

A Debt Unpaid:

Nonprofit Hospitals Fail in Their Community Benefits Mission

By Holly Hermon and Lissa Bell

Northwest Federation of Community Organizations
December 1999

Genesis of the Report

This report was inspired by the Community Benefits Roundtable held on August 23, 1999, at the University of Washington. Roundtable participants included researchers, advocates, activists and community members. At the meeting, participants explored the frontiers of public policy on community benefits and the latest developments in community activism around such benefits. Particular attention was paid to developments in the Northwest.

Participants in the Roundtable had this to say about the Roundtable:

“It was great to think about new ways our community can act locally to expand and protect community benefits. For instance, we learned about how the community might pass local zoning ordinances to encourage hospitals to meet their charity care obligations.”

— Kevin Borden, Lead Organizer,
Idaho Community Action Network (ICAN)

“The Roundtable reinvigorated Oregon’s community benefits work in several ways: It revealed by example the power of engaging and building leadership among people who have been affected by hospital collection practices; it also spotlighted a new, potential organizing handle — running leadership for positions on hospital boards.”

— Ellen Pinney, Executive Director,
Oregon Health Action Network (OHAC)

“It was eye-opening to hear what’s happening in other states — to learn, for example, that there are serious efforts to include HMOs in community benefits legislation. In Washington, we’re working to revise our hospital free care law so that it covers all community benefits. We may also want to extend it to cover all health care institutions.”

— Barbara Barron Flye,
Executive Director, Washington Citizen Action (WCA)

“The round table was invaluable in outlining practical approaches to change. Back in Montana, we were able to make immediate use of what we learned; for instance, we organized a Community Forum on Unmet Health Needs modeled on the forum in Lynn, MA, described by round table speaker Renne Marcus Hodin. At the Forum, low-income community members sat with a number of legislators and candidates for office and together identified the unmet health care needs of Missoula residents.”

— Derek Birnie, Executive
Director, Montana People’s Action (MPA)

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I. INTRODUCTION

Community support has long been critical to the survival and health of nonprofit hospitals. Fifty years ago, when funds ran low at St. Luke's, a nonprofit hospital in Boise, Idaho, community members hosted benefit parties and balls to help purchase medical supplies, and on Friday afternoons when the hospital could not meet payroll, generous citizens wrote paychecks to nurses.¹ Today, nonprofit hospitals like St. Luke's continue to receive community help in the form of donations, special tax breaks, government grants and loans, and preferential regulatory treatment.²

Communities across the U.S. support their nonprofit hospitals. They do so, however, with the understanding that, in return, these hospitals will provide certain badly needed community health services. The obligations hospitals have to provide and to underwrite these services is based on a simple understanding: special community support means special community responsibilities.

Over time, this understanding has become institutionalized in the form of hospital community benefits policies and state community benefits legislation. The term "community benefits" has come to refer to certain health services and resources provided, without compensation, by hospitals (and other health care institutions). These services usually help certain individuals (particularly the underserved and uninsured) but at the same time also benefit the community as a whole. They include free care at hospitals (also known as "charity" care), "premium subsidies by insurers or HMOs, health education campaigns, health screenings, free flu shots" and the like.³ Hospitals have a moral and, in some states, a legal obligation to provide these benefits.

Yet, in recent years, nonprofit hospitals have been "trimming indigent services."⁴ By 1993, only four to seven percent of hospital costs were devoted to uncompensated care.⁵ Moreover, the certain hospital practices raise questions about even today's levels of self-reported community benefits; more than a few hospitals, for instance, have included in their community benefits numbers funding for such things as the building of an arts and science

center and flying lessons to drug-free youth.⁶ Even as communities have continued to support hospitals, many hospitals have reneged on their part of the nonprofit bargain. The result is a crisis in community health services.

In the Northwest, community groups are now demanding that hospitals meet their obligations. This paper begins by discussing laws that provide these groups with the legal bases from which to assert the community benefit obligations of hospitals. It then highlights community benefit campaigns in the Northwest, a region particularly active in the community benefits movement. Based on lessons learned in these campaigns, the paper goes on to outline a number of tactics that can be used and opportunities that can be exploited in current or future community benefits campaigns. It concludes by identifying future goals for community action.

