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Catholic Health Association of the United States
The Committee on Ways and Means Hearing on
"The Tax-Exempt Hospital Sector"
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Good morning, Mr. Chairman and Members of the Committee, I am Sr. Carol Keehan, a Daughter of Charity and chair of the board of Sacred Heart Health System in Pensacola, Florida. I am pleased to be here with you today as chairperson of the Catholic Health Association of the United States (CHA). I would like to discuss the community benefit role of Catholic health care and other not-for-profit health care organizations.

Catholic health care began a tradition of community service in this country in 1727, when 12 Ursuline sisters arrived in New Orleans from France to nurse the sick, care for orphans, teach school, and open a hospital in the territory that would later become the United States. Our tradition of service continued as America's newly formed communities invited religious sisters to establish health care facilities, wanting the values the women religious represented to flourish in their towns: compassion, dedication to service, and concern for persons who are poor or sick. Providence Hospital, here in Washington, DC, where I served as chief executive officer until last year, was established at the request of President Abraham Lincoln to care for wounded from both sides of the Civil War.

Today, while contemporary Catholic health care and other not-for-profit health care institutions excel in quality, innovation and technology, they remain community benefit organizations, founded and sustained because of community need. Our doors are open to everyone regardless of faith, ethnic background or ability to pay. We treat all patients—uninsured and insured—with the same dignity, respect, and compassion.

Community Benefit Mission

We provide benefit to communities because it is our mission to serve our communities. As Catholic health care institutions, we are a healing ministry of the church. Our mission includes special attention to low-income and minority populations, and we reach out to fill the void that exists for many of our disabled, elderly, and chronically ill neighbors.

Our facilities also are committed to pursuing the common good. Therefore we pay particular attention to promoting health and preventive care for all who reside in our communities.

The essence of our community benefit role and that of other not-for-profit community benefit organizations is providing services to disadvantaged persons and improving the health of all. By utilizing our resources to provide programs, staff, and equipment for our communities, we help to make them healthy places to live, work, and raise families.

Community benefit activities include outreach to low-income and other vulnerable persons; charity care for people unable to afford services; health education and illness prevention; special health care initiatives for at-risk school children; free or low-cost clinics; training for physicians and nurses, and efforts to improve and revitalize our communities. These activities are very often provided in collaboration with community members and other community organizations. In fact, in many cases, not-for-profit hospitals are able to be catalysts in helping to organize community health resources to improve access to health care and improve community health.

Another type of community benefit is subsidizing services such as mental health and hospice programs, and trauma units that are truly needed but are high cost and provide low reimbursement. Our organizations routinely open or sustain these needed services, even if they result in a financial loss.

The categories of community benefit include:

- **Community Health Services:** clinics, support groups, support services, and health prevention and promotion activities.
- **Health Professional Education:** training for physicians, nurses, and other health professionals to address unmet community needs.
- **Subsidized Services:** trauma services, hospice and palliative care programs, and behavioral health.
- **Health Research:** clinical research, and studies on community health and health care delivery.
- **Donations:** cash, grants, and in-kind services.
- **Community-Building Activities:** neighborhood improvements, housing programs, coalition building, and advocacy for community health improvement.¹

Let me give you one example that is happening just a few blocks from here. In sight of this very building there is a Washington, DC neighborhood known as Northwest #1. You may have read about the drug trafficking and murders there in the *Washington Post*. In the Post article, it was claimed that even the police are reluctant to go into that neighborhood. The health indices for residents of the area look like the third world. The neighborhood asked Providence Hospital to provide them with care, and every day some of the finest health care practitioners go into that community to provide over 12,000 visits a year. Because we made a commitment to anchor a health facility in a historic building that was the first African American high school in the District following the Emancipation Proclamation, it has become a vibrant community center. A nursery school, job and computer training programs, dance and karate classes are among the many services now available in the heart of the neighborhood. I am sure you can appreciate how helpful it is for the low-income, working mothers of that neighborhood to have a day care center in the same building with the pediatrician.

I would like to emphasize that Catholic hospitals do not provide these services to justify continued tax exemption. We provide them because serving our communities in this way is integral to our history, our identity, and our mission—it is what we always have done.

It also is important for you to understand the broad scope of community benefit. It is more than providing charity care, although for members of our communities unable to afford needed services, free and discounted care (especially emergency care) is indeed important. We look beyond charity care to even more important community benefit programs. Often some of the most efficient programs cost little but can make a huge difference for persons in our communities. For example, relatively low-cost programs supporting pregnant teenagers can make huge differences in the health and well-being of these mothers and their babies, and save potential costly services related to premature birth or developmental disability. Often our very presence, collaborating with others and acting as facilitators for community-wide activity, can have far reaching effects that cannot be measured completely or accurately just in dollars. Yet none of these community benefits are included when we look only at uncompensated care.

