

Burdens Encountered By the Uninsured in the Search for Hospital Care: Are Tax-Exempt Hospitals Fulfilling Their Charitable Obligations?

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This article seeks to define the barriers encountered by the medically uninsured when searching for hospital care, and whether tax-exempt hospitals are fulfilling their obligations to provide charity care to the uninsured and indigent. First, the article outlines the problems facing the uninsured by exposing unethical hospital billing practices. Second, this article defines a tax-exempt institution in terms of a hospital, and the benefits and obligations associated with tax-exempt status. And third, this article rates Utah hospitals with an idiographic, nonprobability study in which seven Utah hospitals were asked about their charity and free care programs and policies. The author concludes by providing policy recommendations to better define charity care and regulate tax-exempt institutions to ensure compliance of a “charitable purpose.”

INTRODUCTION

In February 2002, the fictitious Hollywood screen character John Q. Archibald, played by Denzel Washington in the motion picture *John Q*, brought to light a serious policy issue with regards to the uninsured and their search for hospital care in time of need (Cassavetes 2002). Washington's character, a low-income factory worker in the heart of Illinois, has his hours at the factory cut from full- to part-time, adversely affecting his health insurance benefits.

The plot emerges when Archibald's son, Mike, is diagnosed with a failing heart that requires a heart transplant to save his life. In a somber dialogue between Archibald and the hospital administration, he advises the head cardiologist, Doctor Turner, to proceed with the life-saving procedures by putting his son on a heart transplantation donor list. His request is met with opposition from the hospital director, who explains that other considerations must be made before “a prospective recipient can be placed on a donor list. Transplant surgery is very expensive, in most cases prohibitively so.”

John replies, “...We got insurance, major medical, he's covered.”

“We've already checked with your carrier, Mr. Archibald. There are no provisions in your policy for a procedure of this magnitude.”

John and his wife exclaim with bewilderment, “But we got insurance.”

Unsympathetically, Ms. Payne, the hospital director, declares, “that may very well be, Mr. Archibald, but in the meantime, I'm afraid we're going to have to treat this as a cash account.... We require a down payment before we can put a patient's name on a receiver's list...thirty percent—approximately \$75,000.” She continues with even less enthusiasm, “it costs money to provide healthcare. It's expensive for you, it's expensive for us.”

In a state of defeat, Archibald and his wife encounter another cardiologist as they leave the hospital. She clarifies, “talk again to the insurance company. Check with our human resource department for medical assistance; there's the money there. There are children state services, and there's Medicaid. You find a way to keep [Mike] here. Just don't take ‘no’ for an answer.”

The Archibalds begin the quest for medical aid, which commences with the insurance carrier, who informs them that their policy was changed from a PPO to an HMO to reduce costs. After an exhaustive, discouraging search for coverage, and failure to raise the required \$75,000 to keep Mike in the hospital, John takes the hospital emergency room hostage out of desperation to save his son's life. Amidst the crisis in the ER, John's colleague and good friend James Palumbo declares in an interview outside the hospital, “I got to be honest, this whole thing sucks. I mean, it all could've been avoided so incredibly easily. I mean, none of this had to happen if John had just been a freaking millionaire, right? Or if his name was Rockefeller.... There's a lotta people out there

who don't got \$250 grand in their bill fold. To shame a man like that and back him into a corner, seems to me that something is outta whack, not someone...."

Although *John Q* fictitiously displayed a radical approach to obtaining healthcare, the film demonstrated the desperation of, and unfairness to, those in our society who are unable to pay for medical treatment. Unfortunately, as Dr. Dan E. Jones, Political Science Professor at the University of Utah and professional pollster, once stated, "people don't care about health insurance until they need it and don't have it" (Cassavetes 2002). " (2004). Thus, this essay provides three objectives. The first is to define the uninsured, and the increasing barriers faced by the uninsured and underinsured in their search for hospital care, including recent discoveries behind aggressive hospital billing practices. The second objective of this essay is to determine the obligation of hospitals to care for the medically uninsured, and will provide by providing comparative data for between not-for-profit hospitals and compared to for-profit hospitals, as well as and to explain the federal standards and obligations required of tax-exempt hospitals. Finally, this essay provides information on from an independent survey, conducted by the author, of Utah's not-for-profit and for-profit hospitals, in an effort to determine if Utah hospitals are fulfilling their charitable responsibilities.

DEFINING THE MEDICALLY UNINSURED

Clarification of terms is important to understand the difference between the uninsured, underinsured, and insured, although the uninsured and underinsured are often referred to together. To note, the political terminology for the uninsured is "medically uninsured."

