to be able to tell whether it is a for-profit or a nonprofit.

However, whether you find differences between nonprofit and for-profit hospitals depends on where you look. Most studies of hospital ownership have examined financial measures, and have found little difference among hospital types.[1] For example, research has shown that nonprofit and for-profit hospitals are quite similar in their costs,[2] sources of capital,[3] exercise of market power,[4] and adoption of certain types of technology.[5] Although for-profit hospitals pay higher wages and offer incentives to top managers, nonprofits are increasingly using performance-based pay as well.[6] Finally, during the early 1990s for-profit hospitals and nonprofits had similar margins, although for-profit margins were higher than those of nonprofits by the late 1990s.[7] There is some evidence that in the most recent years the average nonprofit hospital had a negative income per admission, while the average for-profit had a positive income per admission.

Such financial measures, however, provide an incomplete picture of a hospital. Because they are first and foremost providers of care for the sick and injured, to evaluate whether nonprofit hospitals earn their keep we must also know how hospitals differ in the *medical care* they provide.

In my research on medical services, I have found large, systematic, and longstanding differences among hospital types. For-profit hospitals are more likely than their nonprofit counterparts to offer the most profitable services, and less likely than either nonprofits or government hospitals to offer services that are unprofitable yet valuable, even essential.

I will offer a few examples. Psychiatric emergency care is considered an extremely unprofitable service, both because of low reimbursements and because its patients tend to be poor and uninsured. Comparing hospitals that are similar in terms of

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[1] F. Sloan, "Not-for-profit Ownership and Hospital Behavior," in *Handbook of Health Economics Vol. 1* eds. A.J. Culyer and J.P. Newhouse (Amsterdam:Elsevier Science B.V., 2000): 1141–1174.

[2] T.S. Snail and J.C. Robinson, "Organizational Diversification in the American Hospital," *Annual Review of Public Health* 19, (1998):417–453, F.A. Sloan, et al., "Hospital Ownership and Cost and Quality of Care: Is There A Dime's Worth of Difference?," *Journal of Health Economics* 20, no. 1, (2001):1–21.,

[3] M.A. Laschober and J.C. Vertrees, eds. *Hospital Financing in the United States* (Washington, D.C.: Office of Technology Assessment, 1995).

[4] M. Gaynor and D. Haas-Wilson, "Change, Consolidation, and Competition, in Health Care Markets," *Journal of Economic Perspectives* 13, no. 1, (1999):141–164.

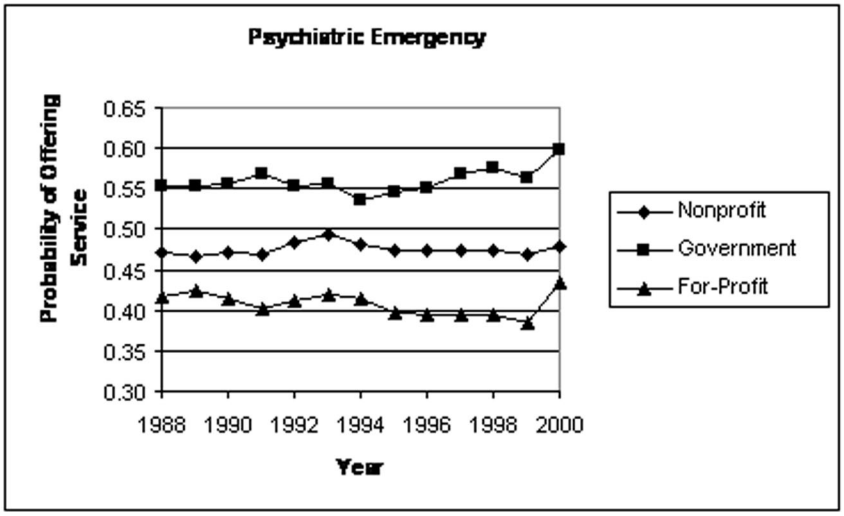
[5] F.A. Sloan, et al., "Hospital Ownership and Cost and Quality of Care: Is There A Dime's Worth of Difference?," *Journal of Health Economics* 20, no. 1, (2001):1–21.

[6] M.J. Roomkin and B.A. Weisbrod, "Managerial Compensation and Incentives in For-Profit and Nonprofit Hospitals," *Journal of Law, Economics, and Organization* 15, no. 3, (1999):750–781, B. Erus and B.A. Weisbrod. Objective Functions and Compensation Structures in Nonprofit and For-Profit Organizations: Evidence from the "Mixed" Hospital Industry. In: E.L. Glaeser, ed. *The Governance of Not-For-Profit Organizations.* Chicago: University of Chicago Press; 2003:117–142.

[7] R. Frank and D. Salkever. Market Forces, Diversification of Activity, and the Mission of Not-for-Profit Hospitals. In: D.M. Cutler, ed. *The Changing Hospital Industry: Comparing Not-for-Profit and For-Profit Institutions.* Chicago, Illinois: University of Chicago Press; 2000:195–215..

size, teaching status, location, and market characteristics, for-profit hospitals were 7 percentage points less likely than nonprofits and 15 percentage points less likely than government hospitals to offer psychiatric emergency services.

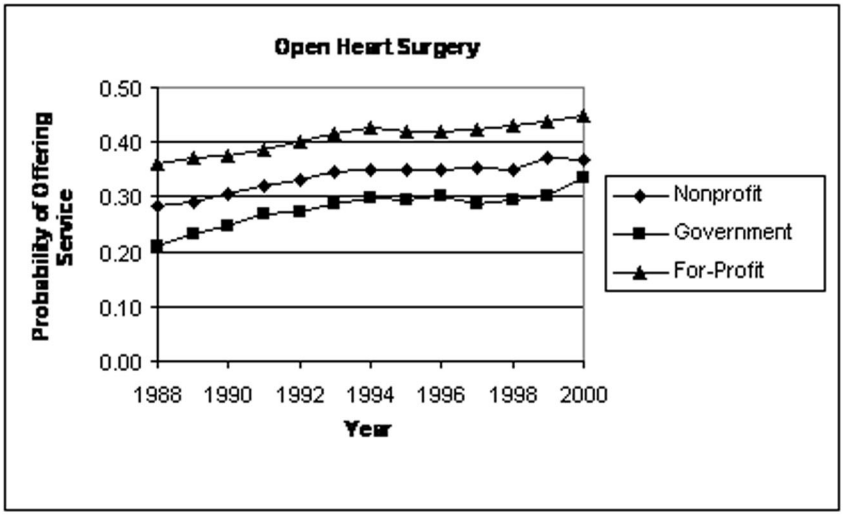
Probability of Offering Psychiatric Emergency Services



SOURCE: Jill Horwitz, "Making Profits and Providing Care: Comparing Nonprofit, For-Profit, and Government Hospitals," Health Affairs, v.23, n.3 (2005): 790–801.
NOTES: Controlling for size, teaching status, location, and market characteristics.

Compare these results to open heart surgery, a service so profitable that is often referred to as the hospital's "revenue center." For-profit hospitals are over 7 percentage points more likely than similar nonprofit hospitals and 13 percentage points more likely than government hospitals to provide open-heart surgery.

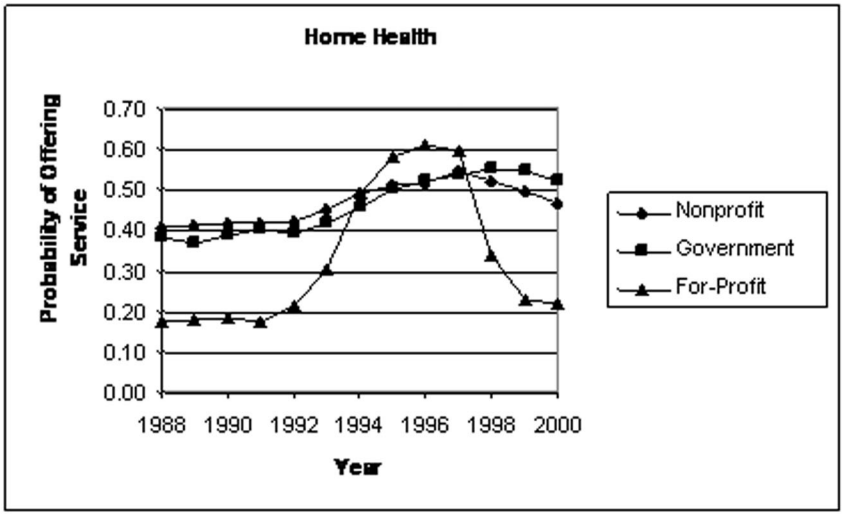
Probability of Offering Open Heart Surgery



SOURCE: Jill Horwitz, "Making Profits and Providing Care: Comparing Nonprofit, For-Profit, and Government Hospitals," Health Affairs, v.23, n.3 (2005): 790–801.
NOTES: Controlling for size, teaching status, location, and market characteristics.

Perhaps what is most striking about for-profit hospitals is how strongly and quickly they respond to changes in financial incentives. The best illustration of this comes from a set of post-acute care services, such as home health-care and skilled nursing services, whose profitability changed sharply over time. These services became highly profitable in the early 1990s, then reversed and became less profitable with the 1997 Balanced Budget Act. All three types of hospitals increased their offerings of home health care when it became profitable, but for-profits did so to a striking degree. From 1988 to 1996, the probability of a for-profit hospital offering home health services more than tripled—from 17.5 percent to 60.9 percent. During the same period, nonprofit and government hospitals increased their investment at a much lower rate (nonprofits went from 40.9 to 51.7 percent, government hospitals went from 38.1 to 51.9 percent). When these services became unprofitable, for-profits were also quick to exit the market, roughly 5 times quicker than nonprofits. This finding provides evidence that for-profits move quickly and strongly in response to financial incentives.

Probability of Offering Home Health Service



SOURCE: Jill Horwitz, "Making Profits and Providing Care: Comparing Nonprofit, For-Profit, and Government Hospitals," Health Affairs, v.23, n.3 (2005): 790–801.
NOTES: Controlling for size, teaching status, location, and market characteristics.

In sum, for-profit and nonprofit hospitals act quite differently. For-profit hospitals are considerably more responsive to financial incentives than nonprofits, not just with respect to their decisions to offer services but also in their willingness to operate at all. Under financial pressure, for-profit hospitals are more likely to close or restructure than nonprofits.[8]

The most important aspect of these findings is that nonprofits are more willing than for-profits to offer services even though they happen to be unprofitable. These services include not just psychiatric emergency care, but also child and adolescent psychiatric care, AIDS treatment, alcohol and drug treatment, emergency rooms, trauma services, and obstetric care.

There are a few clear implications of these findings for the question of whether nonprofits provide valuable benefits to society. First, if the mix of medical services available in a community is strongly determined by the profitability of the services, this is potentially worrisome for all patients—rich and poor, insured and uninsured.

[8] R. Zeckhauser, J. Patel and J. Needleman, *The Economic Behavior of For-Profit and Nonprofit Hospitals: The Impact of Ownership on Responses to Changing Reimbursement and Market Environments*: The Robert Wood Johnson Foundation, 1995).

Patients need what they need, depending on their medical condition not on the price of a service. Even rich and insured patients sometimes need services that it are unprofitable for hospitals to offer.

As I noted above, nonprofits are more likely to offer a trauma center than for-profit hospitals with similar characteristics. One hopes never to be in a serious car crash. But survivors are more likely close to a trauma center if the accident takes place just outside a nonprofit hospital.

Second, extreme responsiveness to financial incentives can be quite costly to the government. Medicare spending per patient and increases in spending rates are higher in for-profit hospital markets than others.[9] This can be explained by investments such as home health. For example, during that period of ramped up provision of home health care services, home health visits per Medicare beneficiary increased by nearly a factor of seven, and payments for those services ballooned. Government spending on post-acute care went from 3 percent of Medicare hospital payments to 26 percent.[10] This increase was not patients getting better care, but hospitals double-dipping—receiving two reimbursements for the same treatment.

Perhaps more troubling is evidence that the relative responsiveness to financial incentives has led to fraudulent billing through a practice known as "up-coding." Up-coding occurs when a hospital shifts a patient's diagnosis to one that receives higher reimbursement from Medicare. For example, a hospital may label a case of pneumonia as a case of pneumonia with complications, at increased cost to the government of about $2,000 per discharge. Although all types of hospitals have done this, for-profit hospitals have done this more than nonprofit hospitals.[11] Moreover, up-coding is contagious. Nonprofit hospitals are more likely to up-code when they have for-profit hospital neighbors than when they do not.

As a final point on differences in hospital behavior, let me say a word about charity care. Over the past fifty years, the legal requirements for nonprofit hospitals seeking tax exemption have increasingly shifted from narrow requirements that hospitals relieve poverty to broader demonstrations of charitable benefit. Yet, public attention to the provision of what is called "charitable care" has remained robust. Whether nonprofit and for-profit hospitals differ in their provision of charity care is difficult to say—in large part because what is typically measured is overall uncompensated care. Uncompensated care provided by hospitals represents items that most of us would not consider charitable. These include bills left unpaid by patients who have the ability to pay or discounts to insurance companies. Given these measurement difficulties, credible evidence shows that hospital types do not differ much in the provision of uncompensated care.[12] Even these results are hard to interpret because for-profit hospitals locate in relatively better-insured areas.[13] My main point in discussing charity care is that although free care for those who are unable to afford it is important, other differences—in services, in quality, in medical innovation—are valuable to all members of society.

Hospital Competition

Do nonprofit hospitals have anti-competitive effects, or represent unfair competition to for-profits? The arguments about competition boil down to the idea that the nonprofit tax exemption is either unfair or distortionary. An older generation of research claimed, for example, that the tax exemption gives nonprofits an extra financial boost that makes it difficult for for-profits to compete. Newer research has dismissed this notion by demonstrating that income tax exemptions do not lower input prices. Furthermore, as an empirical matter, if there were anti-competitive effects we would not see mixed markets with both for-profit and nonprofit hospitals, but we do.

Some argue that nonprofits are less efficient than for-profits and are able to stay in business because they use their surpluses, including tax savings, to offset higher production costs. This idea, too, has little foundation. In determining whether an organization is efficient, it is centrally important to answer the question "efficient at

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[9] E. Silverman, J. Skinner, and E. Fisher, "The Association Between For-Profit Hospital Ownership and Increased Medicare Spending," *New England Journal of Medicine* 341, no. 6, (1999):420.

[10] J.P. Newhouse, "Medicare," in *American Economic Policy in the 1990s,* eds. J.A. Frankel and P.R. Orszag (Cambridge, Massachusetts: MIT Press, 2002), 899–955.

[11] E. Silverman and J. Skinner, "Medicare Upcoding and Hospital Ownership," *Journal of Health Economics* 23 (2004): 369–389.

[12] F. Sloan, "Commercialism in Nonprofit Hospitals," *Journal of Policy Analysis and Management* 17, no. 2, (1998):234–252, G.J. Young, K. Desai and C.V. Lucas, "Does the Sale of Nonprofit Hospitals Threaten Health Care for the Poor?," *Health Affairs* 16, no. 1, (1997):137–141.

[13] E.C. Norton and D. Staiger, "How Hospital Ownership Affects Access to Care for the Uninsured," *RAND Journal of Economics* 25, (1994):171–185.

what?" For-profits are more efficient at earning profits. In the hospital sector, we care about efficiency in providing health care. Overall, empirical evidence shows no appreciable differences in efficiency at providing health care between for-profit and nonprofit hospitals.

A final idea is that tax savings leads nonprofits to produce too many goods of too little value. That is, nonprofits use their financial savings to lower costs and, therefore, patients will buy too much health care. This argument implies that the health care provided by nonprofit hospitals is too cheap. The idea that health care is too *inexpensive* is generally not of great concern, particularly when annual medical inflation rates are back on the rise at 4 percent per year.

The best evidence shows that nonprofit hospitals, rather than using their financial savings to offset inefficient management or lower prices to drive for-profit competitors out of business, provide unprofitable and essential services that are valuable to society. These come not only in the form of more valuable medical services like trauma care, but also in training physicians and nurses. It is the vigorous competition *among* nonprofit hospitals that has produced virtually all the medical innovations on which we rely. Imagine where we would be without the first small pox vaccination developed at the nonprofit HarvardMedicalSchool or the first brain surgery at Johns Hopkins. We can thank nonprofits for robotic surgery, pacemakers, artificial skin, kidney transplants, and new technology to save premature infants. Finally, along with the competition among nonprofit hospitals, having for-profits in the mix provides another dimension of competition, competition between organizational types.

An important lesson of the research I have summarized today is that what you find depends on where you look. If you look at financial behavior, you will find few differences that justify tax exemption. If you look at medical treatment, you will find some striking differences of the sort that need to be included in any thorough discussion of nonprofit benefits.

Thank you for the opportunity to testify today.

Chairman THOMAS. Thank you. Ms. Kane.

STATEMENT OF NANCY M. KANE, PROFESSOR OF MANAGEMENT, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD SCHOOL OF PUBLIC HEALTH, BOSTON, MASSACHUSETTS

Ms. KANE. Thank you. I just want to correct, again, for the record, that I am from the Harvard School of Public Health, not the Harvard Business School. But thank you, Mr. Chairman and the Committee, for inviting me to speak.

Chairman THOMAS. I am not familiar with the local turf, but I assume that was a major concern otherwise.

Ms. KANE. It is a minor issue. In any case, I just wanted to address the question that I have understood to be before the Committee, which is should nonprofit hospitals retain their tax exemption. I think, as many of you heard from my last testimony, I am one of the most severe critics of the way nonprofit hospitals—some nonprofit hospitals have discharged their charitable obligations. From some of the studies I have done, I concluded that many clearly do not provide charity care that is commensurate with the value of their tax-exempt benefits; and some are behaving increasingly distinctly uncharitably toward patients who cannot afford their care, as previous witnesses have described. However, we have to be honest. Federal tax-exempt standards of behavior are minimal and really do not require that hospitals provide charity care, and I think that is part of what we are talking about today. I think it is also important to understand why nonprofit hospitals are increasingly perceived as uncharitable and more commercial than

they used to be in the past. Perhaps some of those issues need also to be addressed when one discusses what kind of behavior one would like to see.

