State Health Watch

Vol. 11 No. 9 — *The Newsletter on State Health Care Reform* — September 2004

THOMSON
AMERICAN HEALTH CONSULTANTS

In This Issue

Indigent Care or Wallet Biopsy?

Hospitals are overcharging the uninsured and then harassing them for payment — that's according to 39 class action suits and testimony before Congress. In this issue is a special report on the questions surrounding tax-exempt hospitals and their collection and billing practices.

Indigent Care or Wallet Biopsy?

Tax-exempt hospital charges to uninsured are being questioned

America's not-for-profit hospitals, which for years have positioned themselves as the leading providers of uncompensated care for the uninsured and underinsured, have come under attack in state and federal courts from critics who say they are greatly overcharging the poor people they claim to be helping.

As of July 22, federal class action lawsuits had been filed against 39 nonprofit hospital systems in 20 states. (**See list, p. 4.**) The hospital systems control some 340 hospitals in total.

In the suits, uninsured patient plaintiffs charge the hospital systems and hospitals with victimizing them by failing to fulfill their obligations to provide government-required charity care in return for tax exemptions. The lawsuits charge the hospitals and health systems with requiring the uninsured patients to pay health care prices that are far in excess of the documented amounts accepted by the health systems and hospitals from their insured patients.

*See **Tax-exempt hospitals** on page 2*

Disease management pilot project seeks to reduce complications, save Medicare money

A Medicare disease management pilot project is producing information that may be helpful in expanding disease management to the Medicaid population.

Fiscal Fitness: How States Cope

The Centers for Medicare & Medicaid Services is funding four disease management pilots. Baltimore-based XL Health chairman and CEO Patrick Hervy, whose company is operating one of the Medicare pilots involving 10,000 patients in Texas, says disease management can have a significant and positive effect on Medicaid patients' lives and on the national health care system. But he adds that disease management only will be successful if physicians are an integral part of the process, participants are educated and actively involved, and technology is used effectively.

XL Health is predicting that the patients enrolled in its Medicare demonstration will see, over three years, an aggregate 50% reduction in amputations and other serious

*See **Fiscal Fitness** on page 11*

State Health Watch
The Newsletter on State Health Care Reform

On-line access / Index

Back issues of *State Health Watch* may be searched on-line for a fee at **www.newslettersonline.com/ahc/shw.** Issues may be searched by keyword and date of publication.

State Health Watch (ISSN# 1074-4754) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Application to mail at periodicals postage rates is pending at Atlanta, GA 30304. POSTMASTER: Send address changes to State Health Watch, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information:
Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m. - 6 p.m. Monday-Thursday; 8:30 a.m. - 4:30 p.m. Friday ET.
E-mail: customerservice@ahcpub.com.
World Wide Web: www.ahcpub.com.

Subscription rates: $369 per year. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Back issues, when available, are $58 each.

Government subscription rates: Call customer service at (800) 688-2421 for current rate. For information on multiple subscription rates, call Steve Vance at (404) 262-5511.

(GST registration number R128870672.)

Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, brenda.mooney@thomson.com.
Editorial Group Head: Lee Landenberger, (404) 262-5483, lee.landenberger@thomson.com.
Managing Editor: Alison Allen, (404) 262-5431, alison.allen@thomson.com.
Editor: John Hope, (717) 238-5990, johnhope17110@att.net.
Senior Production Editor: Ann Duncan.

THOMSON
AMERICAN HEALTH CONSULTANTS

Tax-exempt hospitals

Continued from page 1

Attorney Richard Scruggs, who first gained national attention for his successful lawsuits against major tobacco companies and whose firm is coordinating many of the hospital lawsuits, says the New York, Cleveland, and New Orleans facilities being sued are among the most profitable in the nation. "All three are leaders in performing wallet biopsies on many of their uninsured patients," he says. "Often, through their screening process placing a priority on the patient's wallet rather than the patient's health issue and, in turn, appropriate treatment, New York Presbyterian, Cleveland Clinic, and Ochsner Clinic are able to realize and accumulate their profits because, in direct contradiction of the government obligations, they have for years spent only a small percentage of their sizeable revenues on charity care for the uninsured while reaping enormous cash windfalls from their tax-exempt status."

As an example, Mr. Scruggs says New York Presbyterian is the largest hospital system in the New York City metropolitan area, serving 20% of the area's patients. In 2002, it comprised some 33 tax-exempt, acute care and community hospitals as well as its own tax-free collection agency. In that year, it had total net assets of $1.358 billion among its tax-exempt acute care hospitals, of which 44% was unrestricted.

Mr. Scruggs says New York Presbyterian and the other hospital defendants require uninsured patients to pay sticker price, while providing significant discounts for health care to patients who either are privately insured or who use third-party payers such as Medicare and Medicaid. As a result, he says, the hospitals "force uninsured patients to pay out-of-pocket the full excessive health care costs, even though these patients are those who can least afford such costs."