How our Organizations Provide Community Benefits

Community benefit activities in not-for-profit hospitals and other health care organizations are provided in an organized, deliberate way. Since the last time this committee examined health care tax exemption, and in part because of the work of the committee, not-for-profit hospitals have improved the way they plan and report community benefit programs.

In the late 1980's and early 90's, with the growth of for-profit hospitals, Congress and state legislatures embarked on examinations of whether there was a difference between for-profit and not-for-profit health care, and whether not-for-profit health care organizations continued to deserve the privilege of tax exemption. Interestingly, women religious who sponsor Catholic organizations were asking similar questions: they wanted to know if their health care organizations continued to be mission-driven, dedicated to serving the poor and improving health in our communities.

As a result of these discussions, the Catholic health ministry developed a systematic approach to plan, monitor, report, and evaluate the community benefit activities and services they provide to their communities in order to reinforce our community benefit role and to document that we are, indeed, community benefit organizations.

This systematic approach was first described in CHA's *Social Accountability Budget*, which has been revised, updated, and adapted for use by non-Catholic facilities as well. Hundreds of Catholic and other health care organizations throughout the country use these resources.

The steps involved in the social accountability community benefit process include:

- **Reaffirming the commitment:** assuring that governing boards, managers and all staff understand and act upon the organization's mission, and affirming that policies and procedures support that mission.
- **Planning and budgeting for community benefit programs:** partnering with the community to assess needs and available assets to determine community priorities, and developing a comprehensive community benefit plan; and establishing a detailed community benefit budget.
- **Monitoring services and outcomes:** tracking various community benefit programs and activities and assuring that they are addressing identified needs and priorities. Over 800 health organizations track their community benefit programs using a software program, designed to complement the book, *The Community Benefit Inventory for Social Accountability* (CBISA).
- **Reporting community benefits:** showing accountability to the communities served and to others, and demonstrating that we continue to fulfill our charitable mission.
- **Evaluating community benefits:** determining if the right steps are being taken to serve an identified community need and provide maximum value; adjusting programs accordingly to ensure that they reflect a high standard of quality; and carefully monitoring results to accurately report the community impact.

Over the past year, we have accelerated efforts to achieve greater standardization in reporting community benefits. With VHA, we published *Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability*. This comprehensive document spells out what should and should not be considered community benefits. It directs community benefit programs to measure benefits in terms of cost, not charges; not to include bad debt; and recommends not including the shortfall from Medicare.

With the American Hospital Association, we are advocating widespread use of these guidelines so that not-for-profit hospitals throughout the nation are reporting how they serve their communities in a more standardized way. We also are working with our organizations' chief financial officers, the Healthcare Financing Management Association, and the American Institute of Certified Public Accountants to develop accounting guidelines for more consistent reporting of community benefits.

Budgeting is an important part of this social accountability process. We discovered early on that, in times of fiscal constraint, community benefit services must be proactively assigned a budget, to ensure they are not vulnerable to being reduced or eliminated. We, like every household, must work within a budget that covers expenses, maintenance, and future plans. So, like a typical family having many competing needs, unless they plan in advance to donate to charities important to them, there will be nothing left over at the end of the year. Therefore, as we develop our operational plans and budgets, our facilities assess community need and determine the budget amounts that must be allocated to respond to those needs. The resources for budgets come from various sources. While we are able to raise some funds through foundations and other philanthropic efforts,

community benefit is provided to a great extent by utilizing the resources of the organization.

Benchmarks

We are often asked how much charity care and community benefit not-for-profit organizations should provide. Our facilities, systems and national association struggle with this issue and we have concluded that at least nationally, there is no common benchmark. The key issue is that all our resources are earmarked for the community. Some are in charity care, some in community programs, some in technology, and some held in reserve as prudent stewards of a major community asset.

Community need differs from state to state and from community to community. What is sufficient community benefit in one area may be insufficient in another. In states where the Medicaid programs cover most low-income people there may be minimal need for charity care, but hospitals must make up the difference between what Medicaid pays and the cost of care. In other states where low-income families and persons may not be covered through Medicaid, there will be a large need for charity care.

Another reason we are unable to come up with a benchmark is that we believe asking how much is spent on community benefits is in many cases the wrong question. As I mentioned earlier, low-cost programs often can have more far reaching impact than higher cost programs. Increasingly, our facilities are looking at how they can improve the health of uninsured persons and avoid high-cost charity care in their emergency rooms and their hospitals by reaching out to them before their conditions reach a dangerous stage, managing chronic illness, and preventing episodes of acute illness. For example, teaching children and their parents how to deal with asthma and ensuring that the child's asthma is being well managed can prevent expensive trips to the emergency room and emergency hospitalizations. A numeric benchmark looking only at how much is being spent would not capture this cost saving, let alone the improved health and quality of life for the parents and child.

