



**Testimony of Community Catalyst
submitted to the
Subcommittee on Oversight of the Committee on Ways and Means,
U.S. House of Representatives**

Hearing on Tax Exempt Organizations

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Community Catalyst appreciates the opportunity to submit written testimony to the Subcommittee on Oversight of the Committee on Ways and Means of the United States House of Representatives. In particular, we thank Chairman Charles W. Boustany Jr. for calling this hearing to examine the operations and oversight of tax-exempt organizations.

Community Catalyst is a national, non-profit consumer advocacy organization dedicated to ensuring quality, affordable access to health care for all. We work with state advocacy partners and a variety of other stakeholder groups including hospitals in approximately 40 states on a variety of different issues related to health care, focusing on vulnerable groups such as seniors, low-income children and families, immigrants, racial and ethnic minorities, and people living with chronic illness and special health care needs.

For many years, Community Catalyst has worked collaboratively on a range of issues with non-profit hospitals, critical institutions for our health care safety net. As part of this work, we have advocated for strong community benefit programs. Along with our state partners, Community Catalyst worked on the development and implementation of state laws related to community benefit programs and individual hospital facility agreements, studied existing state laws and standards, and developed tools to enable community groups to collaborate with hospitals and others on community benefit issues.

In addition, we worked closely with Members of Congress in calling for the new requirements in Schedule H and creating 26 U.S.C. § 501(r) for tax-exempt hospitals. The provisions in 501(r) strengthen the requirements around what non-profit hospitals must do to meet their community benefit obligations.

Community Catalyst strongly concurs with Chairman Boustany's statement that it is important that the IRS have the information it needs to ensure tax-exempt organizations are operating in furtherance of their charitable purpose and maximizing benefits provided to the community. This is precisely why we believe the new Schedule H reporting requirements are so important and why additional transparency measures in 501(r) are also vital and need to be implemented expeditiously.

As recent press accounts, such as those appearing in the *The New York Times*,^{1,2} *Charlotte Observer*,³ and *St. Paul Pioneer Press*,⁴ make clear, the current practices of at least some non-profit hospital facilities are failing to meet this standard. Schedule H and the new requirements in Section 501(r) are designed to remedy this by requiring facility level reporting on financial assistance and community benefit, public disclosure of what assistance is available, development of a community benefit plan in consultation with the community and establishing standards for billing and collection actions. We firmly believe these new provisions are an integral part of ensuring much-needed transparency and accountability for non-profit hospitals.

The Importance of Schedule H

The data requested in the revised Schedule H serves an important function: it gives policymakers and the public a clearer picture of the value individual tax-exempt hospitals bring to their communities. Each year, local, state and federal governments forego billions of dollars in tax

revenues with the understanding that tax-exempt hospitals are providing care to financially needy members in their communities. While we have worked with many dedicated hospital professionals who have used community benefit resources innovatively and effectively to improve access to care for vulnerable populations, many hospitals lag behind. Non-profit hospitals should demonstrate how their tax exemptions are clearly benefitting their communities. We believe reporting individual hospital data works to hospitals' benefit, as well, enabling them to show the value they bring to communities in a particularly difficult time for local, state and federal budgets.

In 2008, the IRS reformed Form 990, including introducing Schedule H for tax-exempt hospitals. One of the guiding principles of those changes was to enhance transparency about hospital organizations' operations, providing the IRS and others, including the communities served by tax-exempt hospitals, comparable information about the ways hospitals choose to conduct their business. From a community perspective, Part V, Section B builds on this goal by providing invaluable information about individual hospital practices: information about the way local hospital facilities, as opposed to hospital systems, choose to serve their communities. The communities served by individual hospitals within a hospital system are likely to differ significantly with regard to economic status, unmet health needs and resources, cultural and linguistic preferences, and priorities. It follows that the need for financial assistance, billing and debt collection, and community benefit programs will also differ across communities. Hospitals, including those that are part of larger systems, should take these factors into consideration and use them to tailor policies to meet the unique needs of their local communities. The information found in Part V, Section B is unique because it provides communities with unprecedented insight into their local hospitals' practices. This information, we note, is not repeated elsewhere in Schedule H, and certainly not to the level of detail found in Part V, Section B.

Research has shown that the information requested in Part V, Section B regarding financial assistance, billing and debt collection is simply not consistently available to hospitals' community members and to patients in need, despite the hospital industry's assertions to the contrary, and especially without active government oversight.

Moving forward, we strongly encourage the IRS to retain Part V, with some improvements, and require all hospital facilities to report it. Including this data in Schedule H reporting will provide a valuable – and otherwise unavailable – baseline of qualitative and quantitative data about hospital performance. Hospitals have had ample time to come into compliance, even without additional guidance, and should be able to answer the questions found in Schedule H. Delaying the reporting requirements could unintentionally keep communities and individual consumers from gaining timely information about financial assistance programs and fair billing requirements.