He also charges that the hospitals "often employ predatory and goon-like collection methods to extract payment from the numerous uninsured patients whom they force to pay these sticker prices. Indeed, these three defendant nonprofit hospital systems have a sordid history of pushing over the years numerous of their uninsured patients into personal bankruptcy."

According to the suit against New York Presbyterian, the health system's web site says it "provides charitable and uncompensated care to patients without means," but then requires patients to sign a form contract promising to pay for unspecified and undocumented charges for medical care that are preset by the hospital at its sole discretion.

Mr. Scruggs says New York Presbyterian will not admit a patient into its emergency department for emergency medical care unless the patient agrees to pay in full for unspecified and undocumented charges. And it has an average charge-to-cost ratio of 196.83%, he says, well over the state average of 181.33%.

Another of the attorneys representing uninsured patients in the 39 federal lawsuits, Archie Lamb, who gained national attention suing HMOs on behalf of doctors, says the hospitals' tax-exempt status "is based on the fact they do charity care. The reality is they inflate the amount of charity care they do by overcharging uninsured patients, then writing off that debt and calling it charity care."

He says he has three goals in filing the lawsuits: to make hospital prices fair, to make hospital collection practices fair, and to bring

truthfulness to discussions about charity care and hospital tax status.

Hospitals on the defense

Oklahoma City Integris Health Baptist Medical Center president Stanley Hupfeld, whose hospital was sued by Lamb, says the suit has no merit. "We believe this to be an extortion attempt by some trial lawyers," Mr. Hupfeld explains. "We have for years discounted for our uninsured patients and are very proud to have done that. This organization has been in the practice of offering discounts to the uninsured equal to our best discounts offered to the insured patients. To some extent, this talk about discounting to the uninsured is interesting conversation; but in the real world, it doesn't matter because we aren't going to collect anyway. We collect less than 5 cents on the dollar from all private-pay patients, whether those patients are without insurance or are patients who have deductibles."

In a suit against Florida's Lee Memorial Health System (LMHS), Mr. Lamb says the hospital "uses Enron-style accounting tricks to grossly distort the small amount of charity care it does provide to uninsured patients. LMHS reports this amount of charity care as the amount of gross charges, which are grossly inflated, rather than the actual cost of providing the services."

LMHS director of legal services Robert McCurdy says the lawsuit has no merit because the hospital "does everything it possibly can to see that people who can't afford to pay get the opportunity to get discounts, paying anywhere from nothing to some proportion of their bill. That's been going on for years."

He also points out that a task force of residents near the hospital, many of whom were uninsured, concluded earlier this year that LMHS's discount policies for uninsured patients were liberal and justified.

"They can be prudent and solvent, but not gouge the community," Mr. Lamb adds. "There's a middle ground here, and I'm happy to help them get there."

AHA pulled into fray

The eight most recent suits took a new tack, adding the American Hospital Association (AHA) as a co-defendant with hospitals and health systems in Florida, Georgia, Michigan, New Mexico, New York, Ohio, and Pennsylvania. (In earlier suits, the AHA had been cited in the filings as a co-conspirator with the hospitals.)

Mr. Scruggs says the AHA "has fashioned and promoted to, among others, the administrations and boards of trustees of nonprofit health systems and hospitals, business methods calculated to defeat the rights of uninsured patients even though the co-defendant nonprofit hospital systems and hospitals continue to amass enormous economic benefits from tax exemptions related to providing charitable care to this patient class."

He also accuses the AHA of scheming side-by-side with its co-defendant hospitals to implement "numerous other charitable health care avoidance tactics," including working with hospitals and health systems to manipulate accounting techniques and spinning the public and governmental authorities away from the wrongdoing perpetrated by the hospitals on uninsured patients.

"The facts, as demonstrated in the lawsuits, are clear," Mr. Scruggs says. "The defendant nonprofit hospital systems and hospitals force uninsured patients to pay the gross or sticker price for health care.

Questions for Hospital Administrators

Attorney Richard Scruggs, who is coordinating the federal class action lawsuits against nonprofit hospitals over their billing and collection practices, has suggested that interested citizens ask these questions of their local hospital administrator:

- How much more do you charge the uninsured than patients with HMOs, Medicare, and Medicaid?
- What is your hospital's cost-to-charge ratio?
- Do you have any system in place to evaluate an uninsured patient's ability to pay before you send them a bill?
- What is your collections policy? Do you use collection agencies? How long do you wait before deploying them?
- Do you sue patients who can't afford to pay their bills?
- How much cash and marketable securities are sitting on the hospital's balance sheet? Why?
- Do you classify uncollected billing as both bad debt and charity care?
- Does the hospital have off-shore accounts? Why?
- Are there for-profit businesses and medical practices operating within the nonprofit hospital?
- How much is the nonprofit hospital CEO receiving in pay?
- Do you have any policies in place to ensure proper board governance?

Source: www.nfplitigation.com.

