Federation of American Hospitals®

July 20, 2006

VIA ELECTRONIC MAIL

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Investor-Owned Hospitals and Charity Care

Dear Senator Grassley:

On behalf of the Federation of American Hospitals ("FAH"), this responds, in part, to your July 6th letter requesting information about charity care provided by our investor-owned hospital members. As part of the Senate Finance Committee's focus on tax-exempt hospitals and charity care, this information will allow for a more comprehensive understanding of the current operational environment for all hospitals.

Your letter raises a series of questions in the areas of Charity Care and Community Outreach, Community Accountability, and Taxes. This letter responds to several of your questions. However, other questions require us to collect information from our members. As discussed with your staff, more time is needed to seek and collect this information from our membership. Thus, we will provide a second submission by the end of August which will respond to the remaining questions. We appreciate that the Committee is allowing us the time to answer the questions as thoroughly as possible.

Your request actually comes at an opportune time for us. FAH is currently conducting its annual membership survey for 2006, a process through which a good deal of your requested information is already being collected. However, your letter seeks significantly more detail than would otherwise be collected through our survey as well as different information, so we have requested that additional information from our members.

The current deadline for FAH member survey responses is July 30, 2006. Our members are aware of your inquiry and the importance of timely responding to our survey and to the additional information requests from the Committee. Because it may be of interest to you, we include here

relevant information from last year's FAH member survey.[1] We will be sure to provide new information from the 2006 member survey in the August submission.

Our responses below are arranged to correspond to the format of your letter. We understand that the Finance Committee seeks only information about general acute care community hospitals. Our responses were developed accordingly.

CHARITY CARE AND COMMUNITY OUTREACH

1. **Describe the Federation of American Hospitals ("FAH") and your membership. How many and what types are represented by FAH? What is the average size and capital expenditure of member hospitals by type? What is the average patient composition (uninsured, covered by Medicaid or other state or other governmental programs, or otherwise covered by private insurance) by type of member hospital?**

The Federation of American Hospitals is the national representative of nearly all investor-owned or managed hospitals and health systems. Our members include general community and teaching hospitals in urban and rural areas as well as rehabilitation, long-term acute care, cancer, and psychiatric hospitals. Our institutional hospital members include 20 companies, with some 500 acute care hospitals operating in most of the 50 states (plus Puerto Rico and the District of Columbia), and employing 445,000 individuals.

According to our 2005 survey, the average size of our full service acute care hospitals is 196 beds, and the average capital expenditure per hospital is $7.3 million. We did not collect the patient composition information that you seek, however, we will have those figures and updated hospital size, type, and capital expenditure information in our second submission.

We understand that by "type of member hospital," you seek a designation of either "rural" or "urban." We did not make that distinction in our prior survey, but will do so for reporting purposes in our second submission.

2. **Do your member hospitals have charity care policies or obligations? Among your members, how is charity care usually defined? Does the FAH have a position on the provision of charity care and if so, what is the FAH's position? Does the FAH provide recommended language or materials to members concerning charity care policies? If so, please provide copies of these materials. Provide examples of some of your member hospitals' policies as well.**

FAH does not have a formal position on the provision of charity care, nor do we provide recommended language or materials to our members concerning charity care policies. Our member companies, however, have adopted their own charity care/discount policies. Here are three examples of such polices that are currently in place and reflect the levels of assistance our members offer for the uninsured and indigent:

- One system provides a 100% charity care discount for non-elective uninsured patients at or below 200% of the Federal Poverty Guideline. In addition, all uninsured patients regardless of income are eligible for a discount, the amount of which is equivalent to a managed care-like discount determined at the local level.

[1] Last year's member survey was conducted in the summer of 2005 and collected data from calendar year 2004. This year's survey will collect data from calendar year 2005.

- Another system also provides a 100% charity care discount for non-elective uninsured patients with income below 200% of the Federal Poverty Guideline. In addition, 40 to 80% discounts are available for uninsured patients either (1) with income below 500% of the Federal Poverty Guideline or (2) with balances due for hospital services in excess of 50% of their annual income.