One of the things that is very important, I think, is that hospitals have a charitable mission, but they have Wall Street financing. The newest mantra I have heard many times over is "no margin, no mission." Unfortunately, I am afraid some of that has translated into no mission but a very healthy margin; and it is concerning a lot of people in terms of the priorities of hospitals, nonprofit hospitals. Another issue is that competitive markets have been reducing the availability of subsidies from insured patients, which hospitals used to support the uninsured, and that is because we believe in competitive markets and in pricing systems that allow competition but don't recognize the social obligations of our hospitals. Another issue I think is that hospitals, in order to compete or deal with managed care, and financing methods, have gone on extremely expensive, extremely unprofitable and often unwise acquisition and expansion sprees that have not resulted in value added but have cost a lot of money and that detracted from the hospital system's ability to finance their uncompensated care.

I guess, finally, and one of the issues I am most concerned about, is that many nonprofits—not all, but many—have very weak governance structures. They are different, from investor-owned boards for sure. I think boards are too often chosen for their wealth, their social connections and/or their compatibility with the senior management, instead of actively exercising their duty of oversight. I think those are all issues that we might want to consider trying to strengthen in the nonprofit form, rather than tossing the nonprofit form out the window. I am not supportive of revoking Federal tax exemption. I think we brought the issues about that out pretty well in the testimony to date.

First of all, you are punishing everyone for the sins of a few—not necessarily a few, but some. I think you will lose more value than you will gain in certainly Federal tax revenue because of the philanthropy, the grants, the community prestige, the trust and the State and local tax exemptions, all of which may no longer go toward supporting health care. I think we don't want to push our nonprofit hospitals toward the investor-owned sector, which has even higher incentives to cherry-pick services and service areas, to provide unnecessary care and to exploit loopholes in our very complex tax and payment systems that are hard to detect and cost a lot just to provide oversight for those types of activities.

I do recommend that we should strengthen our standard for Federal tax exemption. I agree with several of the witnesses today, that we should require some of the types of things that have been requested by many parties, including the Catholic Health Care Association, and the Champaign County Board of Assessors and other parties who have suggested that there should be requirements of eligibility standards for charity that should be tied to income and that should relate the magnitude of a payment to the person's income, and that patients should be informed of the availability of charity care. For those who are not eligible, the amount that they have to pay should be related to their ability to pay and a reasonable timeframe to pay it in, that harmful collection practices that

ruin people for life should be stopped, and that hospitals should partner with community groups to focus on indigent populations to improve their care and access.

Finally, I think that hospitals should be encouraged to publicly report on the costs of charity, bad debt and other community benefits in ways that will meaningfully inform the public. I encourage the Committee to consider reducing some of the incentives that have encouraged uncharitable behavior. Perhaps there should be other things such as grant programs, rather than loans for capital requirements, that are deemed essential to the community. I had the opportunity to attend a seminar by a fellow who helps critical access hospitals find loans. However, he said he could only find loans for things like imaging centers and not for obstetric services, even though the community really needed obstetric services. So, I think there is a need to look at the capital distribution and the access to capital and when it should be a loan and when perhaps it should be a grant, and I think there may also be other issues around governance, encouraging boards to self-evaluate and report on their compliance with good governance practices. I think a board should have a permanent Committee that reviews its charitable policies and monitors and reports on them annually to the board and makes that available to the public. Thank you for inviting me to testify, and I am happy to respond to any questions.

[The prepared statement of Ms. Kane follows:]

Statement of Nancy M. Kane, Professor of Management, Department of Health Policy and Management, Harvard School of Public Health, Boston, Massachusetts

Mr. Chairman, Members of the Committee:

I am here to comment on the question of whether or not nonprofits hospitals should remain tax-exempt, and if so, under what standards of behavior. As I have mentioned in previous testimony to this committee,[1] my prior research indicated that many nonprofit hospitals do not provide charity care at amounts that would justify the value of their tax-exempt benefits. As recent events indicate, many exempt hospitals are actively engaged in avoiding the provision of charity care and instead are aggressively billing and collecting from patients who cannot afford to pay their bills. Unfortunately, the federal standard for tax-exemption does not prohibit this kind of activity, and most states have followed the federal definition of exempt behavior as the basis for state and local tax exemption. Some states have attempted to strengthen the standard for state and local exemptions, with limited success.[2] Still ambiguous state standards of community benefit, coupled with limited resources for monitoring and enforcement, have hampered state efforts to increase the provision of charity care by exempt hospitals.

However I do not support efforts to revoke the federal tax exemption for nonprofit hospitals. I strongly urge Congress to strengthen the standard and tie it more specifically to the provision of charity care. Uncharitable behavior is due to a number of forces in the hospital market place that will not go away with the loss of tax-exemption; but the loss of exemption will reduce the already weak incentives in place for hospitals to maintain social as well as economic goals.

Why are Nonprofit Hospitals Behaving Uncharitably Toward Patients Unable to Pay All or Part of Their Bills?

I see at least four major forces that encourage tax-exempt hospitals to behave uncharitably in the face of a weak standard for tax exemption and a growing number of individuals and employers who can no longer afford to buy comprehensive health insurance:

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[1] "Statement to the Subcommittee on Oversight, Committee on Ways and Means, June 22, 2004", Nancy M. Kane

[2] See, for instance, Noble A, Hyams AL, and Kane NM. "Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives," in Journal of Law, Medicine, and Ethics, 26 (1998): 116–37.

- One is the need to obtain and repay tax-exempt debt. Bond rating agencies pressure nonprofit hospitals to produce high profit margins and very high cash balances. For instance, Moody's "Aa" rated nonprofit hospitals in 2003 reported a median total margin in 2003 of 7.3% and a median of 225 days of cash on hand.[3] This median level of profit and cash is higher than what HCA, a major investor-owned chain, achieved in 2003 (6% profit margin and 1.2 days cash on hand).
- Two is the gradual loss of opportunities to cross-subsidize the uninsured and losing services. Private insurance-negotiated rates have reduced the ability of hospitals to subsidize losses from uninsured patients; also, the loss of profitable lines of business to freestanding ambulatory sites and specialty hospitals owned by others erodes the availability of cross—subsidies for losing services that are still needed in a community.
- Three is the competitive response of hospitals to the market power of insurers; nonprofit hospitals over the last decade have made very expensive strategic investments in other hospitals, physician practices, long-term care, managed care and other businesses, at least partly in order to create a strong market presence when faced with high market-share private insurers.
- Four is the unfettered hubris of health system executives who are overseen by boards chosen more for their social connections and business achievements than for their appreciation of the needs of vulnerable members of the community or their willingness to challenge the chief executive's business assumptions.

Why Not Revoke Hospital Tax Exemption?

It would be very dangerous to address a broken system such as ours by simply revoking the federal tax-exempt status of nonprofit hospitals. Revocation of tax status is the policy equivalent of applying a blunt instrument when surgical precision is more appropriate. First, it would punish the many hospitals that have done a good job of balancing margin with mission. Second, a blanket revocation of federal tax-exempt status would revoke more benefit than the tax revenue stream it would produce to support the uninsured. That is because federal tax-exempt status is tied to philanthropic support, loan insurance, research grants, and reputation in the community, all of which add value to the exempt hospital. Furthermore, the dollar value of the federal income tax exemption is relatively small compared to the value of state and local exemptions; it constituted only 27% of the value of tax-exemption in the study I did of 507 hospitals in 1994–95; this would not go very far toward supporting the cost of the uninsured. If hospitals also lost state and local exemptions, the larger dollar value produced would go to cities and states for purposes other than supporting vulnerable populations.

In addition, I would be concerned to see more nonprofit hospitals convert to investor-owned status; two of the largest investor-owned chains have a long history of violating the ethical standards and legal constraints of our healthcare system in their pursuit of profit and rapid earnings growth. HCA, for instance, paid out close to $1.5 billion to the Department of Justice, CMS, and others in 2000–2002 to settle claims of DRG upcoding, inappropriate Medicare billing, violations of anti—kickback laws, and other actions. Tenet, which emerged in 1993 from another investor owned company associated with serious legal problems (NME), is once again facing a series of legal action regarding prices for prescription drugs, outlier payments, and unnecessary cardiac procedures. The hospital industry presents multiple opportunities to violate the public trust; putting our entire nonprofit hospital sector under quarterly earnings pressure and the possibility of private gain encourages more widespread abuse.

A Better Idea is to Define a Higher Standard for Tax Exemption and Governance

I support instead policies that raise the standard for charitable exemption, as well as policies that might address some of the factors mentioned earlier that contribute to uncharitable hospital behavior. Many of the features that would improve the charitable standard have been articulated by others, including the Champaign County Health Care Consumers[4] and recommendations by lawyers from McDermott, Will and Emery.[5] These include:

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[3] Moody's Industry Outlook and Medians, Not-for-Profit Healthcare. August 2004.

[4] Champaign County Health Care Consumers, "Community Leadership Standards for Nonprofit Hospitals", memo by Claudia Lennhoff, August 25, 2004.

[5] "Federal Tax Exemption Developments and Strategies", Bernadette M. Broccolo, McDermott Will and Emery, Chicago, Illinois; presented to the American Bar Association Health Law Sec-

Continued

- hospitals' having official charity care policies with criteria tied to federal poverty levels and the magnitude of bills relative to income;
- a process to inform patients of the availability of charity care at multiple stages in the admission and collection process;
- partnering with community groups focused on the indigent to develop programs to assist these populations in accessing appropriate types of care at the right time;
- discounted rates for uninsured patients not eligible for charity care, and reasonable terms of repayment that reflect the income and circumstances of the debtor;
- ceasing harmful legal, financial, and credit practices against patients;
- consistent and accurate disclosure of charity care, bad debt, and other community benefit costs, using the IRS Form 990 and new Medicare reporting opportunities.

Other recommendations more broadly addressing the four forces mentioned earlier include:

- develop mechanisms that reduce the level of security currently demanded by tax-exempt creditors
- require nonprofit hospital boards to give effective voice to vulnerable populations
- require a standing committee of the board devoted to monitoring and reviewing the charity care and bad debt pricing and collection practices of the hospital
- encourage good governance practices such as those recommended by the Governance Institute[6]

Thank you.

Chairman THOMAS. Thank you very much. The Chair is sorry to announce we have no vote to control our own destiny. We have two votes in a row. We then have debate on a motion to recommit, which is only 10 minutes; and then we have a 15- and a 5-minute vote following. The Chair will try to, after responding to this initial vote, get some determination of those members who would like to come back during that interim on the recommit vote to ask our witnesses questions; and if anyone is willing to accommodate the Chair in providing an opportunity to question during that time the Chair is certainly willing to respond. So, as we go in to vote, I will look for individuals; and I will come back to try to make sure that we have an opportunity for those who can fill in a 15- or 20-minute period. The Chair apologizes to the witnesses. I know there are going to be some very interesting questions. I thank you for your testimony and want to underscore the fact that the initial response to an inquiry in this area is not an attempt to pull the tax exempt status. It is an attempt to clarify, understand, and focus. With that, the Committee will recess for 20 minutes; and then we will be back.

[Recess.]

Mr. WELLER. [Presiding.] The Chairman requests the witnesses to resume their place at the table, and we will resume the hearing to allow members during this series of votes to return for questioning. Otherwise, we will proceed forward. Since several of the witnesses are in place that I wish to direct my questions to, I will take the courtesy of allowing myself to begin. First, I want to com-

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tion: "Charity Care Under the Microscope: The Threat to Tax-Exempt Healthcare Providers," April 28, 2004

[6] The Governance Institute, "Fundamental fiduciary Duties of the Nonprofit Healthcare Director," Summer 2002. www.governanceinstitute.com.

mend Chairman Thomas for conducting this hearing and focusing on the role of not-for-profit community hospitals. As I look at the district I represent in the south suburbs and central Illinois, not-for-profit hospitals are the service providers in the area that I represent. All but one hospital serving the 11th congressional district is a not-for-profit. One is a municipal hospital. Provena Saint Joe's, Provena Saint Mary's are two constituent hospitals serving Kankakee and Joliet; and, as Sister Keehan. pointed out in her testimony, the role they play not only in providing service but helping revitalize older industrial areas—I think of Silver Cross Hospital in Joliet and the role it has taken in helping to revitalize the east side of Joliet, an area that has been neglected and is now coming back, thanks to the leadership of Silver Cross. I would also note that Illinois hospitals provided by $1.2 billion in uncompensated care in Illinois. So, not-for-profits are important in my district and, frankly, in many cases, second to the schools, they are sometimes ahead of our public schools, are the biggest employers in communities that I represent. Mr. Jenkins, my colleague, Tim Johnson, sends his regards; and I just want to pass that on to you. I mentioned to him that you were before our Committee today, and Tim and I are friends going back to our days in the State legislature.

Mr. JENKINS. Thank you.

Mr. WELLER. So, it is good to have two Illinoisans before us here; Professor Colombo, too, as well. Mr. Jenkins, you had indicated, as a member of the Board of Review, that you are a part-time appointee of the county board or the county commissioners of Champaign County. Is that the case?

Mr. JENKINS. County board, yes.

Mr. WELLER. The county board. How long have you been on the board?

Mr. JENKINS. Seven years.

Mr. WELLER. Seven years. How long as chairman of the board of Review?

Mr. JENKINS. Two years.

Mr. WELLER. In your testimony you had said you had done extensive research. Did you do that personally or were you provided with staff for that purpose?

Mr. JENKINS. We don't have a staff.

Mr. WELLER. So, you did this personally?

Mr. JENKINS. Yes. Well, myself and the other two members of the Board of Review.

Mr. WELLER. I assume you are appointed the same way they are in Grundy County, my home county. Usually whoever the top vote getter is for the county, on the county ticket, their party gets to select who their board of review member is for that particular election cycle and the county board makes that appointment.

Mr. JENKINS. That is correct.

Mr. WELLER. That has been my experience, though I never served on the board. That is what I recall on the process, having been precinct Committeeman one time. Have other counties—you had made a decision to revoke the charitable tax exemption for Provena, Covenant Medical Center in Urbana as well as the Carle Clinic and—as a graduate of the University of Illinois—and led the first in—and Gregory in Champaign for 4 years, so I certainly am

familiar with those institutions personally. But have any of other counties in Illinois followed your lead in revoking the charitable tax exemption?

Mr. JENKINS. The short answer to your question is not that I am aware of, no, but I need to just clarify a couple of things that you have said. First of all, in Illinois, the local board of review only makes a recommendation to the Department of Revenue. The Department of Revenue actually grants or denies exempt status. In both cases, we recommended denial. Also, in terms of Carle, it was not Carle Clinic, which is a for-profit entity. This was on Carle foundation, under that umbrella, a Carle Foundation hospital.

Mr. WELLER. Does the Illinois Department of Revenue have a history of reversing the recommendations of the local board of review?

Mr. JENKINS. Oh, frequently. But not in this case.

Mr. WELLER. Not in this case. In the case of Champaign County has there ever been a case during the 7 years that you have been on the Board of Review where they have disagreed with you?

Mr. JENKINS. Oh, sure.

Mr. WELLER. Now, Professor Colombo has advocated essentially removing the Federal tax exemption for most not-for-profit hospitals. Do you share that view?

Mr. JENKINS. Not necessarily. If I could wave a magic wand and make things the way Stan Jenkins thinks they should be in the world, I wouldn't want $1 of tax revenue from any of those organizations. I would like them to fulfill their mission and provide charity care to the extent that they should be providing charity care.

Mr. WELLER. According to your testimony, you argue that essentially their exemption should be discontinued, revoked, basically because they were pursuing debt collection and you believe that they were overcharging their patients?

Mr. JENKINS. Well, they were charging their patients higher rates than anybody else was paying. Some of the debt collection policies were rather draconian. There was a Wall Street Journal article published here a couple of years ago about people who actually wound up being incarcerated indirectly as a result of having unpaid hospital debt.

Mr. WELLER. Now, is the Champaign County Board—do they go on record for or against the position you have taken?

Mr. JENKINS. No.

Mr. WELLER. So, they have taken no position on this. As elected officials in the county, they solely look to you and there is no——

Mr. JENKINS. Well, a local board of review has a lot of latitude. We are appointed. We cannot be appointed at their discretion when our term is up. But they take no position on this. Typically, boards of review in Illinois have a lot of latitude in what they do, as long as it is within the confines of the statutes.

Mr. WELLER. Thank you, Mr. Jenkins. You know, Sister Keehan and Mr. Thomas, you have heard the recommendations of the two gentlemen to your right, one advocating essentially removing for most not-for-profits Federal tax exemption and the other saying that, in the case of his local not-for-profits, they overcharge and they pursue debt collection. I would just like to hear from the

standpoint of the not-for-profit community your response to those charges and your point of view regarding what the impact would be on your individual institutions if you were to lose that not-for-profit status. Sister?

Mr. THOMAS. Well, on the impact, obviously, it would be devastating——

Mr. WELLER. I always say sister is first, but——

Mr. THOMAS. She pointed to me. Obviously, it would be devastating for Baylor and for the Dallas community, in particular the Dallas-Fort Worth community. Baylor was started a hundred years ago by the head of the local Baptist church and a philanthropist, and we still sit on the land the cattle baron at the time gave to the church to start the hospital.

Mr. WELLER. That was Mr. Baylor?

Mr. THOMAS. It was Colonel Slaughter. We didn't think—-I wasn't there 100 years ago. I think they decided Slaughter was not the best name for a hospital. But to my knowledge—or not to my knowledge, in reality, the only hospital that has added capacity and is expanding capacity in the inner city of Dallas is Baylor, a nonprofit hospital that is not tax supported. As I mentioned in our testimony, 30 percent of the population of Texas is uninsured, much higher than that in the City and County of Dallas, with over a million undocumented aliens, many of whom use our hospital, our emergency room, and our hospital's general services.

Mr. WELLER. What percent of your operating revenues are generated by for-profit ventures within the confines of your medical center?

Mr. THOMAS. We have joint ventures with physicians; and, frankly, we need those to help further our mission. About 25 percent of our net, net income, if you will, is our distributions from the joint ventures.