The New Requirements of Section 501(r)

Financial Assistance

Though tax-exempt hospitals may face additional reporting and may need to adjust their policies to comply with the requirements of 501(r), we should never forget that the brunt of the burden of inadequate financial assistance, billing and community benefit practices falls on consumers. A

March 2012 report from the Centers for Disease Control and Prevention (CDC) found that, in the first six months of 2011, one in five people were in a family struggling to pay a medical bill, with one in ten reporting their family carried medical bills they were unable to pay at all.⁵ As this data suggests, medical billing and debt collection practices do not solely affect the patients who received treatment, but the economic well-being of their families and greater communities. Hospital bills can be particularly devastating: on average, uninsured families can afford to pay only 12 percent of the total amount hospitals charge for a hospital stay.⁶

Because Section 501(r) requires hospitals to make their financial assistance policies publicly available and work with patients to determine whether they qualify, it can offer peace of mind to the millions of Americans stuck in precisely the position described by CDC who are uninsured or underinsured due to job loss, inadequate insurance coverage, chronic illness, and other circumstances beyond their control.

For many individuals, hospital financial assistance programs are the only viable link to health care, but reliable information about them has been difficult to come by in many communities, despite assurances from industry stakeholders to the contrary. Without this information, communities have no real gauge for understanding the value their hospitals bring, and individual patients lack timely access to information that would help them seek necessary care without incurring medical debt. Section 501(r) addresses this by requiring hospitals to report uniform information about their financial assistance programs.

Community Engagement

Solid community benefit practices, which include forthright public reporting on hospital practices and decision-making and meaningful community engagement, encourage a stronger, smarter, more flexible use of health care resources that remove barriers to care at the local level. The new requirements that hospitals engage community members and public health experts in researching, developing and implementing a community health needs assessment and plan incentivizes hospitals to “swim upstream”—that is, to collaborate with other providers, experts and community members to address the issues that lead to poor health and drive improper emergency room use. These programs can ultimately help hospitals and communities drive down burgeoning health costs for *all* payers and improve community health.

Fair Billing and Collection Practices

The term “reasonable effort” for determining eligibility for financial assistance in the context of a hospital’s debt collection practices needs further definition. We believe that having strong, uniform, fair financial assistance policies and upfront notification procedures – as described above – is both wholly “reasonable” within the meaning of the law and necessary to achieve its aims of protecting consumers from avoidable medical debt.

In addition certain debt collection activities should be prohibited outright.⁷ For example, patients who qualify for financial assistance or are eligible for public programs such as Medicaid should be exempted from debt collection activity. In general, hospital debts should not be referred to collection agencies or reported to credit bureaus until the patient is screened for financial assistance or public programs. Practices such as selling patient debt to third parties or charging interest on outstanding patient debts should be prohibited outright. Many collections practices

create tremendous hardship for families, with long-lasting effects that spill over into the financial well-being of whole communities.

In sum, we believe that the reporting requirements in Schedule H and the new requirements of Section 501(r) will go a long way toward ensuring non-profit hospitals are fulfilling their tax-exempt purpose and maximizing community benefit. However, we also believe that to be effective, the provisions of 501(r) need to be clarified through regulation. In 2010, Community Catalyst and 66 other organizations from across the country sent comments to the IRS that outlined the most critical protections that belong in 501(r) guidance.⁸ The health care advocacy organizations that signed the letter all believe that we must improve access to quality care, strengthen relationships between hospitals and communities, and alleviate burdens caused by medical debt. Nothing that has occurred in the intervening years has caused us to change our views.

Thank you.

¹ Silver-Greenberg, J., *New York Times*, “Debt Collector is Faulted for Tough Tactics in Hospitals,” April 24, 2012. http://www.nytimes.com/2012/04/25/business/debt-collector-is-faulted-for-tough-tactics-in-hospitals.html?_r=4&pagewanted=all

² Bernstein, N. *New York Times*, “Hospitals Flout Charity Aid Law,” February 12, 2012. http://www.nytimes.com/2012/02/13/nyregion/study-finds-new-york-hospitals-flout-charity-rules.html?_r=1&nl=todaysheadlines&emc=tha2

³ Alexander, A. and Raynor, D., *Charlotte Observer*, “Hospital Suits Force New Pain on Patients,” April 23, 2012. <http://www.charlotteobserver.com/2012/04/23/3193509/hospital-suits-force-new-pain.html>

⁴ Snowbeck, C., *St. Paul Pioneer Press*, “Minnesota AG Blasts Fairview’s Former Medical Debt-Collection Firm for Aggressive Tactics.” http://www.twincities.com/ci_20468315/attorney-general-report-calls-medical-bill-collector-overly

⁵ Centers for Disease Control and Prevention. *Financial Burden of Medical Care: Early Release of Estimates from the National Health Interview Survey, January – June 2011*. March 2012.

⁶ Chappel, A. Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy, Department of Health and Human Services. *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills*. May 2011. <http://aspe.hhs.gov/health/reports/2011/ValueofInsurance/rb.pdf>.

⁷ California, Connecticut, Massachusetts, Washington and New Jersey are among the states that have already taken steps to prohibit hospitals from engaging in some of the practices we discuss.

⁸ Community Catalyst, Letter to IRS Commissioner Ingram and Director Lerner Regarding Notice 2011-39, New Requirements for Tax-Exempt Hospitals, July 21, 2010.

http://www.communitycatalyst.org/doc_store/publications/IRS_Sign-on_Letter_RE_Nonprofit_Hospitals_with_sign_ons.pdf