

# NATIONAL ASSOCIATION OF URBAN HOSPITALS

*Private Safety-Net Hospitals Caring for Needy Communities*

September 12, 2007

Internal Revenue Service  
Form 990 Redesign, SE:T:EO  
1111 Constitution Avenue, NW  
Washington, D.C. 20224

Subject: Comments on Proposed Form 990 and Schedule H

To Whom it May Concern:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to convey our views on the proposed Form 990 and Schedule H.

NAUH supports the concept of holding hospitals to a reasonable community benefit standard in exchange for their tax-exempt status. We do have a few concerns, however, about the manner in which the Internal Revenue Service (IRS) proposes evaluating hospitals to ensure that they truly deserve their non-profit status, and we outline those concerns below.

## **Bad Debt Should be Considered a Community Benefit**

NAUH strongly believes that hospitals' bad debt should be considered a community benefit.

In most of the business world, bad debt consists of bills that customers are able to pay but refuse to pay. In the hospital industry, however, the vast majority of bad debt consists of bills that customers – patients – truly are unable to pay. The Congressional Budget Office (CBO) agrees, noting in its 2006 report *Nonprofit Hospitals and the Provision of Community Benefits* that two separate studies show that “the great majority of bad debt was attributable to patients with incomes below 200% of the federal poverty line.” The CBO also concluded that its findings “support the validity of the use of uncompensated care [bad debt and charity care] as a measure of community benefit.”

The patients who are responsible for most of hospitals' bad debt typically are medically indigent: employed but at low-paying jobs with no health insurance, living from paycheck to paycheck without the means to afford insurance on their own. They are working-class and middle-class Americans, ineligible for Medicaid yet unable to afford health insurance without their employers' assistance. The majority of these people do not have the means to pay their hospital bills, and stories about hospitals' attempts to collect such debts occasionally become headline news, evoking public outrage and inspiring critics, including many public officials, to urge hospitals to be less aggressive in their efforts to collect payments from such individuals.

When patients present themselves for care, hospitals do not always receive enough information to determine immediately whether they should be recipients of charity care – a possible designation for many patients whose bills ultimately become bad debt. Many such patients do not want to complete forms and do not want to be stigmatized by the notion that they are recipients of charity care. These patients often understand that legally, hospitals cannot turn them away in times of medical emergency. Some might even be eligible for

Medicaid or their state's children's health insurance program but will not cooperate with hospital personnel trying to enroll them. Similarly, hospitals know that some of their patients cannot afford to pay for certain aspects of their care – and many of these patients know that the hospitals know. Non-profit hospitals consistently provide this care anyway. According to current accounting standards, hospitals are required to classify patients when they present for care, so learning afterward that a patient does not have the means to pay for care or will not cooperate with efforts to enroll them in Medicaid or a state children's health insurance program cannot lead to their reclassification as recipients of charity care; their unpaid bills for this care must be written off as bad debt.

Medicare actually fosters this approach, requiring hospitals to classify some elderly patients as bad debt immediately if they intend to seek Medicare bad debt reimbursement. Many Medicare patients are dually eligible for government assistance with their health care – that is, they are eligible both for Medicare and for Medicaid – and cannot afford to pay their co-payments and deductibles. Such lost income is clearly charity care in the sense that the patients cannot afford the payments, and it should be counted toward hospitals' community benefit. Medicare, however, requires it to be classified as bad debt – even though hospitals know, from the start, that these patients cannot pay and that Medicare will reimburse them for only 70 percent of this bad debt.