The medically insured (hereafter referred to as "insured") are those individuals "whose interests are protected by an insurance policy, or a person who contracts for an insurance policy that indemnifies him against loss of...health" (WordNet 2004). A medically underinsured individual (hereafter referred to as "underinsured") is defined as one who has some health insurance, which would cover catastrophic events, but not enough to cover all healthcare needs and costs. An individual known as medically uninsured (hereafter referred to as "uninsured") lacks health insurance of any kind (Robert Wood Johnson Foundation 2004). For further reference, the term uninsurance refers to the adjective of uninsured.

REASONS FOR UNINSURANCE

The number of uninsured individuals has exceeded 44 million in the United States. Although it is difficult to determine why each of the 44 million is uninsured, there are two universally-accepted reasons. The first reason is the soaring cost of health insurance premiums that many individuals cannot

afford. Second is the lack of employer-based healthcare. Due to the high costs of health insurance premiums, a number of small business employers do not provide insurance to their employees. Much like the fictitious John Q. Archibald, nearly 70 percent of the uninsured are employed, but either lack coverage or the necessary benefits to provide them with needed care.

Kaiser Family Foundation and Health Research and Educational Trust Although it is true that "not all employees are eligible for their firm's health benefits and not all who are eligible choose to participate in them" (Kaiser Family Foundation and Health Research and Educational Trust [KFF] 2003 Kaiser Foundation 2003, , 50)," statistically it is proven that fewer employers are offering benefits to their employees. In 2003, the number of companies, with 3 three to 9 nine workers, that offered health benefits was only 55 percent, the lowest percentage since 1996. 65 percent of all small firms in 2003, comprised of 3 to 199 workers, offered benefits, again, the lowest since 1996. In contrast, 98 percent of all large firms of 200-plus workers offered health insurance in 2002 and 2003, ironically the lowest percentage in over seven years (Kaiser Foundation KFF 2003, 41).

The consequences of the uninsured on the community are not difficult to identify. Where there are disadvantaged individuals, the immediate community will be indirectly responsible for the deficit. Such costs to the community occur not only in healthcare, but in education, housing, and other lost community benefits.

OPTIONS FOR THE UNINSURED

The government has provided a number of programs to protect the indigent, among which are the Federal Government's Medicaid and Medicare programs, which provide government subsidies to the poor, elderly, and disabled. The eligibility standards of many government-provided healthcare programs are contingent on income level. As previously mentioned, many individuals without health insurance are employed. Many of them do not and cannot qualify for the meager income levels that would allow them to receive care under Medicaid, the federal program for the poor.

For example, an individual with an annual income of \$8,980 would meet the Federal Poverty Guidelines at 100 percent. A family of three with an annual income of \$15,260 would also be at 100 percent of the Federal Poverty Level (FPL). And a family of four with an annual income of \$18,400 would be at 100 percent of the FPL. These individuals or families would likely be eligible for the Medicaid program, which has been designed to benefit the severely indigent. Realistically, though, many individuals and families have income above 100 percent of the FPL, yet cannot afford health insurance.

The dilemma occurs for individuals and families who do not meet these criteria: they have a minimal income, do not

receive health insurance through employment, cannot afford the high monthly health insurance premiums, and do not qualify for government-assisted programs. In a state of medical emergency, like that of the son of John Q, the ability of these individuals to pay for hospital and medical care is questionable.

HOSPITAL CHARITY CARE

In addition to the Federal Medicaid and Medicare programs, the government has provided a way in which institutions may receive benefits for providing care to the uninsured and underinsured. Through not-for-profit hospitals (NFP), which are generally 501(c)(3)s entities, the U.S. tax code provides NFPs with certain tax exemptions, for which these tax-exempt hospitals are required to provide charity care.

Community care, used interchangeably with charity care, is defined as various physician and hospital-related services provided at discounted or zero cost to uninsured or underinsured individuals who are unable to pay for the care (Academy Health 2003). In return, hospitals receive government funding and/or extensive tax benefits on the condition that they provide community benefits.

COMMUNITY CARE PROGRAMS

Many states rely on safety-net hospitals, which to receive funding from the government. These funds are proportionately provided through Medicare and Medicaid. In their 1999 report, Fagnani and Tolbert (1999) explained the importance of safety-net hospitals and their funding structure in their 1999 report on safety-net hospital reimbursement rates through Medicare and Medicaid:

“To ensure access to care for these people, our nation relies on a network of hospitals and health centers—so-called “safety net hospitals”— whose members are willing to provide care to anyone in need, regardless of their ability to pay. These providers receive subsidies to compensate them for the non-reimbursable care they supply. The major sources of such financing are the Medicare and Medicaid Disproportionate Share Hospital (DSH) programs, along with appropriations from state and local governments.”