Mr. WELLER. So, essentially for the privilege of using space that you have on your medical campus, they share their profits with you or their——

Mr. THOMAS. No, sir. It is the opposite. We control those joint ventures, in most cases, and they help us add capacity, and they commit in those joint ventures to the same charity care policy that our nonprofit facilities do. So, they help us meet the mission and provide care more efficiently and cost effectively.

Mr. WELLER. So, they provided a community benefit?

Mr. THOMAS. They provide a community benefit, and the community benefit they provide is not counted toward the $240 million that I have already of reported.

Mr. WELLER. Thank you, Mr. Thomas. Sister Keehan.

Sister KEEHAN. I think it is really important not to look at so much of what we do to our hospitals to revoke the tax exempt status but what it would do to our communities. Clearly, we have the world's strongest health care system because years ago we made a commitment to put all the resources from it into our health care. So, we have technology sooner, we have better technology, we have better staffing, we have more outreach to the poor. We are able—and you heard one of the members earlier say all of the hospitals in his rural district were not-for-profit. You know, those things dry up very quickly. So, the philanthropy that we depend on, the grant

partnerships that we depend on would go away. Most of those are designed to make services available in the community either sooner or services that would not be available without the grants, and they are also designed to help us in our outreach. The Perry School I talked to you about had five foundations joined with Providence Hospital to make that possible. If we were not tax exempt, they couldn't have done it. So, quite honestly, there would be huge ramifications for the communities we serve that would all be negative.

Mr. WELLER. Recognizing that Mr. Stark and I have 7 minutes, just a quick follow-up on that, very short, Sister, and I appreciate your time. You had mentioned in your testimony the role that your institution has played on revitalizing the neighborhood.

Sister KEEHAN. Yes.

Mr. WELLER. Would losing your not-for-profit affect that?

Sister KEEHAN. Absolutely.

Mr. WELLER. Additional item you have taken on.

Sister KEEHAN. Absolutely. We rely on friends and donors and foundations to help us afford to be there. It is the first African American high school since after the Emancipation Proclamation. It was all boarded up. It is now a huge community center with day care, all kinds of services for that community that they never had, as well as health care. We are the anchor. We would have to close. If we closed, they wouldn't be able to stay open.

Mr. WELLER. Thank you, Sister; and recognize my colleague from California, Mr. Stark, for 5 minutes.

Mr. STARK. Thank you, Mr. Chairman; and I thank the witnesses for their patience as we run around about our poorly scheduled duties here. I wanted to touch just on a couple of things. Mr. Jenkins, I was intrigued by your testimony, but I have to ask Mr. THOMAS. Do you know Gary D. Brock?

Mr. THOMAS. Yes, sir.

Mr. STARK. Baylor is a Baptist institution, is it not?

Mr. THOMAS. That is correct.

Mr. STARK. Well, Mr. Brock may have told a fib to our Committee back in March; and, of course, that would be—he would end up down where I am and not where good Baptists should go. I believe that is a tenet in the Baptist Church, to not tell fibs. He told us in answer to one of my colleague's questions on a hearing in March that all cardiac patients for the medical center would be treated at the new Baylor Hamilton Heart and Vascular Hospital. But we did find out that it is the—what the hospital says on their Web site is that the new hospital accepts only inpatient stays of not more than 72 hours and that major heart and vascular procedures such as heart transplant and bypasses will continue to be performed at Baylor University Medical Center, the not-for-profit part. I wrote to him and asked him please to have a chance to correct the record; and I hope you will return so I don't have to keep thinking that a good Baptist chief operating officer would be apt to tell something to the Committee that wasn't the straight skinny. Would you carry my message to Mr. Brock and ask if he would be kind enough to respond to our letter? I would deeply appreciate that.

Mr. THOMAS. Mr. Stark, may I reply?

Mr. STARK. Sure.

Mr. THOMAS. We did send a letter in response to your letter. It was delivered April the first, and I have another copy that I can also hand to you. He did not intentionally misrepresent all the services provided by the Baylor Heart and Vascular Hospital that are provided. They are the only—is the only location on our campus that provides those services. The cardiac surgery and transplants were left in the larger academic medical center because of all the ancillary and supporting services required to provide those services. It was not a good stewardship of assets as we expanded capacity to move those to the new hospital.

Mr. STARK. Okay, and I guess my concern is that Baylor would be a poster child for a combination of profit and for-profit entities all mixed together. I think Mr. Jenkins referred in his testimony that that creates a situation in which not-for-profit institutions might be used to shelter transactions and shift them where they would provide the most profit, and I don't know that. But it is an area that I suspect we ought to think about, and I know that it has been suggested by the IRS as something that concerns having both profit and nonprofit entities, changing back and forth, and allocating revenues back and forth as I suspect were the more revenues to those areas where they would write off the expenses. Yet it is an area that we don't know much about, and maybe we ought—it would be interesting to talk about that at some upon off the record, where we could all be somewhat more candid about what happens. Sister Keehan., thank you for your testimony. Ms. Kane, I have a hunch we are going to be seeing more of you, and I am delighted to note that you are not at the business school.

Mr. WELLER. Gentleman's time has expired.

Mr. STARK. Dr. Horwitz, thank you for your testimony today. I am told my time has expired. Thank you again.

Mr. WELLER. I thank the gentleman from California and ask the witnesses if you could continue to exercise some patience. We have to return for a vote, and the Committee will be returning shortly. There are other members that have requested the opportunity to ask questions of the witnesses. So, again, thank you for your courtesy; and we will suspend the hearing until the Chairman returns. Thank you for your time, and this hearing will be adjourned.

[Whereupon, at 1:58 p.m., the hearing was adjourned.]

[Submissions for the record follow.]

Statement for the Record of Alliance for Advancing Nonprofit Health Care

Mr. Chairman, Ranking Member Rangel, and distinguished Members of the Committee, the Alliance for Advancing Nonprofit Healthcare is dedicated to preserving and enhancing the abilities of nonprofit healthcare organizations to serve society and their individual communities. Through research, public education, and advocacy, the Alliance seeks to provide a strong, cohesive and persistent "voice" for a wide range of nonprofit healthcare organizations sharing many common goals and challenges—hospitals, health insurers, nursing homes, malpractice liability insurers, home care providers, and others. In addition, through education and other types of programs, the Alliance seeks to enhance the performance of nonprofit healthcare organizations in carrying out their unique roles and responsibilities in their communities.

Background on the Alliance for Advancing Nonprofit Healthcare

Started in mid-2003, the Alliance is a unique blend of nonprofit healthcare enterprises, all dedicated to a two-fold mission of advancing and improving the perform-

ance of nonprofit healthcare in the United States. The Alliance also serves as a forum for colleagues on both the nonprofit financing and delivery sides of healthcare to explore how at the regional and local levels they can establish more effective value-based relationships focused on community benefit, including quality, access, and affordability of health care.

To assist nonprofit health care organizations in carrying out their special missions, the Alliance for Advancing Nonprofit Healthcare has developed guidance documents on community benefits and governance. The community benefit guidance incorporates the excellent work previously done by the Catholic Health Association (CHA) and VHA, Inc.

The Alliance commends the Committee for examining the issue of tax-exempt status in the health care community, and hopes that this examination will reaffirm the widespread commitment of nonprofit hospitals and other nonprofit health care organizations to serving their communities. In the face of some well publicized reports in the media that have highlighted some alleged inappropriate behaviors by a very small percentage of nonprofit heath care providers, we hope that these hearings will help publicize the much more prevalent story of the great benefits that the vast majority of nonprofit heath care organizations provide to the communities they serve, as well as to broader society. The Alliance is very willing to explore with you whether some additional reporting or oversight mechanisms may be necessary to further ensure that the public trust is maintained, and that all are serving as good stewards of their community's resources. However, we urge the Committee to carefully consider any alterations to the existing law or regulations to avoid unintended consequences. Each community is different, and each nonprofit hospital tries to address the needs of its community in targeted ways designed to attend to those needs in the most effective manner. It is the flexibility inherent in the current system that is its greatest strength, allowing the government to monitor and work with nonprofit hospitals as they seek the best ways to serve their communities.

Background on Tax-Exemption of Hospitals

Nonprofit hospitals have played a vital role throughout our nation's history in delivering health care services to their communities. According to the latest available data from the American Hospital Association (AHA), there are 2,984 private nonprofit hospitals in the U.S., representing 61% of all of the short-term acute care hospitals (4,895) in the U.S. Another 1,121 hospitals are owned by state or local government (23%), and 790 (16%) are for-profit/investor-owned. 787 (26%) of the private nonprofit hospitals are religiously sponsored.

In order to qualify for tax exemption as a charitable organization under the Internal Revenue Code, an organization must be organized and operated exclusively in furtherance of a charitable purpose, and must not be operated, directly or indirectly, for the benefit of private interests. However, the activities of organizations carrying on many vital charitable functions, notably education and the promotion of health, are at least superficially similar to the activities of commercial organizations, *i.e.,* for-profit schools and hospitals. In addition, educational organizations and hospitals both impose charges (with exceptions) for their services and may operate with an annual surplus of receipts over disbursements. While nonprofit health care organizations must operate under the adage, "No money, no mission", they do not face the demands of the equity markets to maximize earnings for investors. Nonprofit earnings need not be as high, or as constant, and all that they are able to earn is "plowed" back into facilities, programs and services benefiting the community in a variety of ways.

The IRS has appropriately recognized that a nonprofit hospital may qualify for exemption as a charitable organization even though it operates at an annual surplus of receipts over disbursements. Thus, in Revenue Ruling 69–545, the IRS concluded that the promotion of health, like the relief of poverty and the advancement of education and religion, was one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, so long as the class that is benefited is not so small that its relief is not of benefit to the community.

In Revenue Ruling 69–545, the IRS approved the exemption of the hospital considered in that Ruling in large part because, by operating an emergency room open to all persons and by providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement, that hospital was promoting the health of a broad class of persons and thus providing a benefit to the community. The favorable conclusion in Revenue Ruling 69–545 also reflected the fact that control of the hospital rested with a board of trustees, which was composed of independent civic leaders; that the hospital maintained

an open medical staff, with privileges available to all qualified physicians; and that all members of its active medical staff had the privilege of leasing available space in its medical building.

While the conclusion of Revenue Ruling 69–545 rested in part on the fact that the hospital considered in that Ruling operated an emergency room open to all persons, the IRS has characterized the presence of an "open" emergency room only as "strong evidence" of a charitable purpose, and has never made the operation of an "open" emergency room either a sufficient or a necessary condition to tax exemption. For example in Revenue Ruling 69–544 which was published concurrently with Revenue Ruling 69–545, the IRS denied tax exemption to the hospital considered in that Ruling even though that hospital also operated an emergency room open to all persons.

The basis for the denial of exemption in Revenue Ruling 69–544 was the conclusion of the IRS that the hospital considered in that Ruling, which had initially been established as a proprietary institution operated for the benefit of its owners and later transferred to a nonprofit organization, had continued to operate for the private benefit of its original owners who exercised control over the hospital through the board of trustees and the medical committee. Revenue Ruling 69–544 concluded that this group had used their control to restrict the number of doctors admitted to the medical staff, to enter into favorable rental agreements with the hospital, and to limit emergency room care and hospital admission substantially to their own patients.

More recently, the IRS has also concluded that, in appropriate cases, a nonprofit hospital could qualify for tax exemption even though it did not maintain an "open" emergency room. For example in Revenue Ruling 83–157, the IRS concluded that a nonprofit hospital that was not required to operate an emergency room where a state or local health planning agency had found that this would unnecessarily duplicate emergency services and facilities that were adequately provided by another medical institution in the community could still qualify for exemption as a charitable organization based on other significant factors, including a board of directors drawn from the community, an open medical staff policy, treatment of persons paying their bills with the aid of public programs like Medicare and Medicaid, and the application of any surplus to improving facilities, equipment, patient care, and medical training, education, and research, indicate that the hospital is operating exclusively to benefit the community.

More generally, Revenue Ruling 83–157 also noted that certain specialized hospitals, such as eye hospitals and cancer hospitals, offer medical care limited to special conditions unlikely to necessitate emergency care and do not, as a practical matter, maintain emergency rooms. Revenue Ruling 83–157 stated that these organizations may also qualify for exemption as a charitable organizations based on other significant factors that demonstrate that the hospitals operate exclusively to benefit the community.

Tax-Exemption and Community Benefit

The fact that nonprofit hospitals typically find themselves in competitive markets does not mean that they are principally commercial enterprises like for-profit hospitals. To be sure they are often competing for patients who are beneficiaries of large government financing programs like Medicare and Medicaid or who are members of private health plans. They also often face intense competition for private philanthropic support from a variety of other types of national, state and local nonprofit organizations. Despite competition, nonprofit hospitals continue to play a unique and critical role in our society.

The difference between nonprofit and for-profit hospitals has recently been called into question, but the difference is really quite simple: nonprofit hospitals exist to serve their communities, while for-profit ventures exist primarily to serve their investors. While it may seem elementary, this distinction is not a simple one that can be easily quantified through the cursory examination of charity care or other numbers. The community benefits provided by nonprofit hospitals extend far beyond the number of Medicaid patients they treat, their annual amount of charity and discounted care, and even the offering of typically unprofitable services like emergency care or burn care. The true community benefit of a nonprofit hospital is all of these things and more that come together to form a total composite of value for the community.

Nonprofit hospitals also engage in community outreach activities and programs in a variety of ways to promote wellness and improve the health status and well-being of their communities. Community benefit outreach efforts are not sought out for marketing purposes, or increasing potential patient visits for profitable services. Nonprofit hospitals seek ways to address these needs as part of their essential mis-

sion to serve the community. These outreach efforts are not typically uniform to all parts of the nonprofit hospital's geographic service area,, but instead are often specific to the mix of people in the communities they serve. Some hospitals provide culturally sensitive services targeted to underserved immigrant populations in their region, others provide preventive care services in their community such as childhood fitness and screening in conjunction with school districts, others provide free car seats and training on their use, day care services, and outreach and counseling to the elderly. While the costs of such activities in actual dollars may vary widely, the effects and benefits they have in their communities can be immense, albeit very difficult to measure.

An additional challenge to determining the true community benefit of a nonprofit hospital centers around defining exactly what is the community in question. While most people define a community solely by the geographic region or catchment of the hospital, that is an oversimplification of the larger roles that nonprofit hospitals play. Nonprofit hospitals are heavily engaged in medical and health professions education, which serve the entire health care sector, as well as their specific geographic regions. Nonprofit hospitals are often at the forefront of research, not just in the clinical applications of new techniques and technology, but also research into improving patient outcomes, creating new efficiencies, preventive medicine and wellness activities, innovative access demonstration projects, and reducing medical errors. Through the extensive and intensive research being performed everyday by nonprofit hospitals, the entire healthcare industry benefits from the sharing of this knowledge, and achieves even greater degrees of efficacy and efficiency.

Another important type of community benefit is where a nonprofit hospital can demonstrate superior operating performance compared to other hospitals operating in its community with respect to one or more measures of cost, quality and/or patient satisfaction. Some nonprofit hospitals may also have, and be sharing with others, innovations in medical management or in other areas of operations. Excellent performance in various performance dimensions represents a benefit to current and potential future patients and can "raise the bar" for others, resulting in benefits for the broader community. The Alliance has conducted its own review of the research literature and has posted on its Web site, www.nonprofithealthcare.org, a summary of findings which strongly suggests overall superior performance by nonprofit hospitals on various cost, quality and service indicators that were studied.

In addition to this tapestry of community services, nonprofit hospitals also provide more intangible benefits. One essential assurance that for-profit enterprises can never guarantee with the same degree of certainty—nonprofit hospitals are typically permanent fixtures and health care providers in the community, and will not sell, close or move due to short-term fiscal pressures. One cannot put a price tag on community trust that the organization will stay to serve the community through thick or thin, that the organization's business practices will be ethical, and that energies will be expended on a sustained basis by the organization to advocate public policies to improve

One final point requires emphasis. Tax exemptions and other special tax treatments are essential for ensuring that nonprofit hospitals have reasonable access to capital so that they can compete on a fairly level playing field with for-profit hospitals having access to the equity markets.

Observation on Proposed Alternatives

While some observers have chosen to focus their attention solely on the cost benefit analysis of charity care dollars provided in relation to the estimated dollar value of the tax-exempt benefit, the forgoing discussion is intended to underscore that this is not an accurate or appropriate measure of a nonprofit hospital's community benefit performance. If charity care dollars were to become the sole or primary measure of a hospital's community benefit, the system would then be encouraging a "lowest common denominator" approach that would force the hospital to shun unprofitable medical education and research, and shun innovative outreach efforts that could indeed help to reduce the very need for charity care, often provided in emergency rooms and other expensive care settings as a result of a lack of preventive, early detection and early treatment services. Moreover, the demographics of some communities are such that charity care would be far down the list of community health care priorities.

This model would also not encourage hospitals to apply funds back into their facilities, new technologies, research, and the provision of high level specialized care. The ultimate result could be that a charity care-only model of determining community benefit would encourage hospitals to provide emergency triage services, and scale back their efforts to innovate and invest in better facilities and technology.

Accordingly, it is essential that any modifications to the current system of determining community benefit allow nonprofit hospitals the flexibility necessary to address fluctuating health needs in their communities in relation to their operational needs and their financial capabilities at any point in time.

Very few observers have advocated the total elimination of tax-exemptions for hospitals, or for only allowing the exemption in the case of academic medical centers and research intensive hospitals. Can one really imagine what our health care system would be like without a strong hospital sector that puts communities ahead of profits? Can one imagine the consequences of the loss of the predominately nonprofit hospital sector which, together with physicians and other health care practitioners, have made our system the best in the world, despite its shortcomings?

The Alliance for Advancing Nonprofit Health Care strongly urges the Committee to ask the appropriate Federal agencies and bodies to undertake a far more detailed study if any changes to the current model are to be seriously contemplated.