A better question to ask is: what is the value we are providing to our communities? This is the most pressing issue for community benefit professionals today. They are expending considerable effort to assess the return on investment from community benefit activities and to evaluate the impact their services are having.

A final reason why benchmarks cannot be assigned is that, despite efforts to improve standardization in reporting community benefits, there are still major challenges in how health care organizations account for and report community benefits. This is due in part to competing requirements from state governments and other agencies. Our social accountability materials advise organizations to report only those services that meet specific requirements. We recommend, for example, separating bad debt from charity care, although we realize much bad debt represents care given to persons who cannot afford to pay. In most situations we do not consider the shortfall from Medicare, which can be considerable, to be counted as community benefit. So when an organization

following our guidelines is compared with another that counts activities that we do not count, including bad debt and the Medicare shortfalls, the comparison is neither fair nor instructive. Therefore, we are pleased that there are major efforts under way in the hospital and accounting industries to improve reporting standards.

Still, we firmly believe that our organizations should be accountable for the community benefit services they provide. We recommend that the executive and governing leadership of our organizations ask:

- Are we maximizing the use of resources consistent with the community needs we have identified?
- Are we providing our share of community benefit consistent with the resources available to us? How does it compare with past levels and capacities?
- Does our spending on community benefit exceed the value of our tax exemption?

There are several indications that these guideposts are being widely and successfully used. An informal survey of CHA and VHA members indicates that over the past four years, despite fiscal pressures, the amount of community benefit being provided increased. Furthermore, witnesses at the Committee's last hearing agreed that most hospital community benefit spending exceeds the value of their tax exemption.

Many Catholic and other not-for-profit health care organizations set benchmarks and carefully examine their contribution to the community. My organization, the Sacred Heart Health System, reports that in 2004 two dollars was spent on charity care and community benefit for every dollar made in terms of operating income.

In the summer of 2004, a large multi-hospital Catholic system in the midwest undertook to estimate the value of its tax exemption, to determine if it could validate a favorable community benefit being provided for the tax exemption received. The system discovered that there is no established or agreed-upon methodology or formula for making such an estimate. Additionally, many community benefit programs are difficult to value precisely, as intangible and social health and community benefits are often difficult to quantify.

They reviewed the methodology and components of the approach to estimate the value of their tax-exemption with their independent auditors. The auditors provided comments that were incorporated to the extent it was feasible to do so. The system has created an estimate that is reasonably believed to be as accurate as is presently possible.

The components of tax exemptions that were included in their estimate are:

- Reduced interest paid from tax-exempt financings
- Reduced federal/state unemployment taxes
- State and local sales taxes on all purchases of supplies and equipment
- Real estate taxes

- Personal property taxes
- Corporate franchise taxes
- City, state and federal income taxes

Estimated value of 2003 tax exemption as compared to 2003 Community Benefit² or Care for the Poor³:

	Health System	Representative Hospital Region
Care for the Poor	\$137M	\$ 9.2M
Community Benefit (includes Care for the Poor + benefits to the broader community)	\$202M	\$13.5M
Value of Tax Exemption	\$115M (est.)	\$ 6.0M (est.)
Estimated ratio of return to the community of the value of Community Benefit compared to the value of tax exemption	1.76 : 1	2.25 : 1
Estimated ratio of return to the community of the value of Care for the Poor compared to the value of tax exemption	1.19 : 1	1.53 : 1

Note: The Health System ratios are aggregates for a 29 hospital system. The ratios for hospital regions vary considerably, due to the many unique factors in individual communities, but in all instances, the Community Benefit provided exceeded the value of tax exemptions received.

Standards for Community Benefit

For almost twenty years, CHA has worked to improve the standard of planning and reporting of community benefit. In 1992, we established a set of community benefit standards. These call for Catholic health care organizations to ensure that:

- Mission statements reflect a commitment to community benefit;
- Governing bodies adopt, make public, and implement a community benefit plan;
- Community benefit services provided to the materially poor and broader community are designed to improve health status in the community and access to health care services; and
- Annual community benefit reports describe the scope of services and collaboration with others.

Health Care and Not-for-Profit Organizations

I understand that one of the purposes of this hearing is to examine whether there is a difference between the behavior of for-profit, investor-owned, and not-for-profit health care organizations. I believe there are clear similarities and clear differences between the two. To understand the not-for-profit sector and how it differs from the for-profit sector, the committee cannot rely on a single, one dimensional measurement such as uncompensated care. Rather, it is important to look at the organization as a whole and the benefits it provides to the community.

The fundamental distinction between the not-for-profit and for-profit health care sectors is their essential purpose, their mission. I realize that most for-profit health care facilities provide excellent quality of care, but the ultimate purpose of for-profit health care is to be profitable. The purpose of the not-for-profit sector is healing, teaching, research, and community service.