Whereas Federal DSH programs directly subsidize safety net hospitals for care provided to the elder and indigent, NFP hospitals must qualify as a charitable organization that will provide for the community in order to receive tax exemption benefits as a 501(c)(3). The tax benefits provide 501(c)(3)s exemption from federal income taxes, state and local income taxes, sales taxes, and property taxes (Community Catalyst 2003, 9). NFP hospitals currently make up 85 percent of the nation’s 5,000 hospitals (Abelson, 2003). Therefore, community care initiatives are dependent upon the obligations of NFP hospitals.

Historically, the quintessence of hospitals was to provide free or reduced-cost care to the maximum level of each hospital’s financial ability. This provision, however, has become less definitive and demanding, which is why 501(c)(3)s—in

addition to the tax benefits they receive—are required to fulfill certain charitable obligations. Various ways in which these hospitals provide care include, but are not limited to: free care, discounted care, community outreach initiatives, and teaching programs.

Free care is the medical treatment provided by a hospital without the expectation of payment. It is provided without proof-of-payment and upon determination of eligibility (Community Catalyst 2003, 12). Similar to free care is reduced-rate care, which discounts services provided to uninsured or underinsured patients that are determined to be unable to pay. Many hospitals provide community outreach programs. These programs might include free screenings, such as breast cancer or blood pressure screenings, and eye and hearing tests that are advertised and free to the community. Lastly, teaching hospitals generally require a certain number of hours of free services provided to the community. Teaching hospitals usually have the highest number in charity care hours and free services provided.

FOR-PROFIT VS. NOT-FOR-PROFIT (NFP) HOSPITALS

Hospitals are generally classified as either not-for-profit or for-profit. Whereas many NFP hospitals receive tax-exempt status under the federal tax code 501(c)(3), for-profit hospitals do not receive tax benefits. Many policy issues are raised with regards to NFP obligations to charity care. If NFPs are expected to provide hospital care to patients, similar to the son of John Q. Archibald, the question of whether they are giving back sufficiently to the community to justify their tax-exempt status is raised. Furthermore, have the requirements for NFP status been lowered to such an extent that it gives them an economic advantage over the for-profits, who are also expected to provide various community services under federal law? In response, Nesvisky argues that

“Statistics indicate that the amount of uncompensated care provided by NFP and for-profit (FP) hospitals is comparable in similar social and physical environments.... [On] average, NFP hospitals tend to treat slightly less difficult cases than FP hospitals. Such findings suggest that for-profit hospitals deserve attention when they claim tax-exemption spells unfair advantage for NFP’s in the market place” (2004).

The tax tax-exempt status has evolved through court action over several years. A recent case that involved the prominent Utah health maintenance organization (HMO), Intermountain Health Care (IHC), in *IHC Health Plans, Inc. v. Commissioner of Internal Revenue* (Nos. 01-9013 to 01-9015), defined the qualifications of a tax-exempt entity (*IHC Health Plans v. C.I.R.* 2003, 1188). The respondent, Commissioner of Internal Revenue (CIRC.I.R.), clearly defined a charitable institution as one that “serves a public rather than a private interest” (*IHC Health Plans v. CIRC.I.R.* 2003, 1194). A level of quid pro quo reciprocity is expected of a charitable organization in exchange for its tax-

exempt status. The most essential criterion in granting tax exemption is to determine if a hospital operates for those unable to pay for services and not exclusively for those who are able and expected to pay.

CURRENT 501(C)(3) REQUIREMENTS

NFP organizations today are required to adhere to a less restrictive rule in order to maintain tax exempt status. The respondent in *IHC Health Plans v. C.I.R.* stated,

“Difficulties will inevitably arise in quantifying the required community benefit. The governing statutory language, however, provides some guidance. [A]n organization is not entitled to tax exemption unless it operates for a charitable purpose. Thus, the evidence of some incidental community benefit is insufficient. Rather, the magnitude of the community benefit conferred must be sufficient to give rise to a strong inference that the organization operates primarily for the purpose of benefiting the community” (*italics in original*) (*IHC Health Plans v. C.I.R.* 2003).

Moreover, “under section 501(c)(3), a healthcare provider must make its services available to all in the community plus provide additional community or public benefits” (*IHC Health Plans v. C.I.R.* 2003, 1198).