II. COMMUNITY BENEFITS AND THE LAW

With the exception of a fairly vague IRS ruling, federal law is silent on the issue of community benefits.⁷ In the absence of a clear federal statute, the responsibility for legislating such benefits has largely devolved to the states. The result is a thin scattering of state statutes, some conceived for the sole purpose of regulating community benefits, others designed with different ends in mind but relevant to community benefits campaigns. In this section, we take a brief look at the array of laws which serve, for community groups, as both levers of change and targets of reform.

1. Community Benefits Laws

The model community benefits act drafted by Community Catalyst and modified by the Northwest Federation of Community Organizations (NWFCO) sets the standard for comprehensive public policy on community benefits. It specifies that:

- Community benefits are "the unreimbursed goods, services and resources provided by health care institutions that address community-identified health needs and concerns";
- Hospitals must conduct a community needs

assessments. As part of this assessment, they must solicit comments from and meet with community groups, among others;

- Each health care institution must make public an annual report following a standardized format that includes a:
 - mission statement
 - report of its community benefit efforts in the preceding calendar year
 - list of new benefit activities proposed for the future
 - analysis of the impact its community benefits have had on community health
 - description of outreach done to community groups
 - set of specific community benefits goals and outcomes
- An oversight agency must “assess a financial penalty against any health care institution failing to file a timely community benefits annual report.” This agency must also “revoke or decline to renew a license or certificate of authority of any health care institution that fails to provide community benefits as required under the Act;
- Health care institutions must select community members to serve on policy-making boards and task forces and must make public the manner in which such community members are to be selected for these positions.⁸

The Model Act has not yet been fully realized in law, but less ambitious community benefits laws have been adopted in eight states: California, Idaho, Indiana, New Hampshire, New York, Pennsylvania, Texas, and Utah. Because most states have no direct community benefits legislation and because, in the eight states that do, this legislation is a far cry from the Model Act, establishing strong community benefits legislation is one of the goals of the community benefits movement.

2. Free Care Laws

Free care — also known as “charity” care — refers to the on-site services hospitals provide, with-

out expectation of payment, to patients who are uninsured and unable to personally pay for their hospital care. Free care is an important component of the community benefits obligations of hospitals. Only a small number of states have free care laws and in most cases these laws are fairly weak and poorly enforced. Nevertheless, where they exist, free care laws provide yet another opportunity for community groups to influence the community benefits practices of hospitals in their cities and towns.

3. Tax Laws

To become a nonprofit — an entity entitled to tax exemption — a hospital must operate solely for the public’s benefit.⁹ Nonprofit hospitals which fail to satisfy the public benefit test may have their tax-exempt status repealed.¹⁰ In the absence of community benefits laws, challenging hospitals’ right to tax exemptions is one avenue of influence available to community groups.

4. Conversion Laws

In recent years, many hospitals have converted from a nonprofit to a for-profit tax status and, in response, many states have passed “conversion” laws. Conversion laws aim in part to ensure that conversions do not run counter to the public interest. In these laws, states rarely define “public interest” in a way that explicitly requires regulators to take a hospital’s community benefits performance into account when ruling on a proposed conversion. Nevertheless, because the basic intent of these laws is to prevent conversions from producing certain harmful effects, they allow community groups the opportunity to make the case that a conversion which hurts community benefits is a conversion harmful to the public interest.

Where strong hospital conversion laws exist, they allow community members to make the case that community benefits are eroding; a conversion without certain safeguards could speed their collapse, and; it is the government’s duty to intervene to ensure these safeguards are put in place. Where such laws are weak or nonexistent, communities can use hospital conversions as occasions for documenting the need for strong conversion legislation.