Federal Class Action Lawsuits Filed Against Hospitals/Health Systems

As of July 22, 39 federal class action lawsuits had been filed against 39 hospitals and health systems in 20 states, accused of failing to provide government-required charity care to uninsured patients. The suits have been filed by several law firms in an efforts coordinated by Mississippi attorney Richard Scruggs, who gained nationwide attention for winning lawsuits against big tobacco manufacturers. Here are the suits as of July 22:

AL Baptist Health Systems Inc.
AZ Banner Health
CA Sutter Health
CO Centura Health Corp.; Catholic Health Initiatives/ Catholic Health Initiatives Colorado; Portercare Adventist Heath System
FL Lee Memorial Health System; Florida Hospital Healthcare System Inc. (Florida Hospital and Adventist Health Systems); Baptist Hospital of Miami Inc./ Baptist Health South Florida Inc.; Orlando Regional Healthcare System
GA Medical College of Georgia; Phoebe Putney Health Systems Inc./ Phoebe Putney Memorial Hospital Inc.; WellStar Health Systems Inc.-Douglas Hospital Inc.; Kennestone Hospital Inc.; Cobb Hospital Inc.; DeKalb Medical Center Inc./ Dekalb Regional Healthcare Systems Inc.; Medical Center of Central Georgia Inc./ Central Georgia Health Systems Inc./ Medcen Community Health Foundation Inc.; Athens Regional Health Services Inc./ Athens Regional Medical Center Inc.; Northeast Georgia Medical Center
IL Resurrection Medical Center and Resurrection Health Care; Advocate Health Care Network/ Advocate Health and Hospitals Corporation; Provena Health/ Provena Hospitals
LA Ochsner Clinic Foundation
MI Trinity Health-Michigan Inc./ Trinity Health Corp.
MN Fairview Health Systems; Allina Health System
MS St. Dominic Health Services, Inc./ St. Dominic-Jackson Memorial Hospital
MO BJC Health System (BJC Healthcare)
NJ Saint Barnabas
NM Presbyterian Healthcare Services
NY New York Presbyterian Hospital System; Long Island Jewish Medical Center/ North Shore University Hospital, Manhasset/ North Shore-Long Island Jewish Health System
OH Catholic Healthcare Partners/ Community Health Partners/ Community Health Partners Hospital and Surgical Center; Cleveland Clinic Foundation/ Cleveland Clinic Health System; ProMedica Health System Inc.
OK Integris Health Systems Inc.
PA Albert Einstein Medical Center/ Albert Einstein Healthcare Network/ Jefferson Health System
TN St. Thomas Hospital Inc.
TX Baylor Health Care System/ Baylor University Medical Center; East Texas Medical Center Regional Healthcare System/ East Texas Medical Center Jacksonville/ East Texas Medical Center

Source: www.nfplitigation.com.

Consequently, and in direct contradiction of their missions and government obligations, the defendants make the uninsured patients, the patient group that can least afford such expenditures, to pay full excessive health care costs."

In response, AHA president Dick Davidson says the nation's hospitals "are about people taking care of people, often at the most vulnerable times in their lives. . . . As the national advocate for hospitals, the AHA has consistently supported our members as they have developed fair and compassionate policies to help the uninsured. The AHA has worked diligently to push government by emphasizing and seeking solutions to the issue of helping hospitals serve the uninsured. (**See related story, p. 9.**)

"The assault on community hospitals is misdirected and baseless, diverting focus away from the real issue of how we as a nation are going to extend health care coverage to all Americans. When the facts are known, the reality of what's happening in the communities hospitals serve will be found to be far different than the charges outlined in these lawsuits. We are confident the cases will be easily defeated and the resources of these hospitals will again be freed up to address the important mission each has in contributing to its community."

While many health care lawyers agree with Mr. Davidson that these particular suits with their charges about billing and collection practices ultimately will fail, the issues they raise are not going to go away, and are being raised in Congress even as additional suits are being readied and filed.

Concerns about fraud

In testimony before the House Ways and Means Subcommittee on Oversight, AHA board chairman David Bernd, CEO of Virginia's Sentara Health Care, addressed the

issue of hospital tax status, saying the underpinning for charitable tax exemption is public support for activities that serve the larger good. Since 1969, he said, the promotion of health explicitly has been recognized as a purpose meriting tax exemption. The promotion of health alone is not sufficient, however. It also matters how it is done, when, and for whom.

"The focus is not on what the hospital does but whether those actions respond to community need," Mr. Bernd said. "Providing charity care has been only one way to demonstrate that benefit. The community benefit test is still a sound and viable basis for awarding tax-exempt status to hospitals. It places the focus at the local level and examines the merits of individual situations against the community environment in which they serve. The issue has been and should continue to be whether they are providing public benefit."

OIG: Some misinterpret law

In a February 2004 document, the Health and Human Services Office of Inspector General (OIG) said there is no OIG authority that prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills. The document says there have been suggestions that the federal anti-kickback statute and Section 1128(b)(6)(A) of the Social Security Act could prevent hospitals from offering discounted prices to uninsured patients, but the OIG disagrees with this assessment.