In February 2001, the Internal Revenue Service (IRS) recognized the need for clarification of requirements of tax-exempt hospitals; therefore, the IRS “issued a ‘field service advice’ memo on the charity care obligations of nonprofit hospitals” (Hodin 2001). Portions of the “field service advice” memo were published by Community Catalyst, entitled “Hospital Charity Care/NonProfit Status: Internal Revenue Service Issues Guidance on Nonprofit Hospitals’ Charity Care Obligations” (Hodin 2001). The Community Catalyst reports:

“In the memo, the IRS advises its field agents that hospitals may be required to demonstrate that they provide charity care in order to retain their tax-exempt status. According to the memo, ‘a hospital’s mere assertions that it has a policy to provide health care services to the indigent is not sufficient to establish that the hospital meets the charity care requirement of the community benefit standard. Instead, the hospital also must show that it actually provided significant health care services to the indigent (*italics added within text*).’ The memo then provides fourteen questions that IRS agents should ask a nonprofit hospital in order to ascertain whether and to what extent it provides charity care, including:

- Does the hospital broadcast the terms and conditions of its charity care policy to the public?
- Does the hospital maintain and operate a full-time emergency room open to all persons regardless of their ability to pay?
- What inpatient, outpatient, and diagnostic services does the hospital actually provide to the poor or indigent for free or for reduced charges?” (Hodin 2001)

While these guidelines indicate the level of charity care required for tax-exempt status, many hospitals have not

adhered to, and continue to ignore the advisory guidelines. They struggle to provide, at minimum, four percent of their total revenue in charity care, which is needed to maintain tax-exempt status. According to a report published by Community Catalyst, (2003), Inc. in October 2003, many not-for-profit hospitals are not giving back to the community because many low-income individuals who utilize hospitals are not made aware of various programs to help them receive care or pay medical bills (Community Catalyst 2003).

According to Don Mantyla, a Certified Public Accountant and President of Mantyla, McReynolds and Associates CPAs, the tax savings a tax-exempt entity may save is roughly 40 forty percent in tax exemptions. Simply stated, for every one dollar in net income, an organization would likely pay 40 cents in taxes. In addition, an exemption for state property taxes can be estimated at another five percent of net income (Mantyla 2004). However, it must be noted that these figures are an estimation of possible tax savings, and not a certification of savings; they may also not apply to every tax-exempt organization, but are a general estimate. Recognizing the tax savings received from claiming 501(c)(3) status is key in debating how much charity care a tax-exempt entity, particularly a hospital, should provide, and if current practices are enough.

As to the amount of community care provided by NFPs, statistics are difficult to come by. Dr. Anthony Tersigni, CEO of Ascension Health, a large national hospital chain, testified before a congressional subcommittee that his company’s mission is to “serve those who are poor and vulnerable” (U.S. House Energy & Commerce Subcommittee Hearing 2004). Ascension spent \$500 million in 2003 in charity care and community benefits. He assured the House Energy and Commerce Subcommittee that the company will write off hospital charges to the indigent that are at or above the federal poverty level (FPL), although he did not specify the exact percentage above the FPL (U.S. House Energy & Commerce Subcommittee Hearing 2004). Similarly, Mr. Fetter of Tenet Healthcare confirmed that Tenet does provide an uninsured discount program that offers a price discount, similar to those negotiated by HMOs for their members, to the uninsured (U.S. House Energy & Commerce Subcommittee Hearing 2004).

HOSPITAL BILLING PRACTICES

Although all hospitals are required to provide emergency room service to anyone seeking medical attention in an emergency under the 1986 federal law EMTALA (Emergency Medical Treatment and Active Labor Act), NFP and for-profit hospitals have recently come under scrutiny for their unfair hospital billing practices toward hospital patients, including ER patients, which inflates the costs of hospital services (Centers for Medicare & Medicaid Services (CMS)EMTALA, Centers for Medicare and Medicaid Services 2004). As stated previously, 501(c)(3)s are required to fulfill certain

charitable obligations in exchange for the tax benefits they enjoy. They are required to not only provide free and discounted care to qualifying individuals, but to make their various programs known to all prospective patients.

UNCOMPENSATED CARE AND INFLATED HOSPITAL RATES

501(c)(3)s are required to disclose the amount of charity care they provide each fiscal year. However, what is defined as charity care has become a point of controversy due to uncompensated care. Uncompensated care, also known as “bad debt,” is care for which the hospital was unable to receive payment, and ultimately writes off the outstanding charges. It is argued if uncompensated care should be configured with other charitable activities, since it was not initially intended as charity care. Because uncompensated care is the result of outstanding bills that are discounted after collection attempts are unsuccessful, advocacy groups argue that it should not be considered part of the total amount of charity care a hospital provides. Furthermore, horrific stories relating to the aggressive, unethical treatment by hospital collection agencies toward uninsured patients have emerged.