HOW CONVERSION LAWS CAN BE MADE USEFUL TO COMMUNITY BENEFITS CAMPAIGNS

Conversion laws may contain provisions useful to community benefits campaigns. These include provisions that require:

- a formal process for notifying the public about a proposed transaction. When such notice is required, community members can keep alert for public notifications and respond by researching the proposed transactions and assessing their consequences for the community.
- a formal process for including public participation in the review of proposed conversion transactions. This allows community members to voice their concerns about the transaction to the converting entity, the regulatory agency regulating the transaction and the public at large.
- the converting entity to submit a plan showing the health impact the transaction will have on the community and/or the regulator to conduct such a health impact survey. This provision permits community members to review the converting entity's plans for community benefits and, if these plans are wanting, to demand that these plans be improved.
- the regulatory enforcement and monitoring of the commitments made by the newly-converted for-profit. When regulators are required to do ongoing oversight of the newly-converted for-profit to ensure that it meets any commitments made to the community as a condition of approval, community members can intervene in and contribute to this oversight process.

5. Certificate-of-Need Laws

Certificate-of-need laws can also provide communities with points of leverage in their fights to retain and increase community benefits. Periodically, hospitals plan projects that involve substantial expenditures (e.g., the purchase of major medical equipment, the creation of new health services, the purchase of existing hospitals and facilities, and the construction of new facilities). In states with certificate-of-need laws, hospitals must apply for a "certificate of need" before they can proceed with the project. Thirty-seven states have such laws.¹¹

Strong certificate-of-need laws provide community groups an opportunity to ensure that hospitals meet their community benefits obligations. Where such laws are weak or nonexistent, actions which highlight the unmet community need and the inadequacy of current legislation to protect the community are central to community benefit campaigns.

III. THE NORTHWEST INCUBATOR: COMMUNITIES ACT TO PRESERVE AND EXPAND COMMUNITY BENEFITS

Most of the above-mentioned laws were created for purposes not directly related to ensuring or protecting community benefits. Communities have found innovative ways to use these laws, however, to move community benefits campaigns. These campaigns share one overarching objective: to expand the access of low- and moderate-income people to quality, affordable health care. To achieve this, communities have carefully scrutinized existing statutes and discovered ways to use them to demonstrate that (1) community benefits are a vital source of health care for community members, (2) nonprofit hospitals are neglecting their community benefits obligations, and (3) it is the government's responsibility to intervene and stop this neglect. They have also pioneered strategies for demonstrating the weakness of existing law and, by extension, the need for additional legislative remedies.

The Northwest in particular has been an incubator for innovative work on community benefits. In this section, we present a snapshot of community benefits campaigns in Montana, Idaho, Oregon and Washington, each conducted by community organizations affiliated or partnered with the Northwest Federation of Community Organizations (NWFCO).

1. Washington: Community Members Use Charity Care and Certificate-of-Need Laws to Push for Increased Free Care¹²

For Washington Citizen Action (WCA), health care access for low- and moderate-income people is a central concern. When WCA learned that com-

munity benefits in the state were seriously at risk, they immediately set a community benefits campaign in motion.

The campaign included two strategies: one, use the state's certificate-of-need and free care laws to prevent a hospital from sidestepping its community benefits obligations¹³; two, use aspects of the certificate-of-need law — like its public hearing provision — to raise the awareness of the public and government decision makers about the serious limitations of Washington's current regulatory framework: namely, its inability to ensure that nonprofit hospitals give something back in return for the ample community support they receive.

The first opportunity to engage the strategy came in Winter 1998, when the parent company of Tacoma's Puget Sound Hospital decided to sell the facility. Under Washington's certificate-of-need law, the transaction required approval by the Department of Health (DOH). It also required the parties to submit written information on hospital practices to the DOH in preparation for the sale, information which then became available to the public.

Through these documents, WCA community members discovered a number of facts that allowed them to persuade the DOH to call a public hearing.¹⁴ Based on the documents submitted, WCA argued, Puget Sound Hospital's community benefit and charity care programs violated both the state's free care law and its certificate-of-need law. The DOH should hold a public hearing, members argued, so that the community could make its case.