NAUH recognizes that for-profit hospitals also provide charity care and incur bad debt, but there is a fundamental and significant difference between the efforts of non-profit and for-profit hospitals. For-profit hospitals routinely limit their enterprises to communities with the highest proportions of insured patients and routinely close hospitals and abandon communities that fall upon hard times. Mission-driven non-profit hospitals, on the other hand, make it a practice to serve low-income and medically underserved Americans; to remain in those communities during the hardest of times; and to find ways to deliver care even though they will have to provide millions in charity care, and incur millions in bad debt, to do so. There is no rush within the for-profit hospital industry to serve low-income communities – no rush to establish new hospitals in places like Detroit and Newark and Camden and Washington, D.C. Instead, for-profit corporations gladly leave such endeavors to their non-profit counterparts. By virtue of their business strategies, for-profit hospitals, even though they deliver care that results in bad debt, conduct their business in a manner that manages to limit their exposure to potential bad debt. Non-profit hospitals, on the other hand, consistently locate – and remain – in areas where human needs are greatest. Unlike for-profit hospitals, which grudgingly acknowledge that they will not be paid for all the care they provide, non-profit hospitals consistently, and at great financial risk to their institutions, reach out to the underserved, fully aware that many of those underserved people will not be able to pay for their care.

Alongside charity care, bad debt serves as the heart of what these mission-driven organizations bring to their communities. Bad debt, like all uncompensated care, is an unmistakable community benefit that we believe should be recognized and acknowledged when considering hospitals' tax-exempt status.

### **Delay Implementation of the New Schedule H**

Regardless of the form that Schedule H ultimately takes, NAUH urges the IRS to delay its implementation until 2010. The reporting requirements will be new, they will be significant, and they will border on onerous. They will require a good deal of time, effort, and investment in technology, and NAUH fears that such quick implementation could lead to well-intended but inaccurate reporting. Implementing these new reporting requirements in 2008 would impose a major burden on all hospitals – especially since the form is not expected to be finalized and made official until mid-2008. Consequently, NAUH urges the IRS to delay the schedule's introduction for two years and give hospitals an opportunity to prepare for this new, major reporting requirement.

### **Other Selected Concerns**

NAUH has other concerns that we would like to bring to the IRS's attention for further consideration and study.

1. Some of the instructions and definitions for Schedule H are, in our view, insufficiently clear. NAUH urges the IRS to work with hospital industry representatives to improve both the form's instructions and its definitions before finalizing the schedule and its supporting documentation.
2. In particular, the instructions accompanying the draft of Schedule H are not clear about how multi-hospital health systems and multi-campus hospitals should report their data. NAUH urges the IRS to allow multi-campus hospitals and multi-hospital health systems to decide on their own whether to report the required data on an aggregated, hospital-wide basis or on an individual campus or hospital basis. Some such institutions aggregate their accounting and some do it separately, and we believe it would be burdensome to compel any of them change their accounting systems for this purpose alone.
3. While NAUH supports the federal government's effort to ensure that hospitals that enjoy tax-exempt status truly deserve that status, we believe the data collected on Schedule H should be used for IRS purposes only – and only when considering the tax-exempt status of individual hospitals. It should not be used for the creation of public policy and therefore should not be aggregated.
4. NAUH urges the IRS to establish firm, quantifiable standards for community benefit, and for non-profit status, before it begins collecting this data. Without such standards, this process could become little more than a burdensome and costly exercise in data collection for data collection's sake.

### **Conclusion**

Across the country, thousands of non-profit hospitals bring enormous benefits to their communities. Many – like those represented by NAUH – serve as safety-net hospitals in communities that no for-profit company would ever even consider serving. By every measure of hospitals' financial well-being, private, non-profit urban safety-net hospitals like those represented by NAUH are in worse financial condition today than any other group of hospitals in the country. Throughout the country, many are closing their doors, unable to maintain their financial health in the face of so much demand for free or undercompensated care. Many are on the brink of insolvency, and NAUH respectfully urges the IRS to consider carefully any steps that may result in pushing these hospitals over that brink.

### **About the National Association of Urban Hospitals**

The National Association of Urban Hospitals advocates for adequate recognition and financing of private, non-profit, urban safety-net hospitals that serve America's needy urban communities. These private, urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private, urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

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We appreciate your consideration of our views and welcome any questions you may have about them. We also are prepared to work with you, at your request, to address any of the issues we have raised in this letter.

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Sincerely,

Ellen Kugler, Esq.  
Executive Director