In June 2000, Marlin Bushman, a truck driver from Champaign-Urbana, Illinois, was awakened to the police pounding at his front door. Upon answering the door he was arrested for missing a court hearing that was scheduled for an outstanding hospital bill of \$579. Mr. Bushman was booked at the local jail and guaranteed discharge upon payment of \$2,500 (Lagnado 2003, A10).

The same hospital chain obtained an arrest warrant for Kara Atteberry, an uninsured single mother. Ms. Atteberry had incurred a \$1,678 hospital debt due to a miscarriage. After missing two court-ordered appearances, she too was arrested. Her hospital fees then totaled \$2,070.

Mr. Bushman and Ms. Atteberry had both initially attended their court appearances, at which an attorney for the hospital worked out an unfeasible payment plan. When they were each served with another court-ordered appearance after failing to meet the terms of the payment agreement from the first court date, Mr. Bushman and Ms. Atteberry failed to meet their second appearances. They both expressed a fear of having no representation on their behalf and again facing “the whole hounding process” (Lagnado 2003, A10). Mr. Bushman and Ms. Atteberry are not alone; they are among the 44 million uninsured individuals in the United States. Worse, Families USA reported that 82 million people were uninsured at some point within the past two years (U.S. House Energy & Commerce Subcommittee Hearing 2004).

Although such practices seem harsh and irrational, it has come to the attention of the public, as well as the United States Congress, that many hospitals have participated in unfair and aggressive billing practices to retrieve outstanding bills from the uninsured. A number of hospitals have been charged with putting liens on patients’ homes and garnishing wages. The effects have been devastating; many individuals have declared bankruptcy (Community Catalyst 2003, 31).

The media and patient advocacy groups have responded by publishing reports and news articles exposing hospitals that have unjustly billed uninsured, indigent individuals. Their findings indicate that many hospitals bill the uninsured anywhere from a 310 percent to a 1,000 percent mark-up of the charge master price (U.S. House Energy & Commerce Subcommittee Hearing 2004). The charge master price is the catalog price of all services and supplies offered at a hospital.

Unlike the uninsured that have no one to negotiate on their behalf, health maintenance organizations (HMOs) negotiate hospital prices lower than the charge master price in behalf of their insured. Likewise, individuals who qualify for government-funded Medicaid or Medicare programs are also protected by a third-party to bargain for lower hospital charges. Because the uninsured have no one to advocate their cause, they are often charged such outrageous mark-up prices. Worse, the uninsured who could likely qualify for low-income and uninsured programs are not informed of existing charitable programs, or of hospital obligations and policies.

GOVERNMENT INVESTIGATIONS AND LEGISLATION

In order to address discrepant hospital charges and unfair billing practices, Congressman Joel Hefley (R-CO), introduced H.R. 4092, the “Hospital Billing Fairness Act of 2004” on March 31, 2004. This legislation proposed to “amend title XIX of the Social Security Act to require fair billing for hospital services provided to uninsured patients as a condition of Medicaid funding for a hospital” (Hefley Hospital Billing Fairness Act of 2004).

“H.R. 4092 would amend the Social Security Act to limit such charges to individuals without insurance to 125 percent of the *Medicare* rate, as a condition for receiving *Medicaid* funding” (Washington Outlook 2003). The Act

“would require hospitals to apply for and receive federal certification of “fair billing practices,” with non-compliance civil penalties in the neighborhood of three times an “overcharge” amount.... In effect, [Representative Hefley’s bill would] condition eligibility for Medicaid payments on hospitals’ commitment to cap charges to the uninsured at *no more than 25 percent* more than that which Medicare is charged” (emphasis in original) (Washington Outlook 2003).

The government has further investigated hospital billing practices by producing a series of hearings related to the fair practices of hospital billing. On June 24, 2004, the United States House of Representatives Energy and Commerce Subcommittee on Oversight and Investigations held a hearing entitled “A Review of Hospital Billing and Collection Practices,” to address the unfair billing practices of the uninsured. The hearing came in response to raised “public health and consumer protection issues,” as stated in a letter sent to twenty national hospital chains on July 16, 2003 (Washington Outlook 2003).

Among those that testified at the hearing were the top officials and directors from the nation’s leading hospital organizations and academic institutions, including Mr. Jack

Bovender, Jr., Chairman and Chief Executive Officer of Hospital Corporation of America (HCA); and Dr. Sara Collins, Senior Program Officer of the Commonwealth Fund.