DOH decided a public hearing was advisable. At the hearing, WCA, in conjunction with several other groups, argued that the hospital's current free care policy clearly violated the state charity care and certificate-of-need laws by:

- requiring a patient seeking free care to submit a written application,
- requiring multiple documents as evidence of a patient's financial status,

ABOUT WASHINGTON CITIZEN ACTION (WCA)

Washington Citizen Action (WCA) is a coalition of church, senior citizen, community and labor organizations concerned about economic justice issues. WCA has been involved in health care issues as well as minimum wage, child care, tax fairness and other low-income and consumer issues. The mission of WCA is to achieve economic fairness and to establish a democratic society characterized by racial and social justice, with respect for diversity and a decent quality of life. WCA's long-term goals are to increase participation in the political processes and to win concrete improvements in the lives of low- and moderate-income families.

- refusing to determine a patient's eligibility for free care without documentation, and
- requiring a financial deposit before admitting a patient, even if the person appeared to be eligible for charity care.

In addition, they argued, by DOH's own calculations, the hospital failed to match or exceed minimum regional averages for free care and thereby violated Washington's certificate-of-need law. Moreover, the prospective buyer had failed to include a plan for reforming the hospital's woefully inadequate free care performance once it purchased the hospital. Absent such a plan, the hospital's illegal practices seemed likely to continue. For all these reasons, WCA argued, DOH should not approve the sale unless the prospective buyer agreed to strengthen the hospital's free care and community benefits policies.¹⁵

WCA community members won their demands: DOH ordered that Puget Sound Hospital must revise its free care policies and increase the amount of free care it provided. It also ruled that, for three years, the DOH would monitor the hospital's free care and community benefits performance for compliance with state requirements.¹⁶

WCA's campaign to hold Puget Sound Hospital accountable to the public under state law was successful. The campaign also sent a message to the

hospital community at large that Washington's certificate-of-need and free care laws should be taken seriously. WCA's success demonstrates that community groups can effectively use such laws to ensure that hospitals fulfill their community benefits obligations.

2. Montana: A Proposed Hospital Conversion Triggers Community Benefits Investigation¹⁷

Montana People's Action (MPA) began focusing on nonprofit health care institutions and community benefits in 1998 when some MPA members reported they were denied home loans because of their unpaid hospital bills. MPA members are low- and moderate-income people, the very people for whom community benefits programs are designed. The fact that they were accumulating crippling hospital debts was a sign that Montana's community benefits system was malfunctioning.

This lead MPA to research the policies and practices of nonprofit hospitals throughout the state. What they found is that many of these hospitals were seriously neglecting their community benefits obligations, and it looked like the situation might only get worse. A trend toward hospital conversions was well underway in other parts of the country and rumors of proposed conversions had begun to appear in Montana. Montana had no conversion legislation, and the experiences of communities in other states showed that conversion legislation was key to preventing conversions from harming the public good.¹⁸

Based on these findings, MPA decided to launch a community benefits campaign. Community members working on the campaign decided on three strategies: (1) demonstrate the need for better local practices by nonprofit hospitals; (2) highlight the failure of current legislation to protect community benefits statewide, and thereby establish the need for legislative change; (3) introduce legislative remedies.

Their first opportunity to act came in March 1998 when St. Vincent Hospital and Health Center, a

ABOUT MONTANA PEOPLE'S ACTION (MPA)

Montana People's Action (MPA) is a community organization of low- and moderate-income and Native American residents of Montana. MPA began to focus on community benefits and nonprofit health care institutions when MPA members began talking about being denied home loans because of their unpaid hospital medical bills.

nonprofit hospital in Billings, announced it planned to convert its nonprofit HMO into a for-profit HMO, and to sell half the new for-profit to Blue Cross and Blue Shield of Montana (BCBSMT).¹⁹

Although Montana has no conversion legislation, it does have a law regulating the sale of health insurance companies. This law required the State Auditor's Office in Montana's Insurance Department to evaluate proposed sales, and more specifically, to evaluate such issues as the fiscal soundness of the new owner and the new owner's ability to operate the entity competently.²⁰ This legislation provided community members with the first 'legal handle' with which to move their campaign forward. MPA argued that the State Auditor should exercise its power under the law to call a public hearing so that community members could express their concerns about health access and the public assets at play in the proposed transaction and so that parties to the proposed transaction could respond to these concerns.

