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Advancing Health in America

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The Honorable Bernie Sanders
Chairman
Committee on Health, Education, Labor, and Pensions
United States Senate
Washington, DC 20510

RE: Report on Tax-exempt Hospitals

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, two million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes in response to your recent report on tax-exempt hospitals.[1] To summarize our concerns: Much of the report is inaccurate or incomplete and thereby manifestly unfair to America's tax-exempt hospitals. Particularly concerning is the lack of recognition of scope and amounts of community benefits, including hospitals' support for the underfunded Medicaid program, the outsize role commercial health insurers play in creating medical debt, the importance of reserves as a buffer against financial downturns and support for hospitals' charitable mission, the rigor with which executive compensation is determined, and hospitals' robust engagement with the community encapsulated by their community needs assessments.

Our detailed comments follow.

A MORE ACCURATE ACCOUNT OF COMMUNITY BENEFIT

Hospitals provide community benefits in exchange for the privilege of tax exemption, fully report it every year, and respect the obligations that go with tax exemption. Years of precedential court decisions and Internal Revenue Service (IRS) pronouncements confirm that community benefits are not limited to free or reduced cost care as your

[1] Major Non-Profit Hospitals Take Advantage of Tax Breaks and Prioritize CEO Pay Over Helping Patients Afford Medical Care.

report suggests.[2] Beyond the law, however, every credible analysis of community benefit has found that hospitals meet and exceed their community benefit obligation. For example, a recent EY analysis comparing community benefits to the amount of federal revenue forgone found a 9 to 1 return to the taxpayers: For every $1 dollar of revenue forgone tax-exempt hospitals provided $9 in community benefit.[3] Analyses of Form 990 Schedule H filings since their inception are entirely consistent with that finding. They demonstrate that hospitals provide large amounts of community benefit that is wide-ranging yet heavily invested in caring for the poor.[4] For the most recent year for which comprehensive information is available, tax-exempt hospitals provided nearly $130 billion in community benefits, nearly half of which was for free or reduced cost care for those in need or absorbing Medicaid underpayments.[5] The hospitals cited in your report, provided nearly $19 billion in community benefit for an average of 16.8% of total expenses – more than half of which was for financial assistance and Medicaid underpayments. Perhaps most remarkable, tax-exempt hospitals increased their community benefits from the previous year by almost $20 billion in the midst of a global pandemic. Your report not only neglects those facts but fails to acknowledge the importance of hospitals' support for Medicaid patients; this is a significant oversight.

Qualifying Patients for Medicaid and Absorbing the Underpayments is an Essential Community Benefit

Following passage of the Affordable Care Act (ACA) absorbing the cost of Medicaid underpayments and other means-tested programs that provide the poor with regular

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[2] In Santa Rosa Infirmary v. City of San Antonio the Texas Supreme Court case held: "[T]he mere fact that pay patients largely predominate over the charity patients …could not, under the great weight of authority, be said to so detract from its charities as to disqualify it as an institution of purely public charity." In City of Richmond v. Richmond Memorial Hospital the Virginia Supreme Court held: "A tax exemption cannot depend on any such vague and illusory concept as the percentage of free service actually rendered. This would produce chaotic uncertainty and infinite confusion, permitting a hodgepodge of views on the subject." IRS Rev. Rul. 69-545 provides the following factors that demonstrate community benefit:

- Operating an emergency room open to all, regardless of ability to pay
- Maintaining a board of directors drawn from the community
- Maintaining an open medical staff policy
- Providing hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare
- Using surplus funds to improve facilities, equipment, and patient care; and\
- Using surplus funds to advance medical training, education, and research.

[3] https://www.aha.org/press-releases/2022-06-06-new-ey-analysis-tax-exempt-hospitals-community-benefits-nine-times

[4] American Hospital Association testimony for the House Committee on Ways and Means "Tax-Exempt Hospitals and the Community Benefit Standard" April 26, 2023 https://www.aha.org/testimony/2023-04-26-aha-testimony-committee-ways-and-means-subcommittee-oversight

[5] https://www.aha.org/guidesreports/2023-10-09-results-2020-tax-exempt-hospitals-schedule-h-community-benefit-reports

preventive and restorative health care has predictably increased in amount and importance. However, nationwide Medicaid pays only 88 cents for every dollar spent on care based on the cost of that care.[6] In many states, that amount is even lower. The total value of those underpayments was almost $25 billion in 2020.