During the hearing, Dr. Gerard Anderson, Director at Johns Hopkins Schools of Medicine and of Public Health, testified that only one in twenty-three self-pay or uninsured patients is able to negotiate lower hospital bills. Sadly, nearly half of all bankruptcies are due to medical bills. Mr. Mark Rukavina, Executive Director of the Access Project, further reported that half of Americans had problems with medical debt, many of whom used all or most of their life savings to pay for medical bills (U.S. House Energy & Commerce Subcommittee Hearing 2004).

The legislation introduced by Representative Congressman Hefley, and the hearing by the House Energy and Commerce Subcommittee, were in response to a series of newspaper articles in the *Wall Street Journal* and the *New York Times*, nearly a year-and-a-half after they were published, regarding the billing practices of the Yale-New Haven Hospital in New Haven, Connecticut (Community Catalyst 2003). The articles exposed the collection practices at Yale-New Haven and other U.S. hospitals of, which included putting liens on homes, wage garnishments, and jail time, were among the collection practices at Yale-New Haven and other U.S. hospitals in order to retrieve bad debt. Such practices were the cause of financial turmoil among many individuals that had filed for bankruptcy. The news of such discrepancies practices quickly spread, causing an eruption of uncovered information and new committees to investigate the motives behind the harsh hospital billing practices.

THE HOSPITAL INDUSTRY'S REBUTTAL

To refute allegations of harsh and unfair billing practices, representatives for the hospitals have rebutted:

"[Hospitals] say they are forced to recoup every dollar they can because health-care costs are soaring, and insurers and the government are cutting their reimbursements for services. Hospitals have also been squeezed by the rising numbers of the uninsured...who often don't pay their bills. Hospitals say they shouldn't be forced to bear the disproportionate financial burden of a national crisis" (Lagnado 2003).

In defense, hospitals operate as in a business that requires profit and need to make money in order to provide services to the insured and uninsured alike. Hospitals claim that "you can't solve the issue of millions of uninsured by simply turning to hospitals whose financial conditions are quite fragile and say, 'You do it,'" stated by Howard Peters, Senior Vice President of the Illinois Hospital Association (Lagnado 2003).

The policy question is how to fairly apportion limited hospital resources between uninsured and insured individuals, in order to provide hospitals with reimbursement rates that will compensate them for their services without mistreating any one group. Recent articles published in Utah's newspa-

pers also sympathize with burdensome charity care practices (Lampros 2004). In order to compare Utah hospitals with those of the nation, the remainder of this study will focus on Utah and its uninsured.

UNDERSTANDING UTAH'S POPULACE

In 2002, Utah was one of nine states whose poverty rate increased. More than 24,000 Utahns, mainly two-parent households, were considered poor. Three in four impoverished families in Utah in 2002 had a working member in the household (Utah Department of Health and Human Services 2003, 3). Ironically, the greatest economic insecurity is rising among middle-class whites. Consequently, bankruptcy has become common-place among middle-class Utahns. In fact, 1 in 36.7 Utah households have filed for bankruptcy, the highest in the nation. Among the reasons for these statistics are unemployment rates and soaring healthcare costs (Utah Department of Health and Human Services 2003, 9).

UTAH'S UNINSURED

"According to the United States Census Bureau, approximately 335,000 Utahns are uninsured" (Health Access Project/Community Need 2003). Statistically, estimates for Utah's uninsured vary drastically. The Current Population Survey estimates 13.4 percent of Utah's population as uninsured; whereas, the Utah Department of Health's *Health Status Survey* estimates a four percent difference, with just nine percent uninsured (Utah Department of Health and Human Services 2003, 22).

In spite of the discrepancies in reporting, it is apparent that a number of Utahns lack health insurance and/or access to health care. The effects of uninsurance on the community can be burdensome, as stated by the Poverty in Utah 2003 report:

Uninsured Utahns are less likely to have a regular source of care and more likely to delay or go without needed care. This has serious health and economic implications: health care delivered in emergency rooms at later stages of illness can be four times as expensive as primary care, and these additional costs are passed along to private payers or to the state and federal government as uncompensated care. Importantly, the vast majority of Utah's uninsured, 76 percent, are working either full-time or part-time or living in households with workers (Utah Department of Health and Human Services 2003, 24).

In order to provide for uninsured individuals who cannot afford health insurance, including the 76 percent of workers who are not eligible, or are not provided health insurance through their employers, Utah has developed two programs that work together for those who do not meet FPL guidelines to qualify for Medicaid. These programs are the Primary Care Network and the Health Access Project.