MPA community members wanted a hearing because it would provide a public forum from which to make the case that the St. Vincent's/BCBSMT transaction was a conversion, and a conversion requiring careful scrutiny by the state. It also presented the community with the chance to highlight the larger issue of unmet community health needs and the need for legislative remedies.

The State Auditor agreed to call a hearing. On the day of the hearing, MPA members argued two points: (1) the transaction was a "creeping conversion" — that is, it was one in a series of steps by BCBSMT to transfer some of its most profitable assets to for-profit subsidiaries; (2) the con-

version, because it did not come with a guarantee by the proposed owner regarding community benefits practices, raised concerns about whether community benefits would suffer. They asked BCBSMT and St. Vincent's—the buyer and seller, respectively—to describe how the proposed for-profit HMO would handle health care services to low-income and uninsured people.

The law under which the State Auditor called the hearing did not require the new owners to address these concerns, nor did it require the State Auditor to take these concerns into account when ruling on the case. As a result, MPA members anticipated that BCBSMT and St. Vincent's might very well attempt to sidestep the community's questions and that State Auditor might not insist on an answer. MPA members reasoned, however, that, whatever the outcome, their ends were served. If the parties responded willingly, this amounted to a public admission of their accountability to communities and their community benefits obligations and provided an opening for negotiations. If the State Auditor forced the parties to respond, it meant that MPA had pushed the State Auditor to accept the role of regulator of conversions and community benefits. If the parties failed to respond and the State Auditor permitted this, the MPA demonstrated in a public forum that Montana's current regulatory framework was inadequate to protecting the health care rights and assets of Montanans.

In the end, the State Auditor allowed St. Vincent's and BCBSMT to avoid answering the community questions and approved the transaction. MPA community members then used State Auditor's decision to underscore that Montana's current regulatory framework had gaping holes. Next, MPA worked with the Attorney General to draft and introduce a bill, SB 322, based on model legislation by the National Association of Attorneys General (NAAG).

MPA members were aware that passing this legislation might well require a multi-year effort. With such ambitious bills, gathering supporters and educating legislators about the need for legislation takes time. Added to this was the fact that oppo-

nents spent over \$20,000 lobbying that year.²¹ Hence, when the Montana State Senate rejected the Senate bill, largely along party lines, community members were prepared to continue the effort in the next legislative session. Meanwhile, the first year of legislative work had moved MPA's community benefits campaign forward in several ways: first, community members took the vital step of meeting with their elected representatives and educating these representatives both about the unmet health care needs in their communities and the degree to which the nonprofit hospital system was benefiting from the public purse without public accountability. Second, these members became the core activists in MPA's local community benefits campaign.

With the session over and the Legislature recessed, MPA community members turned their efforts to the local scene—specifically, to improve the community benefits performance of nonprofit hospitals in Billings, Montana, the largest city in the state.

Since 1996, welfare reform has removed many needy families from Medicaid, and the already large numbers of uninsured Billings residents has soared.²² Compounding the problem, MPA discovered a disproportionately high number of bankruptcies among its Native American members in Billings caused by large hospital bills. They set out to find out why and discovered that local non-profit hospitals had no clear community benefits guidelines and so, by default, it was left to individual hospital staff to decide whether a low-income uninsured patient should receive free care. The result was an erratic assignment of community benefits. Those refused charity care were sent bills, and many were sent to collections and, ultimately, driven into bankruptcy.

St. Vincent's Hospital and the Deaconess Billings Clinic are the two major health care providers for Billings residents. MPA asked the two hospitals for documents related to their free care practices which. Despite laws requiring that the requested documents be made available to the public, Deaconess did not provide large sections of the information.

