THE CATHOLIC HEALTH ASSOCIATION
OF THE UNITED STATES

Statement by
The Catholic Health Association
to the
Senate Finance Committee Roundtable on
Tax Exempt Hospitals

Michael F. Rodgers
Senior Vice President, Advocacy and Public Policy

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On behalf of the Catholic Health Association of the United States, the national leadership organization of more than 2,000 Catholic health care sponsors, systems, hospitals, facilities and related organizations, we appreciate the opportunity to express our views on policy questions related to not-for-profit status and the role of hospitals in providing for community benefit. As we have previously reported to the Finance Committee, for the past twenty years CHA has been actively involved with helping to define and articulate the community benefit standard.

The Catholic Health Association supports the basic intent of the paper, "Tax-Exempt Hospitals: Discussion Draft." We agree that not-for-profit, tax-exempt hospitals should work to improve health in our communities and to help people who cannot afford to pay for health care services get the care they need.

But we strongly disagree that federal legislation is needed in order to achieve this goal.

Let me outline five reasons why we oppose a legislative approach.

First, we believe that the Community Benefit Standard is the right one and is effective.

Not-for-profit hospitals provide significant benefit to our communities. For the past twenty years, the Catholic Health Association has been dedicated to encouraging sustainable, strategic and accountable community benefit programs that improve health in our communities and increase access to health care service. Literally thousands of nonprofit hospitals use our guidelines for planning and reporting community benefit. We believe that as a result of these efforts and the efforts of our partners in this work, the state of community benefit in America's nonprofit hospitals is very good and is continuing to improve.

Second, we believe that flexibility is imperative for community benefit programs to be responsive to local community needs and that a fixed percentage is not in the best interest of the communities we serve.

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A rigid federal standard would impede this flexibility in serving our communities. Health needs vary from one community to another. While the need for free hospital care to uninsured persons may be the greatest need in one community, the availability of subsidized services or management of chronic disease may be the major concern in others. Counting only charity care could provide incentives to hospitals against subsidized services and management of chronic illness. This would not be in the best interest of many communities. Rather, hospitals should have flexibility to target their community benefit efforts to local needs.

Third, we believe that requiring hospitals to spend up to a certain amount is misdirected.

Some of the most effective community benefit programs are low cost to hospitals. For example, programs directed at teenage mothers may not be expensive to run, but if effective, will lead to healthy, drug-free pregnancies and full term babies. In addition, some community benefit programs greatly expand their capacity to meet communities' needs by applying for grant funds. The value of grant-funded programs is not reflected in what hospitals report as community benefit expense. Therefore, the reported cost of community benefit programs does not adequately reflect the value of these programs. We are concerned that a spending target would discourage these effective but under-valued programs.

Fourth, we disagree that there should be a two-tiered system of tax-exemption that separately recognizes the contribution of charity care and community benefit. This concept mistakenly gives greater value to charity care than other community benefit. It would be legally untenable, requiring change in federal and many state laws. Charitable assets of a 501(c)(3) organization failing to meet the charity test would have to be sold or transferred for fair market value in order to convert to a 501(c)(4). In addition, the converting hospital would have to pay off its bonds which would not be financially feasible.

Finally, the Internal Revenue Service through the revision of the Form 990 and release of the new Schedule H will inevitably increase the quality, visibility and accountability of community benefit efforts. The new 990 form, not yet in use, is already having an impact on the way many organizations address community benefit. Increasingly, charity care and community benefit are gaining importance to hospital boards and senior executives. The staffing and budgets of these hospital community benefit programs are being upgraded and new community partnerships are being forged. As these forces play out, they will help reach the goals presented in the paper.

In summary, the Catholic Health Association believes that the current community benefit standard is working and that the IRS Form 990 and other initiatives focusing attention on community benefit are leading to even better community benefit programs. We believe that an arbitrary “one size fits all” minimal requirement would interfere with the flexibility and creativity needed by hospital community benefit programs, and would discourage innovative low-cost solutions to community programs. We appreciate the level of research and thought that has been invested in this paper, but urge that a legislative approach recommended by the paper not be put in place.

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