Conclusion

The Alliance for Advancing Nonprofit Health Care would be pleased to work with the Committee to determine which areas, if any, of the current system of reporting and oversight may need to be strengthened

The Alliance strongly believes that the current system is not broken, and that the flexibility inherent in the community benefit model is its greatest strength. The IRS has done a commendable job of working with the nonprofit health care sector to preserve the focus on their community benefit mission, and the flexibility needed by hospitals to address their individual community health needs. While the IRS might benefit from a wider array of options in providing corrective guidance and measures to hospitals, we would encourage the Committee to work with them to avoid implementing bright-lines that could have unintended adverse consequences.

We commend the Committee for taking the time to examine this important sector of health care, and would be happy to work with the Committee throughout its deliberations, and to try and answer any questions it might have. The Alliance would also be pleased to discuss with you the voluntary guidance that we have already developed for our members on community benefits and governance and any ways in which such guidance might be embellished. Thank you.

MEMBERS OF THE ALLIANCE FOR ADVANCING NONPROFIT HEALTHCARE

Alabama Blue Cross Blue Shield
Alliance of Catholic Health Care
Cleveland Clinic
Colorado Physicians' Insurance Company
East Alabama Medical Center
Fallon Community Health Plan
Florida Blue Cross Blue Shield
Geisinger Health System
Group Health Cooperative
Henry Ford Health System
Illinois Blue Cross Blue Shield
Jewish Guild for the Blind
Kaiser Permanente
Latrobe Area Hospital
The Lifetime Healthcare Companies
Massachusetts Blue Cross Blue Shield
Metropolitan Jewish Health System
Michigan Blue Cross Blue Shield
Michigan Health and Hospital Association
Minnesota Blue Cross Blue Shield
Rehabilitation Institute of Chicago
Riverside Healthcare
Rocky Mountain Health Plan
Sacred Heart Health System
Santa Fe Healthcare
Tennessee Blue Cross Blue Shield
UMass Memorial Health Care, Inc.
Visiting Nurse Service of New York

Statement of the American Hospital Association

The American Hospital Association represents 4,800 hospitals, health care systems and other health care organizations. Our members are of all ownership types: state and local government, not-for-profit, and for-profit. In 2003, 61 percent of hospitals were operated as not-for-profit tax-exempt institutions, 23 percent by state and local governments, and 16 percent as for-profit investor owned-institutions. AHA strongly supports the continued tax exemption of hospitals that choose to operate under the strictures and conditions that come with exemption.

Tax Exempt Status—Key to Community Care

Exemption is longstanding

Since the enactment of the first income tax law in the United States, hospitals have been accorded tax exemption as charitable institutions. Society and govern-

ment have long recognized that hospitals provide an indispensable public service. The underpinning for charitable tax exemption is public support for activities that serve the larger good—a concept that encompasses the broadest range of public purposes. The governing body of a charitable organization is based in the local community, and has a duty to see that the organization is organized and operated to fulfill its charitable mission.

Not-for-profit hospitals are the cornerstone of community health care

In 2003, 2,984 non-government, not-for-profit hospitals in the U.S. cared for more than 450 million patients. If these not-for-profit hospitals ceased to exist, society would demand that hospital care be supplied by the government itself, which would require an enormous increase in taxes. For this reason alone, all hospitals operated on a nonprofit basis should be encouraged in their mission, and should be granted exemption from tax.

Since 1969, the promotion of health has explicitly been recognized as a purpose meriting tax exemption. Health care organizations may be awarded tax-exempt status by demonstrating that they promote health in a manner that benefits the community as a whole. The premise underlying this community benefit standard is that the promotion of health in a manner that benefits the larger community serves a public purpose. The promotion of health alone is not sufficient, however; how it is done, when, and for whom are important factors. Tax exemption requires more. The focus is not on what the hospital does but whether those actions respond to community need. Providing charity care has been only one way to demonstrate that benefit.

The community benefit test is still a sound and viable basis for awarding tax-exempt status to hospitals. It places the focus at the local level and examines the merits of individual situations against the community environment in which the hospitals serve. The issue has been and should continue to be whether those hospitals are providing public benefit. Exemption is given in return for responding to the community's needs.

Hospitals are open 24 hours a day, seven days a week. The women and men who work there—on the day shift, the swing shift or the night shift—provide compassionate care and help bring new life into the community. They provide medical care both within their four walls and in other community settings. Hospitals provide emergency department care to all, regardless of their ability to pay. Hospitals' uncompensated care, as well as Medicare and Medicaid payment shortfalls, are costs that are absorbed so that communities can continue to receive the care they need.

But hospitals also provide a wide-range of services for the benefit of those who don't seek care from the emergency department, the pediatric unit or any other hospital department. Instead, they take the care to those who need it, delivering charity care and offering special non-compensated services and programs, including community education and outreach programs, health screenings, and subsidized medical education and research.

Most hospitals work with local providers and organizations to assess community status and needs. These assessments help them determine what programs and services should be targeted at various populations, such as minority, elderly or low-income people, as well as to the broader populations.

Tax exemption is key to not-for-profit hospital viability

If society and government have deemed the provision of hospital care to be a fundamental good, and private markets fall short of meeting the needs of all members of society, the case for public assistance becomes compelling. Tax subsidies are one way to provide that assistance. Tax exemptions, tax-deductible contributions, and tax-exempt financing serve the public purpose by subsidizing the availability of health care.

There are nearly 45 million Americans whom the Census Bureau estimates have no health insurance coverage, although as many as 82 million, according to a recent report, lack health insurance coverage at some point during a year. Millions more are underinsured. We lack a social policy in America that provides health care coverage for all. In the meantime, hospitals are asked to fill the gap, and they try to, for everyone who walks through their doors. In fact, in 2003, hospitals absorbed almost $25 billion in uncompensated care for patients who couldn't pay for the services they needed.

A significant portion (estimated by the Joint Committee on Taxation to be $8.6 billion in 2004–2008) of the tax subsidy is for capital acquisition and construction. This subsidy is essential to meet patient care needs where facilities are in short supply or unavailable.

Charitable contributions from a hospital's community and beyond are also an important source of hospital revenue ($23.9 billion in 2004–2008). Public financial sup-

port of an organization through tax-exempt contributions is an indicator that it is publicly accountable and providing a needed community benefit.

While tax-exemption offers important resources to help hospitals meet these needs, more is required, especially with Medicare and Medicaid under funding in the face of soaring demand for hospital services as America ages and gets sicker. Hospitals cannot solve this problem on their own, especially with one-third of hospitals losing money overall, and another third on the financial brink.

Requirements

A hospital qualifies for charitable exemption if it is organized as a nonprofit corporation and complies with the community benefit standard, the prohibitions on private inurement and private benefit.

Community benefit standard

In applying the community benefit standard, the Internal Revenue Service (IRS) considers whether the hospital operates an emergency department that is open to all regardless of ability to pay, accepts Medicare and Medicaid patients on a nondiscriminatory basis, has a governing board that represents the community at large, is open to all medical staff who wish to use it, or conducts medical research and education programs.

Prohibition on private inurement

The rules regarding private inurement stipulate that no part of an institution's net earnings may benefit members of the board, officers, managers, staff, employees, or other individuals associated with the hospital. The function of the rules is to ensure that income and assets serve a public purpose, and to prevent their distribution to insiders.

The purpose of the prohibition against private benefit is to ensure that an exempt hospital is organized to serve the community as a whole and not individuals or groups.

Compensation arrangements

Strict rules govern not-for-profit hospital compensation arrangements with physicians and senior executives. Areas of scrutiny include recruiting incentives, incentive compensation, loans and leases, hospital purchase of physician practices, and levels of compensation of hospital senior executives.

Unrelated business tax

Tax-exempt hospitals are subject to the unrelated business income tax on income derived from a trade or business regularly carried on by the organization that is not substantially related to the performance of its tax-exempt purpose.

Annual reports

Tax-exempt hospitals are required annually to report their gross income, information on their finances, functional expenses, compensation, activities, and other information required by the IRS. This enables the IRS to determine whether the hospital continues to meet the statutory requirements for exemption. This information should be publicly available to the communities they serve.

Government Special Payments to Hospitals

Some have claimed that special payments made through the Medicare Prospective Payment System (PPS) and through the Medicaid program and other government programs are taxpayer-provided "subsidies" for the uncompensated care provided by hospitals—care for which no payment is received. While hospitals in every community serve patients who are unable to pay for their care, not all hospitals receive these special payments; they are targeted only to specific hospitals or other providers. A recent study prepared for the Kaiser Commission on Medicaid and the Uninsured showed that, in 2004, the Medicare program, the federal portion of the Medicaid program and several other government programs together provided $23.5 billion in additional payments to care providers. However, these payments are not intended to offset or subsidize the actual costs of uncompensated care that hospitals incur.

Medicare disproportionate share (DSH) payments.

Medicare disproportionate share payments are made to some, but not all, hospitals that serve low-income patients. While all hospitals provide uncompensated care, 2,724 hospitals, or 55 percent, receive DSH payments. In 2004, according to the Kaiser Commission report, hospitals received $7.6 billion in DSH special payments. There is a minimum threshold that a hospital must meet to receive this special payment and a formula that calculates the amount a hospital receives. The formula combines two measures: the percentage of inpatient hospital days attributable

to Medicare patients in the Federal Supplemental Security Income (SSI) program, and the percentage of inpatient days attributable to Medicaid patients. There is currently no measure for uncompensated care in the DSH payment formula.

In the Balanced Budget Refinement Act of 1999 (P.L. 106–113), Congress directed the HHS Secretary to collect data from hospitals on costs incurred in both the inpatient and outpatient settings for which the hospitals are not compensated, including non-Medicare bad debt and charity care. This is the first year that hospitals' data will be available for analysis.

Medicare Indirect Medical Education (IME) payments.

The Medicare program makes special payments to teaching hospitals under the inpatient PPS. A portion of these payments, directed to the 1,112 hospitals (23 percent of all hospitals) that train our future physicians, was $2.9 billion in 2004, according to the Kaiser Commission report. Indirect medical education payments compensate teaching hospitals for the costs they incur in training physicians. As a result of their education and research missions, teaching hospitals must offer expensive, specialized, and sophisticated services that may not be utilized optimally. Often, teaching hospitals care for the most medically complex and costly patients in our health care system. The Medicare inpatient payment system does not adequately measure and compensate teaching hospitals for these additional patient care costs. The IME payment adjustment is designed to account for patients' severity of illness and the inefficiencies of operating a hospital where teaching and research occur. For example, physicians-in-training may order extra lab or other diagnostic tests because they are inexperienced in practicing medicine. They may also ask questions and rely on other health care personnel in the hospital for help, thus making professional staff less efficient in delivering patient care. IME payments are calculated using a formula that is based on an individual hospital's resident-to-bed ratio. It does not include a measure of uncompensated care.

Today, even including the targeted payments mentioned above, Medicare pays only 98 cents for every dollar of care provided by hospitals to Medicare beneficiaries. If Medicare DSH and IME funds were to somehow be redirected to cover hospitals' uncompensated care costs, rather than their current purpose of helping hospitals provide care to Medicare beneficiaries, the Medicare reimbursement would drop to an estimated 91 cents for every dollar of care provided by hospitals.

Conclusion

Mr. Chairman, the people of America's hospitals work very hard, every day, to get high-quality care to all who come through their doors. They do it with caring and compassion that extends from the bedside to the billing office. And they do it in the face of mounting challenges. They are a key reason why our nation has the best health care in the world. But ensuring that all Americans can take advantage of that health care when they need it is a huge challenge. We can take a giant step forward by working together to address the problem of the uninsured. We look forward to working with you to help solve that problem, and helping all Americans get the health care they need, when they need it. Continuation of hospital tax exemption is an essential ingredient in meeting this goal.

Healthcare Financial Management Association
June 3, 2005

Dear Mr. Chairman:

The Healthcare Financial Management Association (HFMA) is pleased to submit comments for the record of the May 26, 2005 hearing, "A Review of the Tax-Exempt Hospital Sector."

About HFMA

HFMA is the nation's leading membership organization for more than 34,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad

cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards. For the purposes of this statement, the most relevant examples of these activities are:

- *Attributes of tax-exempt status.* In 1988, HFMA formed a chairman's task force to identify the specific attributes of healthcare providers that characterize them as tax-exempt institutions. That report was published in 1991. (See http://www.hfma.org/resource/focus_areas/business_of_hc/articles/02_21_02.htm)

These findings were recently incorporated into HFMA's Principles and Practices Board 2005 monograph: Issue Analysis 05–01: The Relationship of Community Benefit to Hospital Tax-Exempt Status, which seeks to clarify ways in which hospitals can gather and report the information needed to demonstrate their fulfillment of their charitable mission.

- Quantifying bad debt and charity care. In 1993, HFMA published Principles and Practices (P&P) Board Statement 15, which explains how to distinguish between charity care and bad debt. These statements are rigorously peer-reviewed to ensure they reflect the best thinking of the industry. The IRS has recommended adherence to P&P Board Statement No. 15 in all representations regarding charity care. (See http://www.hfma.org/resource/P_and_P_board/Statement_15.htm)

Improving patient financial communications. HFMA leads the *PATIENT FRIENDLY BILLING* Project, a cross-disciplinary, nationwide initiative to make patient financial communications clear, concise, and correct. Five years ago, a Project work group began work on a report aimed at helping hospitals efficiently and effectively review their financial assistance policies to better serve the needs of their communities. The report, *Hospitals Share Insights to Improve Financial Policies for Uninsured and Underinsured Patients,* was published in January 2005. (See http://www.patientfriendlybilling.org/2005report/2005_pfb_report.pdf

Summary Points of this Statement

We would like to make the following points regarding the role of tax-exemption for hospitals, to be discussed in more depth following this summary:

- HFMA strongly urges the Committee to **consider the full range of community services deserving of tax-exemption,** not just charity care. Exempt hospitals are an important part of the healthcare delivery network and provide a wide variety of community services that fall under the IRS definition of "charitable" under Revenue Ruling 69–545.
- Because of this diversity of services, HFMA encourages the Committee to use **great caution when viewing research that compares amounts of charity care provided** by individual hospitals. Some hospitals that provide smaller amounts of charity care may instead devote their exempt resources to other important community services, such as trauma centers, neonatal intensive care units, and a host of other important needs not served by governments or for-profit organizations.
- HFMA asks the Committee to realize that **healthcare needs—including charity care needs—differ greatly by community,** and therefore solutions, whether legislated or voluntary, must be flexible to best serve the needs of the patients and communities they serve.
- In most aspects of daily operations—such as provision of optimal clinical care, effective operations, and business efficiency—**a hospital's ownership type should be transparent to the patient.** Indeed, not-for-profit entities have an obligation to operate as efficiently and effectively as possible to ensure the best possible cash flow, which, in turn allows them to fulfill their missions. Instead, the meaningful distinctions among ownership types are found in specific characteristics such as use of financial surpluses, accountability, and the provision of services.
- **Comparable, scaleable reporting standards** will greatly help tax-exempt hospitals accurately document and report the entire range of the community benefits provided. HFMA believes that these comprehensive reports should be communicated regularly and clearly to the public. We applaud the excellent work that the Catholic Health Association and VHA have done in this area.

The Role of Charity Care and Community Benefit in Justifying Tax-Exempt Status

HFMA believes that while the provision of charity care is an important attribute of tax-exemption, it is only one of many attributes that warrant tax-exempt status, as the IRS defines "charitable" under IRC Section 501(c)(3) and Revenue Ruling 69–

545. Failure to recognize the broad basis for tax-exemption could lead to a specific trade-off between the amount of charity care provided and the amount of tax-exemption allowed, which would undermine important and cumulative community benefits that tax-exempt healthcare institutions deliver.

Our members know that the problem of care for uninsured patients is far greater than healthcare providers can resolve alone. Even if each provider in the country devoted every exempt dollar to the delivery of charity care, there would still be a shortfall of funds to care for the uninsured, and furthermore, vital community services would have to be eliminated, ranging from trauma centers to boarder baby programs.

Attributes of Tax-Exempt Healthcare Providers

Tax-exempt healthcare organizations are formed to address the specific needs of their communities; therefore, the attributes that merit tax-exemption are not standard across all institutions. In 1991, an HFMA Chairman's Task Force released a report identifying the major attributes of tax-exempt organizations. The P&P Board built on these attributes in light of the current environment.

For the purposes of the issues before this Committee, these attributes can be divided into organizational characteristics and types of services.

Organizational characteristics:

Mission to Provide Community Benefit. Mission is a cornerstone of granting tax-exemption. According to federal law, the tax-exempt provider must have a clearly defined mission statement committing the institution to charitable endeavors. Both the institution's historical background and the community's needs are important in determining the mission statement.

Use of Financial Surpluses. No individual may receive any portion of a tax-exempt institution's financial surpluses as a result of ownership. Both federal and state laws require that all financial surpluses must go toward furthering the organization's charitable purpose. Compensation arrangements must be carefully constructed to reflect fair market value for services rendered.

Accountability. The organization's board of trustees must hold itself answerable to its community for maximizing the entity's contribution to the community.

Goodwill. Goodwill is an intangible attribute characteristic of successful tax-exempt hospitals continuing their mission of providing care and meeting their community responsibility over a long period of time. Such organizations usually have stable ownership and governance structures and regularly receive significant philanthropic and volunteer support.

Types of charitable services:

Provision of Charity Care. Free or discounted care is an important component of many hospitals' tax-exempt missions, but is not the only function that hospitals perform to merit tax-exempt status. Organizations that provide charity care must establish and communicate a clear charity care policy based on community needs and input. The policy should include easy-to-understand, written eligibility criteria.

Reduction of Government Burden. Many tax-exempt hospitals provide services that government otherwise would have to provide. Services especially demanded from tax-exempt healthcare providers include high-tech, high-intensity services, emergency care, chronic care, long-term care, and unprofitable services.

Provision of Essential Healthcare Services. Tax-exempt healthcare providers are often the sole providers of healthcare services that are so essential to community health that tax-exempt status is warranted. Examples of essential services include emergency rooms and outpatient clinics serving low-income patients.

Provision of Unprofitable Services. The provision of unprofitable services is commonly a provider's charitable response to a community need. Unprofitable services in this sense lose money because of high costs combined with low volume or inadequate payment rather than inefficient operations. Common examples of unprofitable services include burn, neonatal, and trauma centers and community mental health centers.