- A third system provides a 100% charity care discount for non-elective uninsured patients with household income at or below 150% of the current Federal Poverty Guidelines. Hospitals are given further flexibility to adjust this charity qualifying threshold upwards to at or below 200% of the current Federal Poverty Guideline. Moreover, hospitals are given flexibility to provide discounts for individuals with household income up to 500% of the current Federal Poverty Guideline, regardless of insured status, based on the amount that the patient owes after payment by all third parties in relation to the patient's household income.

With our second submission, we hope to provide further examples of our members' policies and how they usually define charity care.

3. Has the FAH conducted or commissioned research or done any seminars, lectures, or other similar educational campaigns for members regarding charity care? If so, describe the nature of these programs and provide any materials.

FAH has not conducted or commissioned research or done any seminars, lectures, or other similar educational campaigns for members regarding charity care.

4. How much uncompensated care is provided by the average member hospital? What are the components of uncompensated care and their respective amounts? How are each of these components calculated?

This question requires us to obtain information from our members before answering. This information has been requested and the answer will be included in our August submission. For purposes of the 2006 FAH member survey, the term "uncompensated care" is defined to include: (1) charity care; (2) bad debt; and (3) discounts, and each component will be reported separately. We will furnish additional information regarding how each of these components is calculated.

Our 2005 survey requested information on total uncompensated care, defined as bad debt and charity care. Based on that survey, in 2004, the average FAH member acute care hospital provided $15.4 million in uncompensated care.

5. How is uncompensated care reported by member hospitals? How are the components of uncompensated care reported by member hospitals?

This question requires us to obtain information from our members before answering. This information has been requested and the answer will be included in our August submission.

6. **How is charity care reported by member hospitals? How are the components of charity care reported by member hospitals?**

This question requires us to obtain information from our members before answering. This information has been requested and the answer will be included in our August submission.

7. **How much charity care is provided by member hospitals located in the same geographic region as a tax-exempt or government hospitals? How much charity care is provided by member hospitals in regions where there are no tax-exempt or government hospitals?**

This question requires us to obtain information from our members before answering. This information has been requested and the answer will be included in our August submission.

8. **What type of community outreach and educational activities do your member hospitals conduct, and on average how much is expended on such activities?**

This question requires us to obtain information from our members before answering. This information has been requested and the answer will be included in our August submission.

9. **Explain how the amount of charity care your member hospitals provides differs in magnitude and kind from that provided by tax-exempt hospitals.**

We currently have no basis on which to answer this question. FAH has not conducted and has no current plans to conduct a comparative analysis of charity care provided by our member hospitals and tax-exempt hospitals.

10. **Explain the various forms of discounted care your member hospitals provide. What are the components of discounted care? What is the range of discounts provided by your average member hospital?**

Some examples are provided in the answer to question 2. We hope to expand on that information in our August submission.

11. **Please explain FAH's position regarding whether bad debt should be treated as charity care.**

FAH has not taken a position on whether bad debt should be treated as charity care. We would note, however, that our member companies follow GAAP, under which bad debt is treated as an expense item, and charity care is treated as a reduction to gross revenue.

COMMUNITY ACCOUNTABILITY

1. **Some have argued that exemption for non-profit hospitals can be justified solely on the basis that they are accountable to the community, whereas investor-owned hospitals are accountable only to stockholders. How do investor-owned hospitals maintain accountability to the communities they serve?**

From our viewpoint, the premise of the question suggests a false dichotomy. We maintain that the interests of shareholders and communities are aligned, not mutually exclusive. Simply put,

shareholders are best served when communities are best served. If investor-owned hospitals do not provide necessary, high quality services, then the hospital cannot be a successful provider in the community, and investors will suffer from poor business performance. It is in the best interests of both patients and investors when hospitals are full service, fully accessible, and high quality. That is the critical mission for FAH's member hospitals, and a necessary component of how we measure and maintain accountability to the communities we are fortunate to serve.