VOLUNTARY COMMUNITY BENEFITS GUIDELINES

The Oregon Hospital Association's Voluntary Community Benefits Guidelines serve as a common template for all hospitals to use in reporting information about community benefits policies and practices. The Guidelines call on hospitals to (1) explain their purposes, goals and commitments for meeting the health and social service needs of the community; 2) describe their process for evaluating the community's health needs and assets; and 3) distribute a comprehensive description of the community benefits they provide. (Categories of community benefits include subsidized medical care, health research); and (4) document the process by which they evaluate the effectiveness of their community benefits To monitor and evaluate the effectiveness of the benefits, the Guidelines recommend that hospitals employ strategies such as post-activity surveying of benefit recipients, the gathering of feedback from community leaders regarding the value of specific projects, and ongoing review of data and information to assess the impact of the benefits provided.

Source: Oregon Association of Hospitals and Health Systems, "Oregon Hospital Community Benefit Reporting: Voluntary Reporting Guidelines 1998."

Nevertheless, Deaconess took MPA's scrutiny seriously enough to request a meeting with MPA community members and went on record publicly stating that concerns over the lack of charity care options in the city had led the hospital to approach MPA representatives for a meeting. The meeting between MPA and Deaconess marks the start of a dialogue between the hospital and the community and, through this dialogue, MPA is pushing for community input into the hospital's community benefits program.

3. Oregon: Focus Groups and Testing Projects Build the Case for Legislative Remedies to State's Community Benefits Problems²³

After hearing stories about hospitals in Oregon sending people to debt collectors because of their inability to pay for health care, the Oregon Health Action Campaign (OHAC) launched a campaign

aimed at increasing the accountability of hospitals for community benefits. The strategy for the campaign was: (1) to research the unmet health care needs in a selected, local community and the community benefits practices of local nonprofit hospitals; (2) to publicize the magnitude of unmet needs and the fact that these needs can be met if local nonprofit hospitals meet their community benefits obligations; (3) through this public awareness campaign, to create the political impetus for statewide legislative remedies, and; (4) to begin the process of legislative reform by introducing community benefits legislation.

The community benefits legislation drafted by OHAC required federally tax exempt hospitals and health insurers to systematically assess the health needs of their communities and to prepare community benefit plans; it threatened civil penalties for noncompliance. While the bill did not make it out of committee, by introducing it — and through it the threat of mandatory regulations — OHAC put pressure on the Oregon Hospital Association to develop what became known as "Voluntary Reporting Guidelines" for all Oregon hospitals. (See box left.) For OHAC, these Guidelines are a compromise, since solutions which depend on self-regulation by business are less preferable than solutions codified in law. At the moment, OHAC members are giving the Guidelines time to work. If they do not work, they plan to go back to the legislature, now with a stronger case for legislative remedies to Oregon's health access crisis.

Meanwhile, at the local level, organizers selected Marion and Polk Counties as the site of one their first local campaigns. Marion County is home to

ABOUT OREGON HEALTH ACTION CAMPAIGN (OHAC)

The Oregon Health Action Campaign (OHAC) is a coalition of individuals and organizations who have come together to empower the consumer voice in the development of quality, responsive health systems that allow all people to access the health care they need, when they need it, from providers of their choice at an affordable cost.

Salem Hospital, a hospital which, despite its healthy profit margins — it is one of the most profitable hospitals in the state — sends over 1,000 bills a month to debt collectors. Also, Marion and Polk Counties have the highest percentage of Hispanics and the fastest growing Hispanic population in the state.

In the first step of the Marion-Polk campaign, OHAC community members recruited county residents to participate in focus groups. This resulted in a health needs assessment that was firmly rooted in the experiences of the community. OHAC then worked with community members to research the free care policies and practices of the three local nonprofit hospitals in the two counties.²⁴ Through this research, participants developed a detailed understanding of the community benefits practices of local hospitals, including the fact that, when faced with potential patients with low incomes and no insurance, none of the hospitals provided information about free care options.