UTAH'S HEALTHCARE PROGRAMS

The Primary Care Network (PCN) extends healthcare access to individuals at or below 150 percent of the FPL. The PCN provides coverage for certain services, although many services are not covered. Basic services may include physician office visits, hearing and vision screenings, very basic dental care, emergency care, lab and x-ray, and prescription drugs (State Coverage Initiatives 2003, 1).

The PCN provides four enrollment periods per year, after which, it does not allow new enrollees. Furthermore, unmarried individuals without dependant children must wait for a specified enrollment period to apply. Because the PCN does not cover inpatient care, critics have discarded the PCN as a solution to extending health insurance to the uninsured. Individuals who qualify for PCN are required to pay a \$50 enrollment fee, in addition to co-pays, which is argued to be beyond what the indigent can pay. Lastly, PCN enrollees must rely on charity care for services that are not included in the PCN.

The Health Access Project (HAP) was "established in 2001 through a federal Community Access grant provided to fulfill community healthcare services to the uninsured" (Utah Department of Health and Human Services 2003, 28). HAP negotiates with medical providers and facilities in the community to donate services to uninsured individuals who are ineligible for all federal and state programs, and for services not provided to enrollees of the PCN. In some regards, the HAP fills in some of the requirement gap of 501(c)(3) hospitals to provide charity care.

UTAH'S HOSPITAL SYSTEM

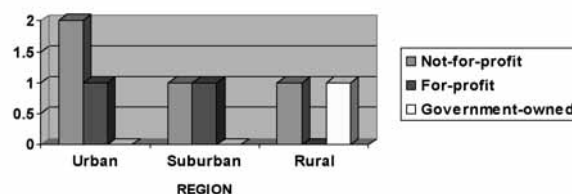
A number of Utah hospitals receive federal tax exemption status, 501(c)(3). In addition, they receive a significant portion of their funding from government programs like Medicaid and Medicare. How much free care do these hospitals provide? Do tax-exempt, not-for-profit (NFP) hospitals in Utah provide more charitable services than Utah's for-profit hospitals? In order to determine the hospital practices and procedures, and charity programs available to Utah's uninsured, seven interviews were conducted with different hospitals in various parts of Utah.

METHODS

A purposive, nonprobability sample was conducted from a sampling frame that was reviewed and narrowed from 95 listings to 64 to represent only hospitals, medical centers, and surgical centers in Utah. The sampling frame, which included a list of billing departments of various Utah hospitals, including some billing departments for the Mountain West Region outside of Utah, was provided for the purpose of retrieving billing information for medical claims. The sample population was drawn from among the 64 hospitals in the study population, which was narrowed to 12 hospitals through a judgmental selection to achieve a sample population representative of the total study population.

Although one sample bias was eliminated by extending the sampling frame beyond the members of the Utah Hospitals and Health Systems Association, which includes only 42 of Utah's hospitals and medical centers (Utah Hospitals and Health Systems Association 2005, <http://www.uha-utah.org/members.html>), another sampling bias may have occurred within the method of selection. Of the 12 hospitals in the sample population, seven responded to the survey interview questions. For purposes of the study, a single-blind idiographic telephone survey was conducted, with the identity of the researcher remaining anonymous to the respondent. Among the seven hospitals that responded, four were NFP and three were for-profit hospitals. Three of the hospitals were from the same NFP hospital chain. Two hospitals were unclassified, one was from a chain of for-profit hospitals, and one hospital was a teaching hospital. The seven hospitals that responded represented three regions of Utah: rural areas; middle-class income and homogenous suburban regions; and low-income and densely-populated urban

Figure 1. Hospital Response Rate By Tax Status and Region



regions of Utah. The results are shown in Figure 1.

The idiographic survey questions were developed with assistance from the Community Catalyst report (2003), and from the article "Hospital Charity Care/Nonprofit Status: Internal Revenue Service Issues Guidance on Nonprofit Hospitals' Charity Care Obligations," also published by Community Catalyst. The survey instrument included the following questions:

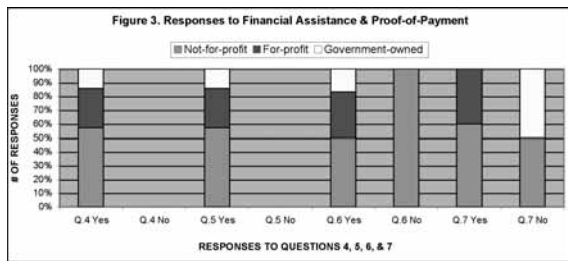
HOSPITAL STUDY SURVEY INSTRUMENT

Does the respondent's hospital/institution:

1. Provide free care if someone's income is limited?
2. Provide reduced-care if someone's income is limited?
3. Have a charity or free care policy?
4. Provide financial assistance, such as payment plans?
5. Employ a financial counselor to work with an individual's financial situation?
6. Provide care to an individual regardless of proof-of-payment in an emergency situation?
7. Require a deposit to provide care?
8. Require an application or other paperwork to receive care?
9. At what point does the paperwork need to be completed before services are rendered?
10. Have a written free care/charity care policy you can mail, fax, or email me, or one that I may pick up?
11. What services are covered under the charity care program?