Despite the large and pervasive payment gap between Medicaid payments and the cost of care, hospitals routinely help to qualify or otherwise transition patients without insurance to a Medicaid plan. That is because preventive and restorative care is better for those patients than episodic emergency care when they are ill or injured due to a preventable illness or accident. This should be evident to all of us who supported the ACA because that law greatly expanded the Medicaid program for just that reason. In the wake of the Supreme Court ruling that limited its expansion, which you criticized, you have repeatedly called upon Congress to further expand and improve Medicaid coverage. Presumably, you did so because poor patients benefit from Medicaid coverage.

It should be beyond dispute that qualifying uninsured patients for Medicaid and then absorbing those underpayments counts as community benefit. To downplay or omit it altogether is entirely inconsistent with advocacy for the program and, more importantly, the benefits it provides to poor patients and the substantial resources hospitals expend to support it and those who rely upon it.

MEDICAL DEBT IS LARGELY ATTRIBUTABLE TO INADEQUATE HEALTH INSURANCE

Hospitals, like their patients, are adversely impacted by commercial health insurance plans that are driving an increase in medical debt attributable to inadequate health care coverage and high-deductible health plans that intentionally push more costs onto patients. These plans leave people financially vulnerable when seeking medical care, despite being insured. Hospitals, unlike commercial health insurers, have financial assistance policies to help those most in need.[7] Even so, they can only help so much and so many. No matter how generous, hospital financial assistance will never be a substitute for a health insurance plan that covers preventive and necessary care at an affordable price on the front and back end of coverage.

The AHA recently provided a comprehensive overview of medical debt and the complex web of laws, rules and other circumstances hospitals are subject to and how inadequate

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[6] https://www.aha.org/system/files/media/file/2020/01/2020-Medicare-Medicaid-Underpayment-Fact-Sheet.pdf

[7] Although we have not done a comprehensive sweep of the field, hospitals appear to have easily accessible financial assistance policies. A quick review of a range of hospital websites found that financial assistance policies were easily accessible within a few clicks of typing in the term ‘financial assistance.’

commercial health insurance impacts hospitals and patients they serve and creates medical debt.[8] The irreducible fact is that hospitals do not control the design of commercial health plan benefits replete with co-pays and deductibles consumers cannot afford that result in medical debt. Effectively tackling medical debt will require a comprehensive overhaul of the way in which commercial health insurers design, market and implement their plans, including Medicare Advantage, which was the subject of a hearing on deceptive marketing practices by the Senate Finance Committee[9] just a few days ago. Attempting to lay this problem at the feet of the hospital field is not fair but more importantly will not solve it for consumers affected by medical debt.

RESERVES ARE ESSENTIAL FOR TAX-EXEMPT HOSPITALS

The hospital field is just now beginning to recover from the devastating financial impacts of the COVID-19 pandemic. That recovery would not have been possible absent financial reserves. The respected consulting firm of Kaufman Hall's report on the role of financial reserves went into impressive depth on the importance of reserves for tax-exempt hospitals.[10] The report describes the essential role that strong financial reserves have in meeting those hospitals' mission for the communities they serve. This was never more apparent than in 2022 when more than half the hospitals reporting had negative operating margins and in order to serve their communities had to rely on reserves as the nation slowly emerged from the pandemic.

The key findings from the Kaufman Hall report are that financial reserves are essential for tax-exempt hospitals to: withstand periods of disruption and financial downturns, make needed investments, borrow at reasonable rates, cover expenses to stabilize operations and sustain their mission to serve their communities. As the report states succinctly "reserves build financial resilience; the ability to withstand adverse changes to core functions and continue to provide services to the community." For tax-exempt hospitals, reserves are essential to keep facilities intact and up-to-date with current medical technology as well as comply with proliferating regulatory requirements. There is no basis to suggest tax-exempt hospitals should not have adequate reserves and every reason to applaud those hospitals that have them. Reserves give these hospitals the ability to assure the communities they serve that they will be there when needed the most, which is an essential part of their charitable mission.