"In addition to the two laws, it has been suggested that hospitals are reluctant to give discounts to uninsured patients because the OIG requires hospitals to engage in vigorous collection efforts against

Continued on page 6

Congress discusses issue in hearings

At least two congressional committees have held hearings into hospital billing and collection practices.

The Subcommittee on Oversight of the House Ways and Means Committee held a hearing on pricing practices of tax-exempt and other hospitals.

Subcommittee chairman Amo Houghton (R-NY) said hospitals were only 1.9% of the more than 300,000 reporting tax-exempt 501(c)(3) entities in 2001, but constituted 41% of total expenditures. Under current law, he said, hospitals are considered tax-exempt because they promote the health of a class of people broad enough to benefit the community as a whole.

Indigent Care or Wallet Biopsy?

Many hospitals increase their charges to shift the costs of treating the indigent onto public and private payers. In 2002, Mr. Houghton said, hospital charges exceeded their average costs by 118%, according to the Centers for Medicare & Medicaid. Individuals without health insurance are billed full charges. Thus, the uninsured are liable for charges that were inflated to cover the costs of indigent medical care. He added that hospital charges are not transparent. So consumers, including the uninsured, don't have access to information on the costs of medical treatment across hospitals. Some advocate empowering consumers with information on hospital costs and quality to increase competition and slow medical cost inflation.

House Energy and Commerce Committee Subcommittee on Oversight and Investigations chairman Jim Greenwood (R-PA) has been looking at hospital billing and collection practices, including overcharging the uninsured.

After a hearing on hospital payment rates for the uninsured, Mr. Greenwood told reporters the system was a form of Russian roulette in which one uninsured person who can't pay for hospital care will pay nothing, while another, under pressure from the hospital billing department, ends up losing his house in an effort to pay for hospital services based on master charges that virtually no one other than the uninsured pay.

While the hospital industry argues that the master charges are the starting point for negotiating rates, Mr. Greenwood said, that's really not the case. Critics, he said, liken the master charges to the sticker prices for cars that only the most naïve shoppers actually pay.

And while hospitals cite the large estimates of the amount of uncompensated care they provide, Mr. Greenwood said they actually "are more than breaking even on their costs for charitable care" because of Medicare and Medicaid disproportionate share payments.

He said he doesn't know yet what changes should be made in the law to protect low-income patients against large out-of-pocket payments, expressing an interest in watching to see if hospitals voluntarily adopt patient-friendly billing and collection practices advocated by the American Hospital Association.

If legislation is necessary, according to Mr. Greenwood, one possibility would be a mandated system to require hospitals to notify patients whether they qualify for charity care. He said he also would consider a ceiling on rates hospitals could charge low-income patients not qualifying for charity care, perhaps Medicare rates plus some percentage. ■

Continued from page 5

uninsured patients," the OIG document stated. "This misperception may be based on some limited OIG audits of specific hospitals' compliance with Medicare's bad debt rules. The bad debt rules and regulations, including the scope of required collection efforts, are established by the Centers for Medicare & Medicaid Services. No OIG rule or regulation requires a hospital to engage in any particular collection practices."

According to the OIG, fraud and abuse laws clearly permit waiver of all or a portion of a Medicare cost-sharing amount for a financially needy beneficiary. And under the fraud and abuse laws, the financial need criterion is not limited to indigence, but can include any reasonable measures of financial hardship.

Thus, Medicare cost-sharing amounts may be waived so long as the waiver is not offered as part of any advertisement or solicitation, the party offering the waiver does not routinely waive coinsurance or deductible amounts, and the party waives the coinsurance and deductible amounts after determining in good faith that an individual is in financial need or reasonable collection efforts have failed.

"While every case must be evaluated on its own merits, it is important to note that the OIG has never brought a case based on a hospital's bona fide discounting of its bill for an uninsured or underinsured patient of limited means," the statement explained.

Coding for payment

At a June 22 hearing of the House Ways and Means Committee's Subcommittee on Oversight, Southern Medical Health System COO Randy Sucher pointed out that establishing prices for hospital procedures has changed as the practices of insurers and Medicare have evolved.

Before Medicare converted to payment to hospitals based on diagnosis related groups (DRGs) in the 1980s, he said, charges for individual items were calculated as a markup of estimated or actual costs. Individual item costs didn't matter too much because Medicare and other payers paid their pro-rata percentage of a hospital's total costs based on a ratio of costs to charges or average cost per day.

But when Medicare adopted DRGs as the basis for payment, it introduced incentives for hospitals to control costs and line-item pricing became even less important because individual item prices have a minimal effect on payments made to hospitals, except in the rare case in which an insurance company or managed care organization pays for certain services based on a negotiated percentage of charges.

To be able to allocate costs for Medicare cost-reporting purposes, identify usage of items involved in providing care to a patient for hospital internal cost-reporting purposes, and provide a detailed bill as often requested by insurance companies, the practice of charging for every individual item consumed by or for patients has continued.