Public Education. Teaching institutions, of course, are exempt because of their role in the advancement of education and science. Most tax-exempt healthcare providers, however, also provide a range of educational programs to enhance public health. Examples of such programs include public health education, wellness programs, and the sponsorship of educational activities.

Serving Other Unmet Human Needs. Some tax-exempt hospitals provide important services that are tangential to health care but that are unmet by any other entity in the service area. Examples of these activities include senior citizen education and outreach programs, care for "boarder" babies, or the operation of a "meals on wheels" program.

Documenting Community Benefit

HFMA believes healthcare providers should identify, measure, and prominently disclose all the attributes of their organizations that warrant tax-exempt status. It is important that all stakeholders, from government officials to members of the provider's community, understand all the reasons why an organization qualifies for tax-exemption and the progress that is being made toward achieving its mission.

This can be accomplished effectively only with appropriate community benefit reporting standards that promote comparability and are still scaleable enough to accommodate the wide variation in provider size and resources that characterize the nation's exempt healthcare providers. HFMA applauds VHA Inc., the Catholic Health Association of the United States, and Lyon Software for their contribution in this area through the development of Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability.

Conclusion

HFMA takes pride in its history of providing balanced, objective healthcare finance technical expertise to Congress, HHS, and advisory groups. We hope that these comments and recommendations are useful as the Ways and Means Committee pursues the best interests of patients, tax-payers, and the nation's healthcare system.

We are at your service to help your Committee gain a balanced perspective on this complex issue. If you have additional questions, you may reach me, or Richard Gundling, Vice President of HFMA's Washington, DC, office, at (202) 296–2920. The Association and I look forward to working with you.

Sincerely,

Richard L. Clarke, DHA, FHFMA
President and Chief Executive Officer

Statement of K.B. Forbes, Consejo de Latinos Unidos, Los Angeles, California

An all-paid ocean cruise is one of the newest bribes offered by one so-called "non-profit" hospital to cover its unconscionable conduct.

Our organization has been fighting to change the egregious behavior of hospitals since 2001. In the last couple of weeks we have been wrangling with a so-called "non-profit" called Florida Hospital, the flagship operation of the "faith-based" Adventist Health System, in Orlando, Florida.

Why?

Because we brought members of an uninsured family that were denied services by FloridaHospital to meet with the professional staff of the U.S. House Ways and Means Oversight Subcommittee on May 9, 2005. Several days later, Florida Hospital contacted the uninsured Vega family on the early morning of Friday, May 13, 2005 with offers of a free ocean cruise and free services.

Rodney Vega, a six-year-old, and his mother Judith Montilla Vega met with Congressional staffers to outline their plight on Monday, May 9. Young Rodney had an aggressive brain tumor last year and Florida Hospital appears to have refused to help the family even though the child had only two weeks to live. The shocking fact is the so-called "Adventist" hospital did not help the Vegas who are practicing Adventists while Rodney's father is an Adventist pastor.

On Wednesday, May 11, the Judith Montilla Vega signed a HIPAA release allowing the U.S. House Ways and Means Oversight Subcommittee to discuss young Rodney's medical history. Two days later, Florida Hospital called the Vegas with "the bribe." Here is Judith Montilla Vega's written testimony given to us on Monday, May 16, 2005:

"I am taking this opportunity to let you know about a call that I received Friday, May 13, 2005 between 6:30 and 6:40 a.m. at my home. Ms. Marilyn (she did not tell me her last name) called me from Florida Hospital. After she introduced herself, she asked me for the name of my husband, and she wanted to know about my experience with my son, Rodney Vega, at Florida Hospital. I told her the name of my husband, and I explained that I had a bad experience with Rodney at this hospital, because last year (2004) when my son needed a very urgent surgery to save his life from his brain tumor (ganglioneuroblastoma IV), they did not help us. I told her, too, that they knew of my son's condition because they had some medical records on him. I said that thank God for the Consejo de Latinos Unidos, Rodney had the

life-saving surgeries, MRIs, bone age tests, medical appointments and all medical services that he has needed. Marilyn agreed about the medical records. She told me she had them, and she apologized for the situation. Marilyn offered me free medical services at Florida Hospital for Rodney. This lady told me that this offer came directly from Florida Hospital's Vice-President. She said she wanted to review the results of Rodney's last MRI in order to know more about my son's medical condition. She finally offered us a paid ocean cruise, too. She said that Florida Hospital can meet any wish Rodney had and they would be willing to pay for the cruise. I was so surprised with this call, because I do not understand the real reason why they called. When I really needed Florida Hospital, they did not help me with my son. Why now, a year later, are they calling me when, thanks to God, Consejo is helping us with our little boy? I met with Congress last week and now Florida Hospital is offering me cruises when my son would have been dead because of their lack of care or charity."

According to published media reports, Florida Hospital executives attempted to call the contact a "clinical" follow-up for young Rodney Vega. The problem is Rodney Vega was last seen by Florida Hospital three years ago, in 2002. Does it take three years for a follow-up and is everyone offered a free cruise?

As easy as it is for Florida Hospital to dish out bold face lies, we warn the committee today to be wary of slick or sugar-coated testimony given by the executives or nuns of non-profit hospitals. Although non-profit hospitals do wonderful life-saving work and give away millions in charity care and uncompensated care, the truth is after all the spin and all the public relations:

- the uninsured are still being charged three or four times more for the exact same care,
- executives are still being paid excessively, sometimes in the millions of dollars,
- the non-profits are still siphoning off billions in off-shore accounts.

Florida Hospital has said the most foolish things to cover their tracks just because the spotlight is on them. We believe the non-profit hospital sector will say anything, justify anything, plea and cry about everything, instead of focusing on the issues at hand since the spotlight is on them.

We appreciate the Committee's hard work and thank you for the opportunity to submit this brief statement.

Statement of Edward Goodman, VHA Inc.

VHA Inc. appreciates the opportunity to submit this statement on the tax-exempt hospital sector. Congress' oversight of the not-for-profit hospital sector and its exploration of the rationale for federal tax exemption are of great interest to not-for-profit organizations nationwide, and a serious matter for VHA-member hospitals throughout the United States.

VHA Inc. is a national alliance of leading not-for-profit health care organizations that work together to improve the health of the communities they serve. VHA delivers industry leading supply chain management services and enables regional and national member networks to improve clinical and operational performance and to drive sustainable results. Based in Irving, Texas, VHA has 18 local offices serving more than 2,400 health care organizations across the United States.

VHA's mission is directly related to the viability of the charitable not-for-profit community hospital in the face of a variety of economic pressures. Indeed, the need to develop economic strategies to preserve the not-for-profit hospital's charitable mission, and at the same time ensure its financial survival, is the principal policy goal that underlies VHA programs and activities.

The Role of Tax-Exempt Hospitals

Historically, the tax-exempt hospital sector has played an important role in American society. Not-for-profit community hospitals have consistently served to lessen the burdens of Federal and State governments by filling gaps in medical care that might otherwise fall to governmental agencies. Such hospitals provide urgent and routine medical care for the indigent, medical research and education, community health services, and essential services such as 24-hour emergency rooms, neonatal intensive care, burn units, and care for terminally ill patients. These services are frequently less profitable and often unprofitable for those who conduct them. The commitment of not-for-profit hospitals to provide a broad range of health care services as part of their charitable mission transforms these hospitals into social charities as well as medical providers.

The Evolution of the Hospital Tax-Exemption Standard

Not-for-profit hospitals are exempt from federal income tax as Section 501(c)(3) organizations if they are organized and operated exclusively for "charitable" purposes within the meaning of the Internal Revenue Code.[1] The meaning of the term "charitable" has evolved over time as changes have been made in the financing and delivery of medical care.

In the 1950s and earlier, hospitals generally operated as almshouses that supported the sick, needy, poor, and other individuals who lived on the margins of society.[2] Consequently, hospitals relied to a large extent on charitable contributions to meet daily operations. The Treasury Regulations at the time reflected this role and defined charitable organizations as those operated for the relief of the poor.[3]

In the 1950s, the Internal Revenue Service ("IRS") relied principally on the "relief of poverty" standard as the rationale for hospital tax exemption. Revenue Ruling 56–185, 1956–1 C.B. 202, stated that a hospital could qualify for tax exemption only if it was "operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay." The ruling set forth four requirements for hospital tax exemption: (1) a hospital must be organized as a nonprofit charitable organization for the purpose of operating a hospital for care of the sick; (2) it must be operated to the extent of its financial ability for those not able to pay for the services rendered, and not exclusively for those able and expected to pay; (3) it must not restrict use of its facilities to a particular group of physicians; and (4) its net earnings must not inure to the benefit of any private shareholder or individual.

After the IRS released Revenue Ruling 56–185, dramatic changes occurred in the financing of medical care, including an increase in the availability of medical insurance.[4] As a result of these changes, hospitals were no longer exclusively dependent on philanthropic and charitable contributions for hospital operations. Instead, caring for patients—both rich and poor alike—became a primary concern of hospitals.[5] While philanthropy still played a role in charitable hospitals, it was no longer the primary source of hospital income.[6] This development shifted attention toward a policy of insuring that adequate health care services were actually *delivered* to those in the community who needed them.[7]

In 1959, new regulations interpreting Section 501(c)(3) were issued. The new regulations moved away from a narrow definition of charitable based on relief of poverty and adopted a new standard definition that defined the term "charitable" in its generally accepted legal sense.[8] As defined, the term is not limited by the separate enumeration in Section 501(c)(3) of other tax-exempt purposes that may fall within the broad outlines of "charity" as developed by judicial decisions.[9]

In 1965, the federal Medicare and Medicaid programs were established. In addition, county governments and other political subdivisions began providing nonemergency hospitalization and medical care for those unable to pay.[10] Following on these developments, the broader regulations, and the changing role of hospitals, the IRS in 1969 issued Revenue Ruling 69–545, 1969–2 C.B. 117, explicitly recognizing the "promotion of health" as a charitable purpose that could qualify for exemption where an organization is promoting the health of a class of persons that is broad enough to benefit the community. This is known as the "community benefit standard."

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[1] Unless otherwise indicated, all section references are to the Internal Revenue Code of 1986 or to the Treasury regulations promulgated thereunder.

[2] *See Sound Health Ass'n v. Commissioner,* 71 T.C. 158 (1978), *acq.,* 1981–2 C.B. 2; *Eastern Kentucky Welfare Rights Org. v. Simon,* 506 F.2d 1278, 1288 (D.C. Cir. 1974); Robert S. Bromberg, *The Charitable Hospital,* 20 Cath. Univ. L. Rev. 237 (1970) (hereinafter, "Bromberg, *The Charitable Hospital* ").

[3] *See, e.g.,* Treas. Reg. § 39.101(b)-1(b) (1939 Code), *reprinted in Eastern Kentucky Welfare Rights Org. v. Simon,* 506 F.2d 1278 at 1286 (D.C. Cir. 1974), *rev'd,* 506 F.2d 1278 (D.C. Cir. 1974), *vacated on other grounds,* 426 U.S. 26 (1975).

[4] *See Eastern Kentucky,* 506 F.2d. at 1288; *see also Sound Health Association,* 71 T.C. 158; Bromberg, *The Charitable Hospital.*

[5] *See Eastern Kentucky,* 506 F.2d. at 1288.; *see also Sound Health,* 71 T.C. at 180;

[6] *Sound Health Association,* 71 T.C. at 180.

[7] *Id.* at 180–181.

[8] *See* Treas. Reg. 1.501(c)(3)-1(d)(2); T.D. 6391 (24 Fed. Reg. 5217 June 26, 1959).

[9] *Id.*

[10] *See Eastern Kentucky,* 506 F.2d. at 1288.

Criteria Used to Assess Whether Hospitals Meet the Tax-Exemption Standard

The community benefit standard enunciated in Revenue Ruling 69–545, as clarified in Revenue Ruling 83–157,[11] remains the standard used today for hospital tax exemption. Revenue Ruling 69–545 is a flexible standard that looks to the facts and circumstances of each case in determining whether tax exemption is warranted. This standard allows the IRS to determine hospital tax exemption on a hospital-by-hospital, community-by-community basis.

Revenue Ruling 69–545 recognized that, in the general law of charity, the promotion of health is considered to be a charitable purpose.[12] It acknowledged that an organization providing hospital care may be operated for a charitable purpose where an organization is promoting the health of a class of persons that is broad enough to benefit the community. Even if the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, an organization may still qualify for exemption provided that the class is not so small that its relief is not of benefit to the community.

The ruling compared two hospitals, one that was found to qualify for exemption and one that did not. The following factors were important in the IRS' determination that the one hospital qualified for exemption.

- *Open Emergency Room.* The hospital operated a full-time emergency room that treated all persons requiring emergency care regardless of ability to pay (the hospital normally referred non-emergency indigent patients to another hospital that served indigents).
- *Nondiscriminatory treatment.* The hospital provided care to all persons in the community who could pay for services, either by themselves or through private health insurance or public programs such as Medicare.
- *Open Medical Staff.* Medical staff privileges were available to all qualified physicians in the area, consistent with the hospital's size and nature of its facilities.
- *Community Board.* The hospital was governed by a board of trustees composed of independent civic leaders.
- *Surplus.* The hospital used its surplus of receipts over disbursements to improve the quality of patient care, expand facilities, and advance its medical training, education, and research programs.

The ruling states that, in considering whether a nonprofit hospital claiming such exemption is operated to serve a private benefit, the IRS will weigh all of the relevant facts and circumstances in each case. The absence of particular factors set forth above or the presence of other factors will not necessarily be determinative.

Tax-Exempt Hospitals' Focus on Charitable Mission

One recurring question central to the Committee's examination is whether not-for-profit community hospitals are "commercial enterprises" that do not significantly differ from shareholder-owned, for-profit hospitals. Not-for-profit hospitals differ significantly from their for-profit counterparts in terms of both their structure and their operations. Fiduciaries of not-for-profit hospitals are driven by the hospitals' charitable mission and not a duty to maximize profits.

One primary aspect in which not-for-profit hospitals substantially differ from their for-profit counterparts is in terms of their governance structure. Tax-exempt hospitals have no shareholders, but instead are governed by community boards. The absence of shareholders eliminates any conflict between maximizing profit and operating in accordance with their charitable mission. For this reason, not-for-profit hospitals typically offer a broad range of low-margin medical services to their communities, including urgent and routine medical care for the indigent, 24-hour emergency rooms, neonatal intensive care, burn units, and care for the terminally ill.

Tax-exempt community hospitals diverge from for-profit hospitals in the use of any surplus of receipts over disbursements. Shareholder-owned, for-profit hospitals generally distribute this surplus to shareholders as dividends or retain such surplus as working capital. Tax-exempt hospitals, on the other hand, *must* use their surplus to benefit the community such as improving quality of patient care, expanding facilities, providing community health services (such as immunization clinics), and advancing medical training, education and research.[13] Amounts spent on these activities do not increase the profitability of not-for-profit hospitals. These activities are

[11] 1983–2 C.B. 94.

[12] *See Restatement (Second) of Trusts,* sections 368, 372 (3d ed. 1967); 4A Austin W. Scott and William F. Fratcher, *The Law of Trusts,* sections 368, 372 (4th ed. 1989); Bogert, *Trusts & Trustees,* section 374 (2d ed. 1964).

[13] *See* Rev. Rul. 69–545.

provided as a benefit to the community in furtherance of a not-for-profit hospital's charitable mission.

It is often thought that not-for-profit hospitals must operate with little to no profit to justify their tax-exempt status. However, the regulations expressly contemplate that a Section 501(c)(3) organization may carry on a trade or business as a substantial part of its activities without jeopardizing its tax-exempt status if the operation of such business is in furtherance of (*i.e.,* substantially related to) the organization's exempt purpose.[14] The provision of hospital care in accordance with the community benefit standard is substantially related to a not-for-profit hospital's charitable purpose.

The Role of VHA in Facilitating Commitment to Mission in a Changing World

Post-1969 changes occurring in the tax-exempt hospital sector include a significant increase in the number of uninsured (or underinsured) patients who seek treatment at hospitals or in other venues. In 2003, an estimated 15.6% of the U.S. population, or 45 million people, had no health insurance.[15] Fewer Americans are covered by employer-provided health insurance today than were covered by such insurance fifteen years ago.[16]

VHA hospitals provide medical services regardless of ability to pay to the growing number of uninsured individuals residing in each individual not-for-profit hospital's service area. However, based on its understanding of the sector, VHA believes that not-for-profit hospitals provide valuable community health benefits to their medical service areas that equal or exceed the associated tax benefits.

VHA believes that not-for-profit hospitals should be prepared to quantify and articulate the value of their community benefit. Since Congress last examined the issue of hospital tax exemption in the early 1990's, VHA has worked in collaboration with the Catholic Health Association of the United States ("CHA") to develop resource tools to assist not-for-profit hospitals in documenting the benefits they provide to the community. The first resource was released in 2002 and was entitled *Community Benefit Planning: A Resource for Nonprofit Social Accountability.* The second was released in 2004 and entitled *Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability.*

Community Benefit Planning: A Resource for Nonprofit Social Accountability provides background on the importance of social accountability and provides an explanation of the differing types of community benefit. This resource sets forth the following guidelines for use by not-for-profit hospitals in setting their social accountability community benefit process:

- **Step 1: Renew the commitment.** Not-for-profit hospitals should regularly review and revise their mission statements, establish the accountability of leaders, establish explicit charity care policies and procedures, and develop an explicit plan for advocacy on behalf of the community and needy populations.
- **Step 2: Plan and budget for services.** Not-for-profit hospitals should assess community needs and assessments, integrate awareness of community needs throughout the organization, and budget to meet community needs.
- **Step 3: Monitor services and activities.** Not-for-profit hospitals should measure and conduct an inventory of services and activities for the poor and underserved, special populations, and the broader community.
- **Step 4: Report community benefits.** Not-for-profit hospitals should determine how their organizations are received by the community, develop a community benefit message and media strategy, and inform external and internal audiences about the organization's mission, values, and community benefits.
- **Step 5: Evaluate effectiveness.** Not-for-profit hospitals should evaluate the structure of the community benefit program, the effectiveness of each program, and the effectiveness of the overall community benefit strategy.