RESULTS

The results of the surveys varied from hospital to hospital, regardless of the hospital chain and tax status of each hospital. In addition, contact with five additional Utah hospitals was attempted, but phone calls were not returned. Three of the five hospitals were NFP from the same hospital chain, while the other two hospitals were for-profit facilities, from different hospital chains. Figures 2, 3, and 4 describe the responses to the survey instrument. The question responses correspond to the question numbers in the survey listed above.



As shown in figures 2, 3, and 4, the answers were rather insignificant between NFP and for-profit hospitals. In contrast to the initial hypothesis that NFP hospitals would be more helpful and informative, the hospital that was most direct and accommodating in terms of thoroughly explaining the services that might be covered, the available programs, and the steps that must be taken prior to, during, or after services rendered was the urban for-profit hospital. Incidentally, the same hospital was one of two hospitals (the other a NFP hospital) to explain that everyone is admitted to the ER regardless of ability to pay or proof-of-payment. As well, payment is discussed with a financial counselor to assess financial need after admittance to the hospital.

Six of the seven hospitals inferred that paperwork, including proof-of-payment was necessary in order to receive care. The most astounding information discovered was the fact that none of the hospitals contacted had information on their charity care programs. None of the seven hospitals had any printed information that could be provided to a potential or admitted patient. Furthermore, three of the hospitals' front-line people—defined as the initial hospital staff that was contacted regarding financial aid and assistance—were unaware of any free care or charity care policy, much less any written policies. The other four hospitals claimed that anything written, other than a hardship application, SFCA

(Special Financial Consideration Application) form, or Medicaid forms, did not exist. One NFP hospital declared that there are no written charity care policies posted within the hospital.

In contrast with the hospital survey results, newspaper articles recently published in Utah papers declare that Utah hospitals contribute millions of dollars in charity care every year to patients who are unable to pay, which is burdening the system (Lampros 2004). Although this essay does not contest the amount of charity care provided by these hospitals, it is questionable as to why NFP hospitals, who receive generous tax exemptions, are insignificantly distinguishable from for-profit utilities. Furthermore, Utah's NFP hospitals are reported as feeling overburdened with charity, yet the amount of care appears to be relatively equal to for-profit hospitals.

CONCLUSION

In response to the various questions posed in the introduction, the epidemic of uninsurance will continue to create controversy until our uninsured are insured. The hospital industry will continue to write-off bad debt incurred by the uninsured while Americans and Utahns alike are without health insurance. Employers may respond by providing health insurance to their employees. Nevertheless, an employer's generosity will not solve the uninsurance conundrum.

Thus, we turn to hospitals. Hospitals are obligated to provide community benefits and charity care to individuals. It is my assessment that 501(c)(3) entities are not fulfilling their obligations to their communities. Not-for-profit hospitals who receive charitable tax-exempt status should provide significantly more than they are currently giving. With consideration of the hospital industry's (speaking of NFP hospitals) excessive net income, with respect to the tax benefits they receive, no argument can outweigh their charitable obligations.

In addition, the study conducted of Utah hospitals finds that many hospitals—holding the NFP more liable—are not doing their part by providing information to the uninsured and indigent in Utah. Although the hospitals claim to provide charity care, many, if not most, individuals are unaware of such existing programs. Hospitals are fiscally compensated with the understanding that they must act as a "charitable" institution, and further provide charity benefits, which also includes providing information to the community about available programs that provide reduced-cost or free care to the uninsured and indigent.

Because such entities are not fulfilling their obligations, many outstanding hospital medical accounts are the cause of bankruptcy and bad credit ratings among the uninsured and indigent. However, this article does not intend to discount the small acts through which hospitals give back to the community; Utah's hospitals are among those that provide some charity care. However, given the statistics of this study, and

the amount of care that is not provided that could and should be, the conclusion is that the amount of community care given to Utah patients is not proportionately great enough to justify federal 501(c)(3) status, which provides significant tax benefits. It is suggested that the obligations of a 501(c)(3) hospital are more proportionate to the tax benefits received. Furthermore, it is proposed that the government more clearly define "charitable contribution" and charity care, in addition to regulating the actions of the many 501(c)(3)s that are currently in operation.

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