Mr. Sucher said charges now are developed based on detailed analyses of prominent payer fee schedules by procedure code. "If Blue Cross pays $2,400 for an outpatient cardiac catheterization and the standard discount for Blue Cross is 50%, the charge [allocated to major components] may be 200% of the fee schedule amount," he explained. "But the allocation of the intended overall charge to the components of the care is difficult because every case is so different. Health care is not like an assembly line at an auto manufacturing plant. Every patient is different with varying complications, comorbidities, and severity of illness. And all physicians are different in their treatment protocols for each patient, using various supplies, pharmaceuticals, and diagnostic tests. Hospital care is much more akin to great chefs making seafood gumbo, where almost all outcomes are successful, but no two taste or cost the same."

According to Mr. Sucher, one reason hospital charges vary so much from costs is every payer contract includes a provision that for any particular patient, the payer will pay the hospital the lesser of the negotiated rate or the hospital's customary charges. Negotiated rates generally are a fixed rate that an insurer pays for an average episode of care.

He said hospitals take huge losses on cases when complications occur, or when routine procedures end up requiring expensive additional services. "So hospitals cannot afford to not make money on the low-end cases by having the charges be less than the negotiated rates," he declared. "High charge markups generally help hospitals avoid this Catch 22."

A second reason for high hospital charges, he testified, is the cost-shifting that has occurred for many years in the industry. "To make up for those payers that often pay hospitals below our total cost [Medicare and HMOs included], hospitals must shift some of these costs to payers [generally PPOs] that sometimes pay a percentage of charges. Although these payers usually represent less than 10% of a hospital's revenue, they can comprise a fair share of hospital profits."

Mr. Sucher maintained that any effort to have hospitals charge all patients the same prices for the same

services results in high prices for the uninsured.

At that same hearing, Richard Morrison, the regional vice president for governmental and regulatory affairs for Adventist Health System in Orlando, FL, which owns and operates 38 hospitals in 10 states, explained that hospitals have extensive chargemasters that may list 25,000 or more items, he said, and it's from that list that hospital bills are created. It also is the basis for information used in the quality assurance process, the utilization review process, cost accounting, and for various reports to state and federal agencies.

He conceded there is little true relationship between health care costs and charges. But, Mr. Morrison said, that situation did not arise arbitrarily and also did not occur overnight. "Rather, the disconnect between costs and charges evolved over the span of nearly 30 years as a result of pressures exerted by the insurance industry, the federal government, and from within the health care industry itself."

Mr. Morrison maintained that charges still have some usefulness even though they vary significantly by institution and have only a passing relationship to cost.

Charges still are required by Medicare and by some insurers. Medicare uses the reported charge to audit cost reports and to calculate outlier payments, and insurance companies use charges to project rates and to calculate some payments. Internally, charges give hospitals some measure of resource consumption.

He said modifying the current charge structure would be a complex task, possible for some institutions that do not have discount-based contracts and don't have an extensive Medicare population, but more difficult for those with extensive contracts based on discounts.

The final issue for consideration, Mr. Morrison noted, is transparency, and whether there is a better way to provide consumers with a clearer sense of what they will pay for care.

For most outpatient services, it is not a major problem as tests are fairly discrete and outpatient surgery has more predictability. But inpatient care is far less predictable. Within a given institution, Mr. Morrison said, the cost for treating a specific diagnosis can vary greatly. Variances can be attributed to differences in physician practice patterns as well as individuals' health conditions. ■

A tale of one state: Hospital tax status in Pennsylvania

While the 39 federal class action lawsuits filed this year are based primarily on nonprofit hospital billing and collection practices, especially as applied to the uninsured and underinsured (**see cover story**), there also are questions raised about the tax-exempt status of nonprofit hospitals. Those questions have been litigated in local and state courts in recent years.

One state that was a hotbed for such litigation a few years ago but now is relatively quiet is Pennsylvania.

The reason tensions have eased there is a 1997 law that redefined what it is necessary for an organization to be an "institution of purely public charity," the type of organization the state constitution says is necessary for tax exemption.

Philadelphia attorney Philip Korb, in a paper written for The Pennsylvania Bar Association, contended that for many years, Pennsylvania nonprofit institutions met relatively little resistance in applications for exemption from real estate and sales taxes.

Indigent Care or Wallet Biopsy?

But by the 1980s, many once small nonprofits had become major institutions with great economic power at the same time that taxing authorities had become financially pressed, often facing greater responsibilities but shrinking tax bases.

Taxing authorities began to challenge historical tax exemptions more often, and in 1987, the Pennsylvania Supreme Court decided the landmark *HUP (Hospital Utilization Project)* case that established five specific tests for qualification for tax exemption based on the state constitution's limiting of exemptions to institutions of purely public charity.

The number of challenges grew exponentially following that decision, and at one point, there was a cottage industry of consultants offering to teach local governments how to challenge the tax status of major nonprofits, especially hospitals and other health care institutions.

Because county and state courts often reached differing results in applying the tests from the HUP decision, there were calls for legislation to provide a consistency in standards for exemption and encouragement for nonprofits to

make payments to local governments in lieu of taxes.