In short, investor-owned hospitals maintain accountability to the communities they serve in many ways, including, for example, ensuring that representatives from the local communities serve on the boards of local hospitals and maintaining programs and projects that focus on wellness, preventive care, and other means of promoting healthy living in the local communities. Moreover, our members' hospital administrators live and work in their local communities, participate in civic activities, and continually engage community leaders to ensure that the hospitals are responsible and valued corporate citizens.

2. What types of research and teaching are performed by your member hospitals?

Our hospital members own and operate several academic medical centers, including, among others: (1) George Washington University Medical Center, (Washington, DC); (2) Tulane University Hospital and Clinic (New Orleans, LA); (3) USC University Hospital (Los Angeles, CA); (4) Hahneman University Hospital (Philadelphia, PA); (5) Creighton University Medical Center (Omaha, NE); and, (6) St. Louis University Medical Center (St. Louis, MO). In addition, our members operate graduate medical education programs and participate in clinical research activities in various non-academic medical centers which focus on studying new medical technologies in a variety of clinical fields. We will expand on this answer in our second submission.

3. To your knowledge, are there instances where your member hospitals are the only providers of health care in their community and thus must admit and treat the medically indigent even though doing so might be inconsistent with an investor-owned hospital's mission?

The mission of our member hospitals is to serve the communities in which they reside, which means that they must address the medical needs of the patients they treat with the highest quality care. So, treating medically indigent individuals is clearly part of our mission, regardless of whether they are the sole provider in a community or compete with other hospitals. Our members' approach to furnishing patient care is the same in all communities.

4. Many non-profit hospitals have come under attack for inappropriately charging the uninsured charges greater than they charged insured patients for the same care and for improper collection practices. What steps has FAH taken with its member hospitals to assure that patients are treated fairly with respect to charges, billing, and collection practices?

FAH and its member hospitals have been monitoring developments with respect to charges, billing and collection for some time. Our largest systems were early and independent adopters of voluntary, meaningful discount and respectful collection programs that are sensitive to the needs of uninsured and underinsured patients. FAH consulted with the American Hospital Association ("AHA") during the development of its model billing and collection policies and has supported AHA's leadership. As you may know, many FAH members are also members of the AHA, so those policies

have been recommended to our members through that avenue. FAH has not adopted separately formal guidelines regarding billing and collection practices.

5. **Do your member hospitals enter into joint venture arrangements with non-profit hospitals, other investor-owned providers, physicians, or others to deliver health care?**

Joint venture arrangements, especially with non-profit hospitals with whom we share the mission of exploring the best ways to serve the health care needs of the communities we are in, are not uncommon among our member companies. Other joint venture arrangements include those with other investor-owned providers and with physicians.

TAXES

1. **Does the FAH collect member information regarding the taxes paid by investor-owned hospitals? If so, provide information on Federal, State, and Local taxes paid by investor-owned hospitals, specifically breaking out income tax, property tax, employment taxes, and other taxes for each level of government. If possible, provide this information as a percentage of gross revenues and a percentage of net income.**

FAH collects information through its membership survey on the amount of tax expense incurred for any federal, state and local income taxes, property taxes, and sales taxes. In 2004, FAH's acute care hospitals incurred $912 million in income taxes, $390 million in property taxes, and $435 million in sales taxes.

However, we do not currently collect information from members on employment or other taxes, as requested in your letter. We have solicited this information and will provide it to you in our August submission along with new tax data received as part of our 2006 member survey.

Thank you for the opportunity for FAH to provide this information. We hope it is helpful to the Finance Committee's work on tax-exempt hospitals and charity care. If you have any questions about this letter or need further information, please contact me, Steve Speil at 202.624.1529 or Jeff Micklos at 202.624.1521.

Sincerely,

Charles N. Kahn III
President