The *Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability* is an extensive guide that defines what activities are considered to be community benefits and how to count and measure each activity. This document provides accounting guidelines for calculating

[14] Treas. Reg. § 1.501(c)(3)-1(e).

[15] U.S. Department of Commerce, Economic and Statistics Administration, U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2003* at 14 (Issued Aug. 2004).

[16] Douglas Holtz-Eakin, Director of Congressional Budget Office, Testimony before the Subcommittee on Health of the House Committee on Ways and Means (March 9, 2004).

costs, including subsidized health services, charity care, and government-sponsored health care. A copy of the guide and other community benefit resources are available to VHA members (and members of the public) on VHA's website at www.vha.com under "Public Policy," "Community Benefit Resources," "More."

As a companion to the resources identified above, VHA, in collaboration with CHA and Lyon Software, also developed the Community Benefit Inventory for Social Accountability ("CBISA") software. This low-cost software program is designed to assist not-for-profit hospitals in collecting, reporting, and preparing budgets for their community benefits. This software is enhanced and revised annually by VHA, CHA, and Lyon Software. Currently, the software is used by over 800 hospitals.

VHA, in collaboration with CHA, also reaches out into the not-for-profit hospital community and hosts a bi-annual national conference on the community benefit process. This conference is open to all not-for-profit hospitals and is intended to assist them in fulfilling their charitable missions. VHA and CHA hosted the first conference in 2002.

Conclusion

The tax-exempt hospital sector continues to play an important role in American society and contributes importantly to the public good by lessening the burdens of government. This sector delivers many essential services to communities—24-hour emergency rooms, neonatal intensive care, burn units, and care for terminally ill patients—that otherwise may not be available. Not-for-profit hospitals differ significantly from their for-profit counterparts in terms of both their structure and operation. These differences allow not-for-profit hospitals to act exclusively in furtherance of their charitable mission to improve the health of their communities.

VHA agrees that not-for-profit hospitals should clearly distinguish themselves from their for-profit counterparts. In collaboration with CHA, VHA is helping not-for-profit hospitals with their community benefit reporting process. These two resources—*Community Benefit Planning: A Resource for Nonprofit Social Accountability* and *Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability*—provide a framework for documenting the value of the benefits currently provided by not-for-profit hospitals to their communities.

VHA looks forward to the opportunity to work with Chairman Thomas, the Members of the Committee, and their respective staffs to address any concerns with the tax-exempt hospital sector in an appropriate manner.

No date available

Oversight and review of not-for-profit facilities is an appropriate topic for the Committee on Ways and Means. Recognizing that many of the not-for-profit facilities are hospitals these comments will focus on the hospital component of the not-for-profit facilities. However, it is important that the Committee also evaluate facilities such as churches or religious organizations that are property owners or acquiring funds from investments and yet are not-for-profit. The question must be asked, is there very clear benefit, in proportion to the revenues the organizations gain, to the community in return for the tax exempt status?

One concern with hospitals within the category of not-for-profit facilities can be highlighted in the following example, the county hospital which is a not-for-profit, tax exempt facility in Beaufort, SC has a 180% cost to charge ratio (meaning 180% above costs) based on their published data, which is an inappropriate position for a not-for-profit facility. A 2002 statewide average operating cost-to-charge ratio study identified Maryland with the lowest ratio of 32% above cost, Nevada with the highest at 255% above cost and Arizona at 190% therefore, for a county, not-for-profit, tax exempt facility in Beaufort, SC to be 180% is alarming.

In a comparison of charges with other facilities it is clear that the charges of this example facility is on the high end and outstrips national and local standards for charges. The focus seems to be only on their per day bed charges being competitive for health insurance review but apparently the charges are shifted to other areas to off-set that charge. For example, a mammogram can be obtained at another facility, that is not tax exempt and enjoying any of those benefits, but charges $55 for the mammogram procedure, yet the county not-for-profit facility in Beaufort, SC charges $106. A sample laboratory battery of tests would be charged at $445 by the not-for-profit, while if obtained at a taxed facility would be $250 or a bone density procedure is $270 at the not-for-profit hospital but the taxed facility charges $133. An emergency room administered tetanus/diphtheria vaccine, that based on national

standards! should be charged at approximately $20, is charged by the example not-for-profit facility at $136.

It is reasonable to draw the conclusion that there is inadequate oversight of the applicability of the not-for-profit, tax exempt status provided to a hospital that gains from that benefit and in addition charges high fees. There is a definite disconnect between not-for-profit and the generation of charges that produce revenue on which no taxes are paid.

In addition, it is unclear that communities monitor the return in providing tax exempt status to facilities, stipulate specific target expectations or measure the benefit received by such not-for-profit facilities. If there is declared jurisdiction or oversight by any elected representatives or legislators that is a further source of ignorance and denial. In contacting elected legislators and representatives in South Carolina, the response has uniformly been one of "no jurisdiction", which can be interpreted by tax payers as not wishing to become involved or of no political interest.

I sincerely hope that the Committee on Ways & Means reviews the role of the unscrunitized high percentage cost to charge ratio, not-for-profit hospital facility as perhaps a part of the problem in the escalating health care crisis and lack of affordable health care access in the U.S.

Thank you.

Sincerely,

Paula Loftis

Southern Illinois Healthcare
Carbondale, Illinois 62902
May 24, 2005

Dear Sirs:

I understand that the Ways and Means Committee is holding hearings this week on the tax-exempt hospital sector. This correspondence is testimony for that hearing.

Southern Illinois Healthcare (SIH) is a three-hospital system located in far southern Illinois. A small, not for-profit system, our largest hospital is 142 beds and our smallest is 25 beds. Despite our relatively small size, SIH hospitals offer sophisticated and modern medical care including open heart surgery, neurosurgery, neonatology, trauma care, and comprehensive rehabilitative care. We serve all patients regardless of ability to pay and serve a population that is heavily dependent upon Medicare and Medicaid.

The exemption of taxes for 501(c)(3) healthcare organizations is critical to Southern Illinois Healthcare's financial stability and its ability to fulfill its mission of caring for the residents of southern Illinois. As a not for-profit, tax exempt organization, SIH uses any excess of revenues over expenses to further invest in facilities, medical technology, and caregivers. Should the tax exempt status of SIH be eliminated, the very survival of SIH's hospitals would be brought into question. In order to survive, a for-profit SIH would be required to limit the charity care it provides, aggressively pursue bad debts, and limit care to Medicaid clients.

In fiscal year 2005, SIH hospitals provided over $3.9 million in charity care and wrote off almost $20 million in patient's bad debts. If SIH's tax exemption were removed, it is estimated that SIH's income tax alone would be almost $13 million. Clearly, this would jeopardize SIH's ability to provide care to all patients, regardless of ability to pay.

A fact of the healthcare industry is that the financial viability of hospital organizations is tied to an ability to access capital for building renovations, new equipment, and new technology. For example, Herrin Hospital, located in Herrin, Illinois, is in the midst of a $20 million expansion to provide patient care rooms replacing areas that are over 30 years old and very small. This addition would not be possible without SIH's ability to borrow the money necessary for this construction. The ability to borrow these funds and the interest rate for this debt is tied very closely to SIH's tax exempt, not for-profit status.

SIH operates a Community Benefits department for the benefit of the communities it serves. Through this department, SIH has provided parish nurse training, coordinated school health education, school nurses, helped place automated external defibrillators in communities, and conducted health screenings to detect diseases earlier. SIH offers these services as part of its mission to care for the residents of southern Illinois.

I applaud the Ways and Means Committee for its examination of the tax exemption issue. If I may offer any further information, please do not hesitate to contact me.

Sincerely,

Philip L. Schaefer, FACHE
Vice President

Statement of Mark Schlesinger, Yale University, and Bradford H. Gray, Principal Research Associate, Urban Institute

We appreciate the opportunity to submit this statement to the committee in connection with its important hearing on tax exemption for nonprofit hospitals. We have each studied the role of ownership in American health care for more than 20 years, and for the past decade have collaborated in these endeavors. We believe the testimony received by the committee provided an incomplete perspective regarding nonprofit and for-profit health care. Our statement is based on the most extensive review of the pertinent research literature that has been carried out to date.*

In 21st Century America, the legitimacy and favorable tax treatment of nonprofit medical care have come under fire from both political and academic fronts. Accusers charge nonprofits with three central failings. Some critics assert that nonprofits have lost public legitimacy and that ownership has become irrelevant to most Americans. They contend that "the vast majority of consumers either did not know the difference between for-profit and nonprofit insurers, or did not care"[1] and "the public seems to have little concern about who owns their hospitals."[2] Second, because empirical comparisons of nonprofit and for-profit performance are judged to have "mixed and inconsistent findings," in much recent scholarship "for-profits and nonprofits are assumed to be similar health services organizations."[3] Third, there are questions about whether nonprofits are deserving of tax exemptions. Many policymakers have grown concerned that a substantial portion of the nonprofit sector has lost sight of its charitable mission and needs to be held more accountable for meeting community needs.

Because these charges have been repeated frequently in academic and policy discourse, it would be natural to assume that they must be accurate. However, although each contains an element of truth, each is in fact deeply mistaken. Our goal in this statement is to set the record straight, distinguishing accurate criticisms from false charges in the assessment of nonprofit healthcare. We consider each of the three charges in light of the best recent evidence. From this assessment we develop an alternative perspective on the realistic benefits and real challenges regarding nonprofit health care in the U.S.

Do People Think Ownership Matters? Public Perceptions of Nonprofit Health Care

The claim that the public is unconcerned about ownership in American medicine is demonstrably false. This is evident whether one asks about healthcare in general terms or related to specific aspects of services. A general assessment comes from public opinion surveys fielded in the late 1990s. Changes in ownership in American medicine were described thusly: "In recent years, some health insurance plans, HMOs and hospitals have changed from not-for-profit status into for-profit institutions." Respondents were then asked whether this was "a good thing for healthcare in this country," "a bad thing for healthcare in this country," or "doesn't make much difference either way." Between 70 and 80 percent (varying across the four surveys) felt that for-profit expansion would make a difference (in ways that we will describe).[4] A 2002 survey inquired about the impact of ownership on specific attributes of medical care. Respondents were asked whether nonprofit or for-profit providers were superior in 10 aspects of medical care (five involving hospitals, five involving

[1] Organizations" *Bulletin of the New York Academy of Medicine* 1997; 74(2): 286–91 at 290.

[2] Frank Sloan, "Commercialism in Nonprofit Hospitals." Pp. 151–68 in *To Profit or Not to Profit: The Commercial Transformation of the Nonprofit Sector,* edited by B. Weisbrod. (New York: Cambridge University Press, 1998) at 167.

[3] T Reeves and F Ford, "Strategic Management and Performance Differences: Nonprofit versus For-Profit Health Organizations" *Health Care Management Review* 2004; 29(4): 298–308.

[4] Srija Srinivasan, *For-Profit Health Care Companies: Trends and Issues* (Menlo Park, CA: Kaiser Family Foundation, 1998)

health plans). Fewer than 3 percent felt that ownership would not matter in at least one aspect of care.[5]

The key question is thus not ***whether*** Americans see ownership as consequential in medical care, but ***how*** they think ownership might matter. The public sees for-profit firms doing better at some aspects of medical care, nonprofits at others. In a nutshell, for-profit firms are considered by a plurality of Americans to (a) provide better quality medical care, (b) be more responsive to consumers, and (c) be more efficient in the provision of health services. Nonprofits, on the other hand, are considered to (a) provide care at lower cost, (b) more generously treat indigent patients, (c) provide treatment in a more fair and humane manner, and (d) be more trustworthy.[6] The most pronounced differences in public expectations are related to efficiency, cost to patients, treatment of indigent patients, and trustworthiness.

Comparative Advantage to the Nonprofit Sector, but Varying Across Different Services: Some scholars conclude from such data that Americans must have no strong preferences about nonprofit versus for-profit healthcare, since each is seen as having certain advantages. This inference is too simplistic, because it presumes that the public equally values the dimensions on which nonprofits and for-profits have distinctive strengths. Evidence suggests otherwise. When explicitly asked whether the growth of for-profit ownership is a "good thing" or "bad thing" for healthcare in the United States, two to three times as many of those surveyed (varying across polls) saw the change as bad rather than good.

Alternative measures yield even larger portions of the public favoring nonprofit healthcare. When asked whether nonprofit or for-profit hospitals and health plans are "more helpful" for communities in which they are located, three to four times as many respondents favored nonprofit over for-profit organizations.[7] And in the 2002 survey that itemized expectations for 10 aspects of services, more than three times as many Americans identified more nonprofit than for-profit advantages. Lest readers suspect that these negative assessments of for-profit firms might be an artifact of biased wording or questionnaire design, the *Wall Street Journal*—a stalwart proponent of free enterprise and the profit motive in American society—recently concluded, based on its own 2003 survey, that "most of the public do not view healthcare as a business which should be driven by the profit motive. . . . There is little appetite for businesses to run home care, health insurance, nursing homes, hospitals, or medical research."[8]

The Real Challenge: Misunderstanding and Misperceptions of Ownership: Although it is clearly wrong to suggest that the American public thinks ownership is irrelevant in medical care, there is one sense in which the skeptic's critique is on target. Many Americans' awareness and understanding of ownership is sketchy at best. When asked about their reaction to "for-profit healthcare" in a 1996 survey, a quarter of the respondents indicated that they were not familiar with the term.[9] If asked to define how nonprofit and for-profit organizations differ, roughly a third of all Americans cannot even hazard a guess, and another 20–30 percent have difficulty articulating what that difference is, even in simple terms.[10]

Limited public comprehension of a legal abstraction like ownership form is probably not surprising, but it can have consequences. People who don't understand ownership are less likely to see nonprofits as providing medical care in a beneficial manner.[11] Widespread misunderstanding can thus undercut the legitimacy of the nonprofit sector. And it biases downward the public's valuation of nonprofit medical care expressed on surveys of opinion or in political discourse.

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[5] Mark Schlesinger, Shannon Mitchell and Bradford Gray, "Restoring Public Legitimacy To The Nonprofit Sector: A Survey Experiment Using Descriptions Of Nonprofit Ownership" *Nonprofit and Voluntary Sector Quarterly* 2004, 33(4): 673–710.

[6] Mark Schlesinger, Shannon Mitchell, and Bradford Gray, "Public Expectations Of Nonprofit And For-Profit Ownership In American Medicine: Clarifications And Implications" *Health Affairs* 2004; 23(6): 181–91.

[7] Mark Schlesinger, Shannon Mitchell, and Bradford Gray, "Public Expectations Of Nonprofit And For-Profit Ownership"

[8] Harris Interactive, *Most People Uncomfortable With Profit Motive in Health Care* Harris Interactive, Volume 2, Issue #12, p.1

[9] This question was a part of a survey conducted in the summer of 1996 by Princeton Survey Research Associates. The question cited in the text has the Roper Center identification number: USPSRA.073086,R05H.

[10] Mark Schlesinger, Shannon Mitchell and Bradford Gray, "Restoring Public Legitimacy To The Nonprofit Sector

[11] Mark Schlesinger, Shannon Mitchell, and Bradford Gray, "Public Expectations Of Nonprofit And For-Profit Ownership"

Does Ownership Matter? Differences in Nonprofit and For-Profit Health Care

The legal formulations of nonprofit and for-profit organizations create differences in the incentives facing their administrators and staffs, the sources of capital that they can tap, and the sources of influence over their governance. Whether and how these organizational features translate into distinctive services has been extensively studied. More than 250 empirical studies have been published comparing organizations nonprofit and for-profit auspices. These studies have examined hospital care, psychiatric services, nursing-home care, home healthcare, treatment of end-stage renal disease, hospice care, rehabilitative services, preventive examinations and various forms of ambulatory treatment. The studies consider many attributes of services: cost, quality, accessibility for indigent clients, trustworthiness of the organizations' practices, pricing policies, and stability of service provision over time.

Supporters and critics of nonprofit healthcare agree that the measured differences between nonprofits and for-profits in terms of cost, quality and accessibility vary greatly across studies. Critics find this troubling. For them, varied findings suggest a sort of randomness, implying that ownership can't count for much if it does not predict a consistent difference between nonprofit and for-profit practices. But this interpretation misconstrues how legal form can be expected to affect organizational performance. When an organization operates as a ***not***-for-profit, its ownership form does not define precisely ***what it is for.*** This indeterminism can be seen as an attractive feature in healthcare settings. Purchasers may be unwilling to pay for services that provide *community* benefit. These valuable aspects of care will be different among organizations that provide well-insured services (e.g. treatment of end-stage renal disease or hospice care) compared organizations that provide services for which tens of millions of patients lack adequate coverage (e.g. hospital care). They will be different for activities whose benefits go beyond individual patients (e.g., health promotion and disease prevention programs) compared with those that help only patients or their families (e.g. long-term care). They will be different in communities with high rates of poverty compared with those in which most residents are well off.

Arguably, it is precisely because these public good aspects of medical care are difficult to define in a consistent manner across services, among communities, and over time that nonprofits have a vital place in American medicine. Viewed from this perspective, variability in the nature of ownership-related differences can be seen as a virtue rather than a liability. To better understand the variability of findings from the empirical literature, we consider here three types of variation: over different medical services, across studies, and among different communities. We address the first two sources of variation in the next section, the third in the section that follows.