Act 55's five prongs

Pennsylvania Act 55 of 1997, the Institutions of Purely Public Charities Act, follows the five-prong HUP test set forth by the Supreme Court in 1987, but attempts to precisely quantify the standards for meeting each of the prongs.

The law says institutions must do the following:

1. advance a charitable purpose;
2. donate or render gratuitously a substantial portion of its services;
3. benefit a substantial and indefinite class of people who are legitimate subjects of charity;
4. relieve the government of some burden;
5. operate entirely free from private profit motive.

One of the reasons for challenges to tax-exempt status of nonprofits, especially hospitals, was that some of them were operating businesses that seemed far removed from their charitable purpose.

For instance, questions were raised about an Erie health system that owned and operated a Lake Erie marina, and about hospitals that used their laundry facilities to compete with private laundries.

Act 55 legislated a counterweight to the protection given charities by prohibiting them from competing with small businesses. Under the law, a charity may not fund or subsidize a commercial business that is unrelated to its charitable purpose.

During the debate over Act 55, Pennsylvania's Catholic bishops issued a white paper making a strong care for tax exemption as the "key to charitable service."

After reciting the wide-ranging services provided by Catholic Charities agencies, the bishops noted the many activities of other nonprofit tax-exempt organizations that, among other endeavors, furnish human services, help the physically and mentally challenged, and treat drug and alcohol abuse.

"All of these organizations, whether under Catholic or other auspices, differ in many ways, but share one common thread: Through charity, they improve the lives of Pennsylvanians — in many cases the most needy and impoverished — in urban and rural communities where they are located," the bishops said.

"They enhance the spiritual and material well-being, the health, and the educational and cultural life of all the commonwealth's citizens. . . . Loss of tax-exempt status may well force charitable organizations to cut back their services or close their doors.

"One of the great ironies of the current situation is that many charitable organization serving those in need are located in educationally distressed areas. These organizations shouldering the greatest burden by serving the poor are also being attacked most severely by their local municipalities.

"If the charities were forced to curtail services or go out of existence altogether, government would have to assume the crushing burden of providing these services, at an even greater cost. These additional and substantial costs would have to be passed on to the taxpayer, increasing the tax burden, which already is perceived as unduly heavy," they wrote

Law still in force

Since the law's passage in 1997, it has weathered several challenges to its constitutionality and has greatly reduced the number of local government challenges.

Because it doesn't address the issues of billing and collections, however, it remains to be seen whether it will be useful to hospitals that are named in the latest federal lawsuits.

Jim Redmond, senior vice president of The Hospital and Healthsystem Association of Pennsylvania, who was one of the key figures in the negotiations that led to passage of Act 55, tells *State Health Watch* that he expects hospitals named in the federal suits will cite their compliance with the law as a defense in terms of how much charity care they provide. But he says the law's silence on the question of the amount hospitals should be charging the uninsured could be a problem.

"The new suits are dealing with slightly different issues," Mr. Redmond adds. ■

This issue of *State Health Watch* brings you news from these states:

The AHA adopts principles, develops guidelines

The American Hospital Association (AHA) has adopted principles and guidelines on billing that confirm the commitment of America's hospitals to serve their communities with compassion and professionalism.

The principles approved by the AHA board of trustees include:

- treating all patients equitably, with dignity, with respect, and with compassion;
- serving the emergency health care needs of everyone, regardless of a patient's ability to pay for care;
- assisting patients who cannot pay for part or all of the care they receive;
- balancing financial assistance for some patients with broader fiscal responsibilities to keep hospitals' doors open for all who may need care in a community.

The AHA board contends hospitals' work is made more difficult by the nation's fragmented health care system — a system, it says, that leaves millions of people unable to afford the health care services they need; a system in which federal and state governments and some private insurers do not meet their responsibilities to cover the costs of caring for Medicare, Medicaid, or privately insured patients; a system in which payments do not recognize the non-reimbursed services provided by hospitals; a system in which a complex web of regulations prevents hospitals from doing even more to make care affordable for their patients.

In the guidelines, AHA is striving to get 5,000 member hospitals to agree to cover helping patients with payment for hospital care, making care more affordable for patients with limited means, and ensuring fair billing and collection practices.

Indigent Care or Wallet Biopsy?

In testimony before the House Ways and Means Subcommittee on Oversight, AHA board chairman David Bernd, CEO of Virginia's Sentara Health Care, said that as AHA developed its principles and guidelines, "it became clear that hospitals were concerned about violating federal regulations governing billing and collections that had accumulated over many years. This became an impediment to hospitals' efforts to assist patients of limited means with their hospital bills.

"The rules are numerous, often confusing, and, as even the administration acknowledged, scattered among many different official publications. The AHA sought to address that issue and asked the administration to bring new clarity to the rules to assist hospitals in their efforts to improve their charity care and other payment policies for patients of limited means."

Mr. Bernd credited Health and Human Services Secretary Tommy Thompson for a guidance addressing many of the concerns AHA raised on behalf of the field.