Our institutions are not "for-profit" in the sense that revenue surpluses may not enrich any individual. Rather, the not-for-profit sector health care provider uses surpluses to expand health care services, meet future capital needs, invest in technology and innovation, cover future deficits, and to provide community services. Not-for-profit organizations must earn a surplus when circumstances permit because failure to do so would result in at least a gradual degradation in the quality and a decline in services.

Not-for-profit health care providers also are less market sensitive and more likely to remain within a community and to continue necessary clinical programs in times of economic distress. That long-term commitment to our communities, and our efforts to remain in them through good times and bad, also distinguishes not-for-profit health care.

In 1995, Cardinal Joseph Bernardin in a speech before the Harvard Business School Club of Chicago said, "The not-for-profit structure is better aligned with the essential mission of health care delivery than is the investor-owned." He argued that health care's purpose is to serve human need, not to promote economic ends. This primarily non-economic goal, he said, is best advanced in the not-for-profit health care system because that structure is best suited to promoting access, a patient-first professional ethic, and attention to community-wide needs.

Community Benefit and Tax Exemption

The Catholic Health Association commends the Committee for reexamining the tax exemption for all types of federally tax-exempt organizations and asking whether the community benefit standard, now 36 years old, continues to be the appropriate standard for the Internal Revenue Service to apply in determining a health care facility's entitlement to exemption. Although Catholic hospitals and other not-for-profit health care providers are motivated by far more than just IRS expectations in serving their communities, it is also true that continued tax exemption is vital in allowing or encouraging our community service role.

Tax-exempt hospitals would lose the ability to access tax-exempt bond financing for new facilities and equipment in the event they were no longer exempt. While taxable debt and equity capital may be available for investment in hospital activities during favorable times of the nation's economy, that is not always so. Moreover, the ability to use tax-exempt financing allows facilities to borrow at lower costs, thereby allowing them to make the necessary capital investments to replace or update the facilities and equipment to fulfill their mission. That ability to update facilities and technology in health care is closely tied to quality and healthy outcomes.

Other benefits of continued exemption include not having to pay federal income tax on net income or federal unemployment tax; state and local tax exemptions on income, sales and use, and real property; access to favorable pricing on drugs and medical supplies and mailing rates; and access to certain government grant programs.

The value of tax exemption varies from facility to facility, depending on its net income, the value of its property and local tax rates, and the value of its outstanding tax exempt bonds. A recent study by PricewaterhouseCoopers' Health Research Institute estimates that the total tax benefit of exemption (federal, state, and local) for a 300-bed average community hospital equals about \$6.5 million annually. This amount is twice the hospital's surplus, and would take the hospital from a small positive margin to a loss if the facility had to pay all taxes.

While we agree that a review of the standards for exemption and the charity care and community benefit activities of hospitals is valuable, we also want the Committee to be aware that Catholic hospitals and other not-for-profit providers are already themselves reevaluating their charity care policies and reexamining their pricing and the availability of discounts for the uninsured. The PricewaterhouseCoopers' study points out that 70 percent of hospitals reported a voluntary revision of charity care and pricing policies for the uninsured over the last year.

Sponsors, governing boards, and executive leaders continue working to assure ready access to charity care by simplifying and strengthening charity care policies and procedures. One advantage of the flexibility of the current IRS community benefit standard is that hospitals can make needed changes to their policies and practices that reflect the unique characteristics of the communities they serve and adjust them according to experience within that standard.

Conclusion

In conclusion, Mr. Chairman, the community benefit tradition in Catholic and other not-for-profit health care organizations is thriving and being reinforced by efforts to better account for these activities and to evaluate their effectiveness. Our long-term commitment to the people in our communities is being demonstrated every day, but we strive to do better. We believe that the not-for-profit health care sector and the communities we serve continue to deserve tax exemption, and that it is the responsibility of our organizations to demonstrate this to their governing bodies, staff and communities.

Over a decade ago, Senator Daniel Moynihan said, "A distinguishing feature of American Society is the singular degree to which we maintain an independent sector—private institutions in the public service. This is no longer true in most of the democratic world; it was never so in the rest. It is a treasure, a distinguishing feature of the American democracy." It is important to us in Catholic health care that we continue that tradition of service. That is our mission. That is our commitment to you and to the communities we serve.

1. For additional information see *Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability*, Catholic Health Association, St. Louis, 2004.
2. Community Benefit includes Care for the Poor, plus the unreimbursed cost of health professional education, unreimbursed cost of research, and the cost of programs that benefit the health of the broader community (e.g., stop smoking groups, nutrition classes, etc.) It does not include bad debt expenses or losses on the cost of providing Medicare services.
3. Care for the Poor includes the cost of charity care, the unreimbursed cost of Medicaid and the costs of programs that specifically focus on the poor (e.g., free immunization programs).