Variation Over Services: Much of the apparent inconsistency in the effects of ownership on medical care emerges when scholars carelessly combine findings drawn from different health services or differing measures of performance. By contrast, a series of recent articles have applied rigorous meta-analysis to aggregate only studies involving a single type of service organization and employing a single well-defined outcome. These studies find consistent ownership-related differences: higher mortality rates in for-profit hospitals and renal dialysis facilities,[12] higher prices in for-profit hospitals,[13] higher rates of adverse events in for-profit nursing homes,[14] and larger barriers to access for indigent patients in for-profit psychiatric facilities.[15]

Many of these ownership-related differences vary a great deal across services. We illustrate with the empirical research comparing three categories of outcomes for nonprofit and for-profit hospitals and nursing homes: economic performance, quality of care, and accessibility for indigent patients. The appended Exhibit 1 summarizes

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[12] P. J. Devereaux, Peter T. L. Choi, Christina Lacchetti, et al "A Systematic Review and Meta-Analysis of Studies Comparing Mortality Rates of Private For-Profit and Private Not-for-Profit Hospitals." *Canadian Medical Association Journal* 2002; 166: 1399–1406; P.J. Devereaux, Holger Schunemann, Nikila J. Ravindran, et al. "Comparison Of Mortality Between Private For-Profit And Private Not-For-Profit Hemodialysis Centers: A Systematic Review And Meta-Analysis". *Journal of the American Medical Association* 2002; 288(19):2449–57

[13] P.J. Devereaux, Diane Heels-Ansdell, Christina Lacchetti, "Payments For Care At Private For-Profit And Private Not-For-Profit Hospitals: A Systematic Review And Meta-Analysis" *Canadian Medical Association Journal* 2004; 170(12):1817–24

[14] Michael Hillmer, Walter Wodchis, Sudeep Gill, Geoffrey Anderson, Paula Rochon, "Nursing Home Profit Status and Quality of Care: Is There Any Evidence of an Association?" *Medical Care Research and Review* 2005; 62(2): 139–66.

[15] Pauline Rosenau and SH Linder, "A Comparison of the Performance of For-Profit and Nonprofit U.S. Psychiatric Inpatient Providers Since 1980" *Psychiatric Services* 2003; 54(2): 183–87.

results from 151 studies that use sophisticated methods (either multivariate models or matched samples to account factors other than ownership form). Because some studies reported multiple outcomes, we have a total of 199 distinct comparisons. Exhibit 1 groups these by the types of outcome, the type of service (hospitals vs. nursing homes), whether the analyses indicate a statistically significant advantage to nonprofit or for-profit providers (or insignificant differences between the two), and the specific type of outcome measure that was compared.

The impact of ownership on hospitals and nursing homes appears to be strikingly different. Consider first costs and efficiency. There is overwhelming evidence that for-profit nursing homes have lower costs and greater efficiency: 20 studies support this conclusion; the only other study found no statistically significant difference. For the eight studies with the most sophisticated comparisons of technical efficiency, seven found for-profits to be significantly more efficient. Among hospitals, however, costs and efficiency results are more mixed, but predominantly favor ***nonprofit*** facilities. Among the most sophisticated models of technical efficiency, for example, five found greater efficiency among nonprofits, three found no statistically significant differences, and three found for-profit hospitals to be more efficient. Although it's difficult to determine conclusively whether ownership matters one way or the other for hospital costs, it clearly matters quite differently for hospital services and nursing homes.

The differences are equally striking in the other two domains of performance. Nonprofit nursing homes have a marked pattern of higher quality care than their for-profit counterparts, but ownership differences involving hospitals are less dramatic. (One can see this most clearly by contrasting similar measures of quality. Among studies that examine the frequency of adverse treatment events, for example, nine of the twelve studies in nursing homes found these to be less common in nonprofit settings; only one favored for-profit homes. Among hospitals, in contrast, only five of 10 studies found adverse events to be less frequent in nonprofit settings, and three gave for-profits the edge.) But the relationship of ownership to access (the ability to obtain care by patients who are indigent or especially costly to treat) is much larger among hospitals than nursing homes and in the opposite direction. Of the 39 studies that compared hospitals, 29 found care to be more accessible in nonprofit settings; only one found significantly greater access in for-profit hospitals. However, for the six studies that looked at access in nursing homes, only one favored nonprofits and four found greater access in for-profit facilities.

The pattern illustrated by our comparison of hospitals and nursing homes is a general one. Our examination of the research literature has not found a single type of service for which there were not somedifferences between nonprofits and for-profits regarding cost, quality or accessibility. However, the effects of ownership manifest themselves in different ways for these services. Ownership ***always*** appears to matter, but ***never*** to matter in precisely the same manner from one service to the next.

Four other attributes of medical care are related to ownership in a more consistent manner across services. First, for-profit organizations are more aggressive than their nonprofit counterparts in their markup of prices over costs and in other efforts to maximize revenue. This pattern has been documented among community general hospitals,[16] nursing homes,[17] psychiatric hospitals,[18] drug treatment cen-

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[16] Devereaux et al, "Payments for Care"; Jan P Clement and Kyle L. Grazier. "HMO Penetration: Has It Hurt Public Hospitals?" *Journal of Health Care Finance* 2001; 28: 25–38; Glenn Melnick, Emmett Keeler and Jack Zwanziger, Market Power And Hospital Pricing: Are Nonprofits Different?. *Health Affairs.* 1999; 18(3):167–73; John R. Meurer, Evelyn M. Kuhn, Varghese George, Jennifer S. Yauck and Peter M. Layde, "Charges for Childhood Asthma by Hospital Characteristics." *Pediatrics* 1998;102(6): E70–7.

[17] Jeffery Ballou, *The Role of the Not-for-Profit Firm in the Mixed Industry: Three Empirical Analyses of the Long-Term Care and Hospital Industries* Doctoral thesis, Northwestern University, 2000; Howard A Birnbaum, A. James Lee, Christine Bishop and Gail Jensen, *Public Pricing of Nursing Home Care.* Cambridge, MA: Abt Books, 1981; Michael Koetting,. *Nursing-Home Organization and Efficiency.* Lexington, MA: Lexington Books, 1980

[18] Rosenau and Linder, "Psychiatric Inpatient Providers"; Barbara Dickey, "A Comparison of For-profit and Not-for-Profit Hospitals on the Cost of Mental Health Admissions" *Harvard Review of Psychiatry* 1994; 2(2): 97–103; Michael McCue and Jan P Clement, "Relative Performance of For-Profit Hospitals in Investor-Owned Systems and Nonprofit Psychiatric Hospitals" *American Journal of Psychiatry* 1993; 150(1): 77–82.

ters,[19] rehabilitation facilities,[20] and health plans.[21] Second, nonprofit organizations appear to deliver health services in a more trustworthy manner: They are less likely to make misleading claims,[22] less likely to have complaints lodged against them by their patients,[23] and less likely to treat less-empowered patients in a manner different from other clientele.[24] Third, nonprofits typically serve as the incubator for entirely new services, using philanthropy and cross-subsidies to finance the development of services for which payment systems have not been regularized and for which, therefore, there is not yet a market.[25] Fourth, nonprofit healthcare providers appear to be slower to react to changing conditions, both in terms of increasing their capacity when demand for care is expanding[26] and in dropping services or withdrawing from markets that have declining profitability.[27]

A second sort of variation across studies can be traced to the context in which healthcare is delivered. Some studies in each group compare organizations operating under relatively benign conditions, others in far harsher contexts. If the financial pressures and external constraints are sufficiently intense, even the most publicly spirited organization has limited capacity to generate revenues with which to support community benefit activities[28] This helps explain why studies that compare organizations before and after they convert from nonprofit to for-profit ownership generally find only small differences in accessibility or quality of services.[29] The non-

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[19] J. Wheeler, H Fadel and T D'Aunno, "Ownership and Performance in Outpatient Substance Abuse Centers" *American Journal of Public Health* 1992; 82(5): 711–18; M. Edlund, JR Wheeler, and T D'Aunno, "Payment Systems and Payment Incentives in Outpatient Substance Abuse Treatment" *Public Budgeting and Financial Management* 1990; 4(1): 107–23.

[20] Michael J McCue, and Jon M. Thompson. "Association of Ownership and System Affiliation with the Financial Performance of Rehabilitation Hospitals." *Health Services Management Research* 1997; 10: 13–23.

[21] Treo Solutions, 2004. "Costs, Commitment and Locality: A Comparison of For-Profit and Not-For-Profit Health Plans" *Inquiry* 41(2): 116–29; Mark Schlesinger, David Blumenthal, Eric Schlesinger. "Profits Under Pressure: The Economic Performance Of Investor-Owned And Nonprofit Health Maintenance Organizations" *Medical Care.* 1986; 24:615–627

[22] Mark Schlesinger, Nicole Quon, Mattthew Wynia, Deborah Cummins, Bradford Gray. "Profit-Seeking, Corporate Control And The Trustworthiness Of Health Care Organizations: Assessments Of Health Plan Performance By Their Affiliated Physicians" *Health Services Research* 2005; 40(3): ___–___; E Silverman and Jonathan Skinner, "Medicare Upcoding and Hospital Ownership" *Journal of Health Economics* 2004; 23(2): 369–89

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[24] S.Y. Chou, "Asymmetric Information, Ownership and Quality of Care" *Journal of Health Economics* 2002; 21(2): 293–311; H.T. Tu and JD Reschovsky, "Assessments Of Medical Care By Enrollees In For-Profit And Nonprofit Health Maintenance Organizations" *New England Journal of Medicine.* 2002; 346(17):1288–93

[25] Mark Schlesinger and Bradford Gray. "Nonprofit Organizations And Health Care"; Theodore Marmor, Mark Schlesinger and Richard Smithey. "Nonprofit Organizations and Health Care." Pp 221–39 in *The Nonprofit Sector: A Research Handbook,* edited by W.W. Powell. New Haven, CT: Yale University Press, 1987

[26] Horwitz, "Why We Need the Independent Sector"; Anup Malani, Tomas Philpson, and Guy David, "Theories of Firm Behavior in the Nonprofit Sector: A Synthesis and Empirical Evaluation" pp. 181–215 in *The Governance of Not-For-Profit Organizations,* edited by Edward Glaeser Chicago, University of Chicago Press, 2003; Marmor, et al,, "Nonprofit Organizations and Health Care"

[27] Henry Hansmann, Daniel Kessler and Mark McClellan, "Ownership Form and Trapped Capital in the Hospital Industry" pp. 45–69 in *The Governance of Not-for-Profit Organizations* edited by Edward Glaeser Chicago; University of Chicago Press, 2003; Horwitz, "Why We Need the Independent Sector"; Mitchell Glavin, Christopher Tompkins, Stanley Wallack and Stuart Altman, "An Examination of the Factors in the Withdrawal of Managed Care Plans from the Medicare+Choice Program" *Inquiry* 2002/2003; 39(4): 341–54.

[28] Amy Davidoff, Anthony LoSasso, Gloria Bazzoli, and Stephen Zuckerman, 2000. "The Effect of Changing State Health Policy on Hospital Uncompensated Care" *Inquiry* 37(3): 253–67

[29] R Town, Roger Feldman and Douglas Wholey, 2004. "The Impact of Ownership Conversions on HMO Performance" *International Journal of Health Care Finance and Economics* 4(4): 327–

profits prone to conversion were typically struggling financially, prior to changing ownership.

The Real Challenge: Understanding How Context Affects Ownership-Related Differences: Evidence of these contextual effects have led some skeptics to dismiss nonprofit healthcare as an anachronism, no longer compatible with a healthcare system that is market-driven and dominated by large corporations providing services. This seems quite intuitive—if market pressures and corporate hierarchies constrain provider behavior, how much can ownership actually affect cost, quality or accessibility of medical care?

The answer, surprisingly, turns out to be "quite a bit." Evidence suggests that the growing competition and affiliation with multi-unit systems have ***not*** diminished the magnitude of ownership-related differences in performance.[30] Quite the contrary, the gap between nonprofit and for-profit hospitals in the provision of uncompensated care appears to be growing as markets have become more competitive,[31] and ownership-related differences among system-affiliated providers are larger than among independent organizations in terms of accessibility of services, quality of care, and trustworthiness.[32] These findings do not demonstrate that ownership-related performance is independent of context, only that the major institutional transformations of American medicine over the last few decades have not vitiated the impact of nonprofit ownership.

Does Ownership Matter Enough? Accountability and Reliability in Nonprofit Healthcare

Performance differences between nonprofit and for-profit healthcare are substantial in size, significant in a statistical sense, and relatively resilient to changing market conditions. But are these differences large enough, relative to the tax advantages afforded nonprofit enterprise? Are the benefits associated with nonprofit ownership provided with sufficient reliability that policymakers can be sure that any given nonprofit agency is honoring its social obligations?

Variation in the Forms of Community Benefit: These questions prove challenging to answer. It is difficult to assess the full impact that healthcare organizations have on the communities in which they are located. Some forms of community benefit can be more readily measured than others. Some forms of community benefit carry a more robust historical pedigree than do others. Caring for indigent patients falls into both these categories. One can readily count the number of uninsured patients or the dollars spent on uncompensated care (though whether the latter should include "bad debt" remains a matter of continuing controversy.). Caring for the indigent has long been a standard for assessing charitable activity—prior to 1969, it was the primary criterion used by the IRS to determine federal tax exemption for nonprofit healthcare providers.[33]

Judged by this standard, the performance of nonprofit healthcare appears far from adequate. For nursing homes and health plans, nonprofit ownership is not con-

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42; John H. Goddeeris, H. and Burton A. Weisbrod. 1998. "Conversion from Nonprofit to For-Profit Legal Status: Why Does It Happen and Should Anyone Care?" Pp. 129–50 in *To Profit or Not to Profit: The Commercial Transformation of the Nonprofit Sector,* edited by B. Weisbrod, New York: Cambridge University Press; Jill Marsteller, Randall R. Bovbjerg, and Len M. Nichols. 1998. "Nonprofit Conversions: Theory, Evidence and State Policy Options." *Health Services Research* 33: 1495–1535.

[30] Schlesinger and Gray. "Nonprofit Organizations And Health Care"

[31] Davidoff et al, "Hospital Uncompensated Care"; James M. Ferris and Elizabeth A. Graddy, "Structural Changes in the Hospital Industry, Charity Care and the Nonprofit Role in Health Care." *Nonprofit and Voluntary Sector Quarterly* 1999; 28: 18–31; Richard A. Hirth, "Competition between For-Profit and Nonprofit Health Care Providers: Can It Help Achieve Social Goals?" *Medical Care Research and Review* 1997; 54: 414–38.

[32] Schlesinger et al, "The Trustworthiness of Health Care Organizations"; Bruce E. Landon, Alan M. Zaslavsky, Nancy D. Beaulieu, James A. Shaul and Paul D. Cleary. "Health Plan Characteristics and Consumers' Assessments of Quality." *Health Affairs* 2001; 20: 274–86; William Luksetich, Mary E. Edwards and Thomas M. Carroll. 2000. "Organizational Form and Nursing Home Behavior." *Nonprofit and Voluntary Sector Quarterly* 29: 255–79; Armel M Hughes, Kate L. Lapane and Vincent Mor. 2000. "Influence of Facility Characteristics on Use of Antipsychotic Medications in Nursing Homes." *Medical Care* 38: 1164–73; Mark Schlesinger, Judith D. Bentkover, David Blumenthal, William S. Custer, Robert Musacchio and J. Willer. 1986. "The Growth of Multi-Facility Health Care Systems and Access to Medical Services." Pp. 121–40 in *Advances in Health Services Research,* edited by L. Rossiter and G. Wilensky. Greenwich, CT: JAI Press.

[33] Margaret Potter and Beaufort Longest,"The Divergence of Federal and State Policies on the Charitable Tax Exemption of Nonprofit Hospitals." *Journal of Health Politics, Policy and Law* 1994; 19: 393–410.

sistently associated with ***any*** propensity to treat low-income patients.[34] Even in hospitals, the commitment to caring for uninsured patients is not always of sufficient magnitude to in itself justify tax exemptions. If one does not count bad debt as a form of uncompensated care, as many as three-quarters of all nonprofit hospitals fail to provide uncompensated care of a value equivalent to their tax benefits.[35] (In some states, nonprofits' commitment to uncompensated care appears stronger. But even in these jurisdictions, 20–40 percent of all nonprofit hospitals fail to cover the value of their tax benefits.[36] Even by the broadest standards, between a quarter and a third of nonprofit community hospitals in the United States provide insufficient free care to offset the value of their favored tax treatment.

However, care for the uninsured is neither the only meaningful form of community benefit nor the sole form of charitable activity in healthcare settings. For example, a recent study found that although there were no significant ownership-related differences among health plans in the extent of free or subsidized services, nonprofit plans were significantly more likely than for-profits to support safety-net healthcare providers or contribute to other community health initiatives that benefit the poor.[37]

More generally, this study found that although nonprofit plans were not more involved than similar for-profit plans in ***any*** of three areas defined by legal precedent for tax exemption, they were significantly more involved in three of five other domains of activity that can benefit community health. A small but growing body of research suggests that nonprofits provide substantially more of these diverse forms of community benefit.[38] And one study found that the nonprofits that are least involved in free or subsidized treatment are precisely those that are most engaged in the other forms of community benefit.[39]

The Real Challenge: Clarifying Expectations for All Forms of Community Benefit: The forms of community benefit used to justify tax exemption do not include most ways in which healthcare providers can and do influence the health of communities.[40] Enlarging and clarifying the scope of activities that could justify tax exemption would improve the accountability of nonprofit healthcare. However, it can be difficult to tell when nonprofit organizations have a sufficient commitment to some forms of community benefit. Their provision and consequences are difficult to measure, so it is hard to sum their combined effects meaningfully. One could count the resources devoted to an activity (probably as meaningful as counting the amount of uncompensated medical care), but this would account for spending, rather than effectiveness of initiatives. Until we have better measures of the scope and impact of community benefit activities, it is difficult to determine when nonprofits are sufficiently charitable.

Variation Among Locales: Does This Undermine the Legitimacy of Nonprofit Healthcare? A second challenge to accountability involves geographic variation in nonprofits' commitment to particular forms of community benefit. Since the mid-1980s, researchers have come to recognize that the presence of nonprofit pro-

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[34] Schlesinger and Gray, "Nonprofit Organizations and Health Care"

[35] Kane and Wubbenhorst, "Exploring the Value of Tax Exemption"; U.S. General Accounting Office. *Nonprofit Hospitals: Better Standards Needed for Tax Exemption.* GAO/HRD–90–84. Washington, DC: General Accounting Office, 1990.

[36] Michael A. Morrisey, Gerald J. Wedig and Mahmud Hassan, "Do Nonprofit Hospitals Pay Their Way?" *Health Affairs* 1996; 15: 132–44; General Accounting Office, *Better Standards Needed for Tax Exemption*

[37] Mark Schlesinger, Shannon Mitchell, and Bradford Gray. "Measuring Community Benefits Provided By Nonprofit And For-Profit HMOs" *Inquiry* 2003 40(2): 114–32.