Because of that guidance and a forum at which hospital representatives were able to ask specific questions, he said, hospitals are moving ahead to improve their charity care and financial assistance policies and practices and make them available to even more patients of limited means. ■

Pay for performance, standardized billing could help

The provision of charity care or a sliding-scale discount for patients deemed bad debtors is not a requirement for hospital tax exemption at the federal level, Harvard Business School professor Nancy Kane told the House Ways and Means Committee's Subcommittee on Oversight in a June 22 hearing.

Some state and local taxing authorities have challenged hospitals that fail to provide a reasonable level of charity care to patients (**see related story on Pennsylvania, p. 7**), but most states have been reluctant to specify a quantity of charity care that hospitals must provide to retain their state and local tax exemption.

Indigent Care or Wallet Biopsy?

Ms. Kane said that research she and others conducted in the mid-1990s indicated that the quantifiable value of hospital tax exemptions far exceeded the average cost of charity care provided. She said that transparency in hospital pricing would be a useful supplement to stronger policies that reinforce the safety net for the uninsured. One such policy, she said, could be to strengthen the tie between hospital tax exemption and provision of medical services to the uninsured.

"Hospitals could be required to demonstrate how they earn the value

of their tax exemption with higher priority, safety-net activities counting for more than those activities that primarily benefit insured populations, the hospital's competitive position, or the general public," she said. "Incentives for hospitals to provide preventive, primary, and chronic care to vulnerable uninsured populations could both save money and greatly reduce human suffering."

According to Commonwealth Fund president Karen Davis, hospital care is not like other goods and services because of a lack of information, lack of choice, the complexity and life-critical importance of health care treatment decisions, physicians' decision-making role in health care, and the need for insurance to protect financial security.

Ms. Davis said that while other countries have accepted an activist role for government in health care financing, the United States has had only sporadic, short-lived attempts to shape the health care sector through governmental policy. She reviewed many of the federal and state attempts for the committee, and said the basic lesson to be learned from the historical experience is that government leadership matters.

Fragmented financing system

"When government establishes a payment framework for purchasers — whether Medicare, Medicaid, or employer health plans — and uses that collective purchasing power to set or negotiate prices from providers," she declared, "the rise in hospital costs is slowed, there is greater equity by income of patients and across different sources of coverage, and better access to care for the uninsured.

Large purchasers — Medicare, national managed care plans, large employers — also can obtain good deals on their own, but they are less effective both in controlling overall cost increases and in ensuring equitable payment and access. A fragmented financing system, with each payer setting its own rules, also inflicts a toll in the form of higher administrative costs.

On the flip side, if purchasers join together to exact steep discounts, this system may undermine the financial stability of the hospital sector, dampen investment in innovation such as information technology, and undermine important social missions."

Changes that could work

Ms. Davis contended the greatest promise lies in a combination of improved information on quality and efficiency, pay-for-performance purchasing by private and public insurers, and investment in the capacity to modernize the health care system.

She also argued in favor of transparency in price, not necessarily in terms of prices of individual hospital or physician services, but rather information on the total cost of care over an episode of illness or period of time.

"If a patient goes to a hospital where he or she will be seen by 10 different physicians and spend a long time in the intensive care unit, it is the total bill for hospital, physician, and other services that is of concern to the patient, not the daily room rate or the charge for a day of intensive care," she said.

Ms. Davis said one of the difficulties in providing this kind of information is the absence of a multipayer claims database with unique provider identification, and one important step would be for Medicare to lead in forging collaboration among Medicare, Medicaid, and private insurers to assemble such a database and make it widely available to researchers and providers.

Ms. Davis also supports a pay-for-performance philosophy in which purchasers reward high performance hospitals that demonstrate better quality and efficiency, as well as high-performance integrated health systems and accountable physician group practices. Purchasers are in a far better position to promote better quality and efficiency than are individual patients, she said.

Addressing pricing guidelines, Ms. Davis said the current system of hospital pricing is inequitable and administratively inefficient. She said a major effort should be mounted to identify ways of reducing provider administrative costs and simplifying payer rules and pricing practices.

To deal with the wide disparities in prices faced by different sets of patients, she suggested consideration of limits or bands on how much prices can vary depending on payer source. And given urgent concerns about the financial burdens on uninsured and low-income underinsured Americans, she said, net charges (after discounts) to such patients certainly should not be higher than those charged insured patients.

"In the current environment," Ms. Davis explained, "nonprofit hospitals that provide uncompensated care to the uninsured and fulfill other vital social missions should be preserved and strengthened. It would be reckless to undo tax preferences for nonprofit hospitals. They are a major source of uncompensated care and community benefit.

"It may be reasonable to refine expectations about what nonprofit hospitals should contribute to their community. It is reasonable to ask that the uninsured not be charged more than other patients, and that hospitals work out feasible repayment plans and not employ unreasonable collection tactics," she added. ■

Fiscal Fitness

Continued from page 1

diabetes foot complications and a 50% decrease in repeat heart failure events. Though never measured before, the company also plans to delay progression of renal failure in diabetic patients by 25%.