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[8] AHA Comments to CFPB highlights the Unique Nature of Medical Debt. https://www.aha.org/lettercomment/2023-09-11-aha-comments-request-information-regarding-medical-payment-products

[9] Senate Finance Committee hearing on Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences, October 16, 2023.

[10] The Essential Role of Financial Reserves in Not-for-Profit Healthcare, Kaufman Hall, 2023 https://www.kaufmanhall.com/sites/default/files/2023-04/KH_AHA-Essential-Role_Financial_Reserves_Not-for-Profit_Healthcare_2023-04.pdf

THE RIGOR IN DETERMINING EXECUTIVE COMPENSATION

For tax-exempt hospitals the IRS developed a process to ensure that compensation for executives is determined in a fair and impartial manner taking relevant comparative data into account. Called the Rebuttable Presumption of Reasonableness, it consists of three steps: (1) the compensation must be approved in advance by an authorized body of the hospital or hospital system composed of individuals without a conflict of interest, (2) the body must obtain and rely on appropriate comparability data in determining compensation, and (3) the body must document its decisions at the time they are made.

Tax-exempt hospitals follow these steps rigorously to determine appropriate compensation and fully report it each year in their Form 990 Schedule J. There is no lack of transparency or accountability in the manner in which compensation is established. But comparing it to any other hospital expenditure misses the point – the rigor and impartiality assure the process by which compensation is set is fair and reasonable. Other expenditures should be judged on their own merits, which is particularly true for community benefit. As noted, the most recent report demonstrates that tax-exempt hospitals spent nearly $130 billion or 15.5% of their total expenses on community benefit and those called out in your report spent $19 billion. In a report focused on community benefit that is the statistic that matters the most.

Beyond just the numbers, it is important to recognize the pivotal role hospital CEOs and other executives play in overseeing the health of their communities and well-being of their workforce. This includes assuring there is 24/7 access to care 365 days a year, caring for all who seek emergency care regardless of ability to pay, and disaster readiness and response, whether it's a hurricane, pandemic, mass incidents of violence or other catastrophic event. Meeting these challenges require years of training and experience that is appropriately reflected in compensation decisions.

COMMUNITY NEEDS ASSESSMENTS DEMONSTRATE ENGAGEMENT

Tax-exempt hospitals' Community Health Needs Assessments (CHNA) were significantly downplayed in your report. Required at least every three years, it includes input from public health agencies and members of minority, low-income or underserved persons served by the hospital to determine which high priority needs the hospital will devote resources to address. By all accounts, the CHNA process works exceptionally well, and there is no basis for a remote federal agency, such as the IRS, to attempt to "define it."

Specifically, Section 501(r)(3)(A) requires a tax-exempt hospital organization to conduct a CHNA every three years and to adopt an implementation strategy to meet the community health needs identified through the CHNA. Hospitals define the community served, considering not only geography, but the target populations, such as women and children, and "principal functions" such as focus on specialty areas or targeted diseases. The community served must encompass those who may be medically

underserved. Hospitals also must identify the significant needs of the community and the resources it will bring to bear to meet them. The needs must be prioritized based on extensive input from the community, including from at least one public health department, members of the community who are medically underserved, low income or minority or who represent them and any written comments provided. The established priorities must be fully documented, including the underlying data, rationale and participants along with a fully documented implementation strategy. Finally, it must be approved by the hospital's board of trustees or one of its committees.

CHNAs are the epitome of community engagement. As described above, virtually every member of the community, including those most in need, have the opportunity to be either directly involved or ably represented in the development and execution of the CHNA. And the hospital's board or a committee authorized by the board gives its approval to the CHNA after a thorough review providing yet another layer of community involvement and oversight.

CONCLUSION

Tax-exempt hospitals, like any organizations, are not perfect, and there have been missteps. But the transparency, frequency and completeness with which those hospitals engage with their communities assures that missteps will be corrected with all deliberate speed. Your report, however, magnifies those issues unfairly while ignoring the enormous benefits tax-exempt hospitals provide to the communities they serve in the face of every kind of adversity. The fact is, hospitals provide more benefits to their communities than any other sector of health care. Disregarding or downplaying the demonstrated benefits tax-exempt hospitals provide is unfair and fails to advance a discussion about effective ways to improve health insurance coverage and medical services for those most in need. Regretfully, your report should be viewed with those disqualifying shortcomings in mind.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer