National Report

The New York Times

Nonprofit Hospitals Face Scrutiny Over Practices

By ROBERT PEAR

WASHINGTON, March 18 — Congressional leaders, concerned that many nonprofit hospitals are not providing enough charity care to justify their tax-exempt status, say they will set standards for the industry if it does not do so itself.

The chairman of the Senate Finance Committee, Charles E. Grassley, Republican of Iowa, who had already been examining nonprofit groups like United Way and the American Red Cross, is broadening his focus to include nonprofit hospitals, with an eye to legislation that would clarify standards for their tax exemptions. Representative Bill Thomas, Republican of California, the chairman of the House Ways and Means Committee, began investigating the financial practices of nonprofit hospitals last year.

The commissioner of internal revenue, Mark W. Everson, said tax officials often found little difference between nonprofit and for-profit hospitals "in their operations, their attention to the benefit of the community or their levels of charity care."

Huge changes have reshaped the health care industry in recent years, Mr. Everson said, but the basic standard for granting tax exemptions to hospitals has changed little since 1969.

Since 1969, Mr. Thomas said, "less and less has been required for hospitals to maintain tax-exempt status."

Before 1969, the Internal Revenue Service required hospitals to provide more of it to "take care of unmet health needs in the community."

In the last few years, Sister Carol said, a small number of Catholic hospitals have been accused of overly aggressive collection practices. These practices, she said, "resulted more from inattention than from a deliberate decision to hound poor people."

State officials have shown a keen interest in the issue. The attorney general of Kansas, Phill Kline, said he had opened an investigation of the billing and collection practices of nonprofit hospitals after receiving complaints from consumers. Some nonprofit hospitals have hired debt collection agencies that "harass the poor," Mr. Kline said.

In Illinois, Attorney General Lisa Madigan recently proposed legislation that would require hospitals to provide a minimum amount of charity care, equivalent to 8 percent of hospital operating costs. The Illinois Hospital Association opposes the legislation, saying it would "threaten the survival of many hospitals" by imposing new financial burdens.

In Minnesota, the state attorney general, Mike Hatch, said that stronger government regulation was needed because self-regulation was not enough.

Some nonprofit hospitals and health systems in Minnesota have provided "lavish gifts" and "grossly excessive" compensation to top executives while providing "paltry levels" of charity care, Mr. Hatch said.

charity care to quality for tax-exempt status. Since then, the agency has not specifically required such care, as long as hospitals provide benefits to the community in other ways — for example, by offering health fairs, screening for cancer and cholesterol, providing emergency care, training doctors and conducting medical research.

Health insurance companies typically negotiate with hospitals to secure large discounts off hospitals' posted prices. Uninsured people, with no one to negotiate on their behalf, are often charged much more than the insured, and some hospitals have been aggressive in trying to collect payment from the uninsured.

In a letter to the American Hospital Association this week, Mr. Grassley said he had "serious concern" about their billing and debt collection practices. He also expressed concern about the high salaries of some hospital executives, their joint ventures with commercial profit-making organizations and their use of profit-making subsidiaries.

While Congress is taking the initiative, administration officials have expressed similar concerns. President Bush has strongly encouraged hospitals to disclose detailed information about their prices, and tax officials say they intend to do more audits of nonprofit hospitals.

In the last few years, low-income people around the country have filed dozens of lawsuits arguing that private nonprofit hospitals are required to provide free or reduced-price services to the uninsured. Judges have generally rejected these arguments.

In a typical ruling last year, Judge Loretta A. Preska of the Federal District Court in Manhattan wrote: "Plaintiffs here have lost their way. They need to consult a map or a compass or a Constitution because plaintiffs have come to the judicial branch for relief that may only be granted by the legislative branch."

Federal tax law does not give patients an enforceable right to affordable medical care, Judge Preska said.

Sister Carol Keehan, president of the Catholic Health Association of the United States, said that nonprofit hospitals, like for-profit institutions, tried to earn a surplus, but used

James Estrin for The New York Times

Senator Charles E. Grassley has examined nonprofit hospitals.

When members of Congress raise questions about executive pay, they sometimes point to the compensation paid by teaching hospitals in New York. Tax-exempt organizations generally have to file annual returns with the Internal Revenue Service.

These forms, which are open to public inspection, show that the president of NewYork-Presbyterian Hospital, Dr. Herbert Pardes, received more than $4.3 million in compensation in 2004, plus $1.2 million in contributions to his employee benefit plan. About half of his pay was a reward for performance in prior years, the hospital said.

Dr. Spencer Foreman, president of Montefiore Medical Center in the Bronx, received $1.1 million in compensation and $712,000 in benefits.

In an interview, Dr. Foreman said, "Congressional interest in this area is quite appropriate, and we as an industry have to come forward with a comprehensive response." But in defining the proper level of charity care, he said, it is "totally unrealistic" to apply the same mathematical formula to nonprofit hospitals in destitute urban neighborhoods and affluent suburbs.

"If a hospital provides a benefit proportional to the community's needs and the institution's resources, it meets the community benefit test," Dr. Foreman said.

HB 1358 Health Care for All - Amend constitution to by needed

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PETITION re: New Policies and Operational Changes at UNC Hospitals

Erskine Bowles, President
General Administration
The University of North Carolina
Chapel Hill, NC 27599

We the undersigned, residents of Orange and adjacent counties, are concerned about new policies and operational changes recently enacted within the UNC Health Care System. In signing this petition we are particularly mindful of the plaque placed on the wall when the main hospital was dedicated on 23 September 1952: "Operated for and by the people of North Carolina."

Generally, we are concerned that:

1) UNC Hospitals increasingly works on a fee-for-service basis with an excessive profit margin;
2) The commitment of UNC Hospitals to the people of North Carolina is increasingly disregarded; and
3) Those without health insurance in North Carolina face increasing difficulty in accessing the UNC Health Care System.

More specifically, we are concerned that:

1) In practice, access to sub-specialty clinics is denied to many. Commendably, there is a schedule of reduced fees available to those without health insurance. In order to make an appointment in these clinics, however, a patient must make the co-pay in advance. Many of the uninsured do not have the means to meet the required up-front payment, and as a consequence are effectively prevented from making an appointment—and from receiving treatment.
2) Many, discouraged by the difficulty of receiving early treatment, wait until the problem worsens to the point where they must be treated in the Emergency Room, the most expensive way to deliver health care.
3) During 2005 several hundreds of patients were taken to court by UNC Hospitals over bills they were unable to pay. In such cases use of the courts to secure payment for services is not only inhumane, but also counterproductive. Certainly it is contrary to the intention for UNC Hospitals when it was founded.
4) The geriatric unit serving frail elders is no longer adequately staffed by professionals trained in geriatrics. Many team members have left, especially social workers and nurses. The unit does not function as it was envisioned.
5) Serious deficiencies have developed in discharge planning. The personnel, often new and inadequately trained, are not fully familiar with community resources. Furthermore, their plans frequently do not involve the patient and his/her family members.

6) The Emergency Room is a worsening nightmare, especially for the elderly with dementia or severe pain. The turmoil, long waits, and overworked staff present formidable challenges.
7) As a result of losing many employees and of management's sometimes unreasonable expectations, morale of the staff has declined to a worrisome level. Feelings of low self-esteem experienced by employees reduce their productivity.

Nonprofit hospitals throughout the United States are subject to similar criticism, as evidenced by a recent article in The New York Times with the headline, "Nonprofit Hospitals Face Scrutiny Over Practices." It begins with this statement:

> Congressional leaders, concerned that many nonprofit hospitals are not providing enough charity care to justify their tax-exempt status, say they will set standards for the industry if it does not do so itself. (19 March 2006, page 14)

We think that the state-subsidized and supposedly nonprofit UNC Hospitals, with its mandate to serve the people of North Carolina, should lead in this reform effort. Therefore we urge that you give these matters your early attention.

Please return no later than July 31, 2006, to either:

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Coalition for Continuity of Care for The Geriatric Community
The University of North Carolina
301 Pittsboro Street CB #3550
Chapel Hill, NC 27599-3550

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PETITION re: New Policies and Operational Changes at UNC Hospitals

PRINT NAME	SIGNATURE	ADDRESS