Burcham Fuqua, the XL Health project's medical director, tells *State Health Watch* the project is for patients with advanced congestive heart failure or those with diabetes complicated by heart disease and lower extremity disease. They have recruited 14,000 patients — 10,000 who will receive disease management intervention and 4,000 who will be in a control group and not have any further contact with XL Health, but whose Medicare claims will be tracked.

The treatment group members, Mr. Fuqua says, receive a comprehensive, unlimited drug benefit, plus disease management interventions based on the specific problems the patients have.

Home health nurses evaluate each patient recruited for the test and complete a comprehensive medical profile. Data from the profile go to Omnicare, XL Health's pharmaceutical partner, whose software suggests interventions that are recommended to the patient's attending physician. "We expect to find contraindicated or duplicated drugs and other problems," he adds, "and will ask the patient's doctor to make changes. We'll identify the patients who are not receiving the classes of drugs that have been shown to be useful."

Congestive heart failure patients receive a smart scale that can transmit their weight to a call center daily. The scale also can be remotely programmed to ask the patient yes/no questions and send the answers to the call center. The responses trigger interventions as needed, with nurses calling the patient or the call center alerting the patient's doctor.

For diabetics, the emphasis is on prevention of complications of the lower extremities. Mr. Fuqua says XL Health tries to obtain an in-person evaluation, including an intensive evaluation of the lower extremities.

Patients seen as being at risk for complications are referred to an associated podiatrist who has special training and interest in diabetic foot care. The program also provides special protective shoes. He explains that when a similar program was run with Humana, leg amputations were reduced by half.

Docs play important role

Potential enrollees are identified based on Medicare claims data. XL Health also approaches doctors about participating in the project and asks them to identify patients who might be eligible.

Participating doctors are asked to collect limited data sets on study patients quarterly and are compensated for this effort. "The amount we pay is modest and not the strongest factor in physician recruitment. The strongest factor is doctors' enthusiasm for the unlimited prescription drug benefit."

XL Health's philosophy, he says, is to remove the obstacles that interfere with patient compliance with a treatment program and encourage physicians to prescribe what have been identified as best practices.

He says the company expects to spend a lot of money on its unlimited drug benefit and has budgeted 19% of its total budget for drugs.

"We expect that by getting patients the drugs they need, we can keep them from being hospitalized as much. The savings on hospital days and surgical procedures will more than offset the cost of the drugs."

A different drug formulary

XL Health has created a very different drug formulary from the typical insurance company model. For insurance companies, tier one usually is low-cost generic drugs, tier two is the preferred branded products based on their price, and tier three is the nonpreferred branded drugs.

Under the XL Health model, tier one contains all drugs that are crucial for a good health outcome, regardless of their price. Likewise, drugs known to worsen outcomes are in the highest tier, regardless of their pricing. "We try to spend our money where it will have the most impact to keep people out of the hospital," Mr. Fuqua says. "Lifestyle drugs have a high copay. We're focused on global outcomes and global costs rather than on how much money is going to the prescription drug category."

XL Health is at financial risk for its Medicare demonstration project. If the cost of the program ends up being greater than the savings on Medicare claims, the company is at full risk for the difference. If the company ends up saving money, the savings are shared with Medicare.

XL Health executive vice president Paul Serini tells *SHW* physicians are responsive to XL Health because of the way the program is put together and XL Health was founded by and is currently run by physicians and other health professionals. "We try to function as an extension of the doctor's office."

"Chronically ill patients usually should be seen by the doctor weekly or monthly, but often it's quarterly at best. Between office visits, there are a lot of data that can and should be collected and some of the data

should trigger action by the physician between office visits," he says.

"Sending data between visits makes the office visits briefer and more organized and comprehensive," Serini adds. "Often, patients are not organized when they come in. We offer the ability to organize their chronically ill patients for the doctors. We alleviate their administrative and financial burden. Most doctors view what we do as a positive for their patients."

The program succeeds, according to Mr. Serini, because it makes life easier for patients. The demonstration project includes some of the neediest, sickest patients that can be encountered, according to XL Health. Many of them have comorbid conditions and a poor support network. "People need someone who can ask questions because they don't want to 'bother the doctor,'" he says. He also says that while the robust drug benefit is important, there are a fair number of patients joining who already have a drug benefit or say that they are joining because of the nurse contact rather than the drug benefit.

Credibility is a tough issue with consumers, Mr. Serini says. Convincing skeptical patients that this is truly a free program is the most difficult challenge. Once patients believe it is real, 70% to 75% of them sign up. He says they have been more successful than they had anticipated in signing up patients.

While it's early in the three-year demonstration, Mr. Serini says XL Health feels very good about the financial risk the company is assuming. "It's too early for a claims analysis but preliminary indications make us feel cautiously optimistic that we can save money."

[Contact Mr. Fuqua and Mr. Serini at (888) 284-0001. Web: www.xlhealth.com.] ■