[38] Research to date is limited largely to hospitals and health plans. Both have been shown to provide more health promotion services to the community, to support safety net providers, to collaborate more extensively with other local health care providers to meet community needs, to conduct community health assessments, and to work with local health departments. Gregory Ginn and Charles Moseley, "Community Health Orientation, Community-Based Quality Improvements and Health Promotion Services in Hospitals" *Journal of Healthcare Management* 2004; 49(5): 293–306; Treo Solutions, "Costs, Commitment and Locality"; Mark Schlesinger, Bradford Gray, and Michael Gusmano. "A Broader Vision For Managed Care, Part III: The Scope And Determinants Of Community Benefits Provided By HMOs" *Health Affairs* 2004; 23(3): 210–221; E. Jose Proenca, Michael D. Rosko and Jacqueline S. Zinn, "Correlates of Hospital Provision of Prevention and Health Promotion Services." *Medical Care Research and Review* 2003; 60: 56–78; Glen P. Mays, Paul K Halverson, Arnold D Kaluzny and Edward C Norton, "How Managed Care Plans Contribute to Public Health Practice" *Inquiry* 2000/2001; 37(4): 389–410; E Jose Proenca, Michael D. Rosko and Jacqueline S. Zinn, "Community Orientation in Hospitals: An Institutional and Resource Dependence Perspective." *Health Services Research, Part I* 2000; 35: 1011–35.

[39] Kane and Wubbenhorst, "Exploring the Value of Tax Exemption"

[40] Mark Schlesinger, Bradford Gray, Gerald Carrino, Mary Duncan, Michael Gusmano, Vincent Antonelli and Jennifer Stuber, "A Broader Vision For Managed Care, Part 2: Toward A Typology Of Community Benefits Provided By Hmos" *Health Affairs* 1998; 17(5): 26–49

viders influences for-profit organizations (and vice versa) in a wide variety of ways. The presence of for-profits in a locale seems to encourage nonprofit hospitals to (a) respond more aggressively to revenue-enhancing opportunities,[41] (b) add more profitable services,[42] (c) discourage admissions of unprofitable patients,[43] and (d) reduce the resources devoted to treating those patients who they do admit.[44] Conversely, the presence of nonprofits in a community is associated with increased quality of care in for-profit nursing homes,[45] reduced mortality rates in for-profit renal dialysis facilities,[46] and increased trustworthiness of for-profit health plans.[47] Researchers have also found that for-profit firms tend to build or purchase facilities in communities that have few uninsured or low-income residents.[48]

The Real Challenge: How Much of Each Ownership is Enough? The policy import of these cross-ownership influences is only partly clear. On the one hand, the presence of nonprofit competitors appears to have a generally positive effect on the performance of for-profit healthcare providers. Nonprofit neighbors appear to rein in some less-palatable practices associated with the profit motive, though the precise mechanism for this influence is poorly understood. (It may involve patients' sorting themselves between nonprofit and for-profit settings, providers' adapting to local practice norms, or employers and other large purchasers of medical care revising their expectations). For-profit competitors have a more mixed effect on nonprofits. They can exert a positive influence by stimulating more efficiency and greater responsiveness to changing market conditions. However, for-profit influence appears to erode nonprofits' commitment to charity care, a vital concern for at least some health services and many local communities.

Whatever the net effect of these cross-ownership influences, identifying the most appropriate mix of nonprofit and for-profit providers in each community depends in part on how sensitive each is to the presence of the other. There is only a smattering of evidence on these relationships. It appears that even a small for-profit presence (a share of 10% or less in the local market) will induce greater efficiency from their nonprofit competitors.[49] But a larger presence of nonprofits appears required to induce for-profit counterparts to behave in a more trustworthy manner—market shares of at least 20–30 percent.[50]

Concluding Thoughts: Maintaining a Vital Nonprofit Presence in Each Community

Although nonprofits' community benefits vary across services and localities, the sector plays a vital role in American healthcare. The ownership-related outcomes that can be sensibly counted add up to be quite consequential. Although not all nonprofit hospitals (even in communities with many low-income residents) provide extensive free care, were private nonprofit hospitals to treat uninsured patients at the same rate as for-profit hospitals, the burden on government hospitals treating unin-

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[41] Silverman and Skinner, "Medicare Upcoding and Hospital Ownership"; Jason R Barro and Michael Chu, "HMO Penetration, Ownership Status, and the Rise of Hospital Advertising" pp. 101–116 in *The Governance of Not-for-Profit Organizations* (Chicago: University of Chicago Press, 2003); Mark Duggan, "Hospital Market Structure and the Behavior of Not-for-Profit Hospitals" *Rand Journal of Economics* 2002; 33(3): 433–46.

[42] R.G. Hughes and Harold S. Luft. "Keeping Up with the Joneses: The Influence of Public and Proprietary Neighbors on Voluntary Hospitals." *Health Services Management Research* 1990; 3: 173–81.

[43] Mark Schlesinger, Robert A. Dorwart, Claudia Hoover and Sherrie Epstein, "Competition and Access to Hospital Services: Evidence from Psychiatric Hospitals." *Medical Care* 1997; 35: 974–92; Mark Schlesinger, Judith D. Bentkover, David Blumenthal, Robert Musacchio and J. Willer. "The Privatization of Health Care and Physicians' Perceptions of Access to Hospital Services." *The Milbank Quarterly* 1987; 65: 25–58.

[44] Daniel Kessler and Mark McClellan, "The Effects of Hospital Ownership on Medical Productivity" NBER Working Paper #8537 (Cambridge MA: National Bureau of Economic Research, 2001); Susan L. Ettner and Richard C. Hermann. "The Role of Profit Status Under Imperfect Information: Evidence from the Treatment Patterns of Elderly Medicare Beneficiaries Hospitalized for Psychiatric Diagnoses." *Journal of Health Economics* 2001; 20: 23–49.

[45] David Grabowski and Richard Hirth, "Competitive Spillovers Across Non-Profit and For-Profit Nursing Homes" *Journal of Health Economics* 2003; 22(1): 1–22.

[46] Pushkal P.Garg, Kevin D. Frick, Marie Diener-West and Neil R. Powe, "Effect of Ownership of Dialysis Facilities on Patients' Survival and Referral for Transplantation." *New England Journal of Medicine* 1999; 341: 1653–60.

[47] Schlesinger et al., "The Trustworthiness of Health Care Organizations"

[48] Jan P.Clement, Kenneth White and Vivian Valdmanis, "Charity Care: Do Not-For-Profits Influence For-Profits?" *Medical Care Research and Review* 2002; 59: 59–79; Bradford H. Gray, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals.* Cambridge, MA: Harvard University Press, 1991; Marmor et al., "Nonprofit Organizations and Health Care"

[49] Kessler and McClellan, "The Effects of Hospital Ownership on Medical Productivity"

[50] Schlesinger et al., "The Trustworthiness of Health Care Organizations"

sured patients would double. Although not all studies find inpatient mortality to be lower in nonprofits, on average the reduced risk in nonprofit settings is about on par with the quality benefits from teaching hospitals, which policymakers have generally viewed as vital to a high-quality healthcare system. And if the price markups associated with for-profit ownership were extended to other health care organizations, a 5–10 percent spending increase would result, hardly trivial when total annual medical costs in the United States are predicted to exceed $3 trillion dollars by the year 2013.

But in many respects, the most precious aspects of nonprofit healthcare are those that cannot be counted. As we learn that even effective programs for patient education leave many consumers ill informed and vulnerable, nonprofits' comparative trustworthiness will seem an essential attribute of American medicine. As we come to better appreciate the importance of the social determinants of health, nonprofits' greater predisposition to pursue community-based health promotion programs will become increasingly central to health policy. As the prevalence of chronic illness increases in an aging population, nonprofits' predisposition toward collaborative involvements with other community healthcare providers will become increasingly valuable.

Most Americans care about maintaining nonprofit healthcare; we believe that they are right to do so. In our assessment, however, capturing the realistic benefits of nonprofit ownership does not necessarily require an entirely nonprofit delivery system, as some advocates have argued.[51] However, it does require at minimum that there be a vital and robust nonprofit presence (perhaps 30–40 percent for each service) for all health services in every community, a situation that currently exists for few services outside of acute care hospitals. And it further requires that policymakers address in a concerted and constructive manner the challenges raised by Americans' current misunderstandings of ownership, by nonprofits' sometimes limited involvement with the communities in which they are located, and by lack of clarity regarding community benefit expectations beyond the care of the uninsured.

EXHIBIT 1

Categorizing Empirical Findings Comparing Organizational Performance by Ownership: Acute Care Hospitals vs. Nursing Homes

[Citations are available from the authors.]

Direction of Finding	Specific Measures (Number of Studies Using This Measure)		
	Economic Performance	Quality of Care	Accessibility for Unprofitable Patients
	Studies of Acute Care Hospitals		
Nonprofit Advantage	Administrative overhead (3)[52] Costs per admission (10)[53] Measures of inefficiency (5)[54] Revenues per admission (6)[55]	Post-discharge mortality (7)[56] In-hospital mortality (1)[57] Adverse outcomes (5)[58] Process measures (4)[59] Regulatory violations (1)[60]	Locating in low-income areas (5)[61] Treating uninsured patients (12)[62] Restrict access of uninsured (4)[63] Providing unprofitable services (6)[64] Treating Medicaid patients (2)[65]
No Difference	Cost per admission (7)[66] Revenues per admission (2)[67] Measures of inefficiency (3)[68]	Malpractice suits (1)[69] In-hospital mortality (7)[70] Post-discharge mortality (9)[71] Adverse outcomes (2)[72] Process measures (1)[73] Hospital re-admissions (1)[74]	Treating uninsured patients (6)[75] Treating Medicaid patients (3)[76]

[51] Stephanie Woolhandler, David Himmelstein, Marcia Angell, Quentin Young and the Physicians' Working Group for Single-Payer National Health Insurance, "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance" *Journal of the American Medical Association* 2003; 290(6): 798–805

EXHIBIT 1—Continued

Categorizing Empirical Findings Comparing Organizational Performance by Ownership: Acute Care Hospitals vs. Nursing Homes

[Citations are available from the authors.]

Direction of Finding	Specific Measures (Number of Studies Using This Measure)		
	Economic Performance	Quality of Care	Accessibility for Unprofitable Patients
For-Profit Advantage	Cost per admission (5)[77] Measures of inefficiency (2)[78]	Adverse outcomes (3)[79] Post-discharge mortality (1)[80]	Treating Medicaid patients (1)[81]
	Studies of Nursing Homes		
Nonprofit Advantage	Administrative overhead (1)[82] Revenues per admission (4)[83]	Malpractice suits (2)[84] Satisfaction with treatment (2)[85] Process measures of quality (6)[86] Regulatory violations (6)[87] Adverse outcomes (9)[88] Physical restraints (4)[89]	Services at reduced charge (1)[90]
No Difference	Administrative overhead (4)[91] Measures of inefficiency (1)[92]	Regulatory violations (2)[93] Functional improvements (3)[94] Adverse outcomes (2)[95] Process measures of quality (2)[96] Physical restraints (2)[97]	Medicaid admissions (1)[98]
For-Profit Advantage	Average operating cost (7)[99] Measures of inefficiency (7)[100] Average total cost (6)[101]	Adverse outcomes (1)[102] Anti-psychotic use (1)[103]	Medicaid admissions (4)[104]

[52] Stephanie Woolhandler and David Himmelstein, "Costs of Care and Administration at For-Profit and Other Hospitals in the United States." *New England Journal of Medicine* 1997; 336:769–74; Richard B. Carter, Lawrence J. Massa, "An Examination of the Efficiencey of Proprietary Hospital versus Non-Proprietary Hospital Ownership Structures." *Journal of Accounting and Public Policy* 1997; 16:63–87; R Eskoz and K.M. Peddecord, 1985. "The Relationship of Hospital Ownership and Service Composition to Hospital Charges" *Health Care Financing Review* 6(3): 51–8.

[53] Clement and Grazier, "HMO Penetration: Has It Hurt Public Hospitals?"; Ettner and Hermann, "The Role of Profit Status Under Imperfect Information: Evidence from the Treatment Patterns of Elderly Medicare Beneficiaries Hospitalized for Psychiatric Diagnoses"; Sharyn Potter, "A Longitudinal Analysis of the Distinction Between For-Profit and Not-For-Profit Hospitals in America" *Journal of Health and Social Behavior* 2001; 42: 17–44; Terri J. Menke, "The Effects of Chain Membership on Hospital Costs" *Health Services Research* 1997; 32:177–96; William S. Custer and Richard J. Wilke, "Teaching Hospital Costs: The Effects of Medical Staff Characteristics." *Health Services Research* 1991; 25:831–57; Carol M. Lawrence, "The Effect of Ownership Structure and Accounting System Type on Hospital Costs" *Research on Governmental and Nonprofit Accounting* 1990; 6:35–60; Charles A. Register, Ansel M. Sharp and Lonnie K. Stevens, "Profit Incentives and the Hospital Industry: Some New Evidence" *Atlantic Economic Journal* 1988; 16:25–58; Thomas W. Grannemann, Randall S. Brown and Mark V. Pauly, "Estimating Hospital Costs: A Multiple Output Analysis" *Journal of Health Economics* 1986; 5:107–27; Edmund R. Becker and Frank A. Sloan, "Hospital Ownership and Performance" *Economic Inquiry* 1985; 23:21–36; Eskoz and Paddecord, "Hospital Ownership and Service Composition"

[54] Niccie L. McKay, Mary E. Deily and Fred H. Dorner, "Ownership and Changes in Hospital Efficiency" *Inquiry* 2002/2003; 39(4): 388–99; Gary Koop, Jacvek Osiewalski and Mark Steel, "Bayesian Efficiency Analysis Through Individual Effects: Hospital Cost Frontiers: *Journal of Econometrics* 1997; 76(): 77–105; Stephan Zuckerman, Jack Hadley and Lisa Iezzoni, "Measuring Hospital Efficiency with Frontier Cost Functions" *Journal of Health Economics* 1994; 13: 255–80; Yasar A. Ozcan and Roice D. Luke, "A National Study of the Efficiency of Hospitals in Urban Markets" *Health Services Research* 1993; 27: 719–39; Yasar A. Ozcan, Roice D. Luke and Cengiz Haksever, "Ownershop and Organizational Performance: A Comparison of Technical Efficiency Across Hospital Types" *Medical Care* 1992; 30: 781–94.

[55] Devereaux et al, 2004; Clement and Grazier, "HMO Penetration: Has It Hurt Public Hospitals?"; Melnick et al., "Market Power and Hospital Pricing: Are Nonprofits Different?"; Meurer et al, "Charges for Childhood Asthma by Hospital Characteristics"; Lyrik, 1995; Eskoz and Peddecord, "Hospital Ownership and Service Composition".

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[57] ME Pitterle, CA Bond, CL Raehl and T Franke, "Hospital and Pharmacy Characteristics Associated with Mortality Rates in United States Hospitals" *Pharmacotherapy* 1994; 14(5): 620–30.

[58] Sarah Broome, *Market Characteristics and Hospital Organizational Factors that Affect Hospital Nursing Quality* Doctoral thesis, University of North Carolina, 2002; Yu-Chu Shen, *The Effect of Market Reforms and Ownership Choice on the Quality of Care in Hospitals* Doctoral thesis, Harvard University, 2001; Lanksa and Kryscio, 1998; Christine T. Kovner and Peter J. Gergen, "Nursing Staff Levels and Adverse Events Following Surgery" *Image: Journal of Nursing Scholorship* 1998; 30: 315–21.

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Statement of Jay Wolfson, Tampa, Florida

We have studied comparative data about for-profit and not-for-profit (NFP) hospitals in Florida and other states. We sought to find objective, quantitative bases for assessing the relative value and contribution made by NFPs to community benefit as against the corporate benefits of tax exemption enjoyed. "Community benefit" was broadly and consistently defined.

Not-for-profit health care organizations enjoy benefits consisting of:

- Not paying most local, state or federal taxes on income, purchases or properties;
- Receiving contributions from individual and corporate benefactors that are generally tax deductible for the donor;
- Being eligible for certain grants or contracts by virtue of their tax exempt status;
- Being eligible to receive proceeds from certain bond issues (often at very low rates of interest) for various projects.

In exchange for these and other benefits, NFP health care organizations are expected to afford their communities distinctive value and services.

Many NFPs are distinguished by the fact that they may be the only provider of certain services in their community. Others have demonstrated a high level of commitment to providing indigent and uncompensated services and/or reaching out to high risk populations to provide care.

The value of the services provided by NFPs has been subject to increasing state and federal attention because there is evidence that there are often few distinctions between NFP and their for profit competitors' operations and patient services.

A reasonable hypothesis is that NFP health care organizations should provide *at least* as much distinctive community service *value* as they receive in tax exempt benefits.

The simple model would ask, does the combined economic value of programs and services such as: indigent and charity care; special services to high cost/high risk populations; equal or exceed the totality of taxes NOT paid (federal income, state corporate, property, use, etc.)?

Our studies have found that it is the *exception* for a NFP health care organization to be able to demonstrate that the totality of its quantifiable community benefits resulted in value equal to or greater than the dollar value of the tax exemption enjoyed.

Too, executive compensation arrangements within NFP organizations may often consist of base and bonus salary packages that equal or exceed private, for-profit competitors.

One of our early studies (attached), published in the Journal of Healthcare Financial Management (July 1994) provides an example of the work we have done. Our goal has been to provide objective information for health care organizations and policy makers.

There is value in conducting additional studies within and across a spectrum of communities. The model in the attached publication may serve as a template that can be applied across such a spectrum of communities.

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Scott L. Hopes is President of Healthcare Management Decisions, Inc., a health industry consulting group that provides health policy research, strategic health services planning for governing and private sector providers. He served as Director of Health Planning for the State of Florida, and has provided research-based technical assistance to legislative and executive branches of government, as well as to the health care industry.