The results of the free care research, particularly the lack of information given out by hospitals, angered and motivated OHAC volunteers. Together, they have initiated a public education campaign. As part of this campaign, they are doing outreach to the community so that residents can learn about the poor state of free care in their community and then can help join in developing the campaign to improve community benefits. In particular, they are reaching out to bilingual and monolingual Spanish-speaking families without health insurance and to people on Medicaid and the Oregon Health Plan, the state-subsidized welfare plan for low-income individuals. Together, community members are now preparing to enter negotiations with targeted hospitals in Marion and Polk Counties to implement accessible and understandable free care policies.

4. Idaho: Direct Action and the St. Luke's Hospital Campaign²⁵

In 1995, with federal welfare reform looming on the horizon and promising to push thousands of Idaho residents into jobs with little or no health

ABOUT THE IDAHO COMMUNITY ACTION NETWORK (ICAN)

The Idaho Community Action Network (ICAN) is committed to progressive social change and to develop the power necessary to create those changes. ICAN works to accomplish our mission by empowering disenfranchised people, developing leadership, and striving to maintain a stable, membership driven funding base, while remaining committed to inclusiveness, the democratic process and non-violent action. ICAN also runs a statewide food program that assists low-income families with their monthly food budget.

insurance, members of the Idaho Community Action Network (ICAN) began to take a closer look at their state's own health care provisions for the low-income and uninsured. What they discovered was a regulatory approach to hospital free care probably unique among the 50 states.

Under this regulatory framework, not only does government fail to require nonprofit hospitals to provide free care, it effectively acts as a collection agency for these hospitals. An individual unable to pay for needed care must apply to the "County Indigency Program." The Program pays the hospital for the cost of care (determined at cost-of-care rates set by Medicaid), but then turns around and assigns a mandatory repayment schedule to the individual and puts a lien on any property owned by that person until the county is fully repaid.²⁶ The patient is not only still loaded down with debt, but has now lost control of what little property he or she may have accumulated, the county is transformed into a collections agency, and the nonprofit hospital is exempted from any financial responsibility to share in community care.

In this context, all it took was a spark to set off a campaign by ICAN members for more humane and more just system of community benefits. That spark came when St Luke's, a Boise-area hospital which had net revenues of \$15.2 million²⁷ — double the national average for nonprofit hospitals²⁸ — announced that it would increase its patient charges by 6 percent.²⁹ Outraged, ICAN com-

munity members began to research St. Luke's and discovered that it spent two times more on interior design than on charity care and that its hefty profit margin was due in part to the almost four million dollars in county property tax exemptions the community granted the hospital that year.³⁰

ICAN immediately launched a community benefits campaign. Community members set four goals for the campaign: (1) bring to the public's attention the fact that St. Luke's was not meeting its community obligations and compel St. Luke's to improve its community benefit policies and to reinvest some of its profits into the community's unmet health needs; (2) increase the decision-making power of communities in the development of hospital community benefit plans; (3) raise awareness about the government's failure to adequately enforce the implicit contract between nonprofit hospitals and local communities in which the public gives special support to nonprofits in exchange for hospitals' providing community benefits; (4) introduce statewide legislative remedies.

Among the first fruits of ICAN's public campaign against was a Primary Care Consortium made up of local hospitals (St. Luke's among them), government representatives, and public interest organizations in Ada County.³¹ The overall goal of the Consortium was to establish a health coverage program which would provide primary care health insurance for low-income families in Ada County.

Even as the Consortium began to develop its plan, ICAN found unexpected allies among the Ada County Commissioners. St. Luke's and Ada County had been coming into increasing conflict over the hospital's approach to community benefits and its tax exempt status. The county determined that St. Luke's was perfectly capable of providing community benefits to low-income, uninsured patients. (The hospital had recently built a multimillion dollar facility in Meridian, just west of Boise, and was planning expansion into Twin Falls in Eastern Idaho and Sun Valley in Central Idaho.³²) Rather than providing these benefits, however, it was systematically passing along the cost of caring for low-income, uninsured patients to the county by directing these patients to the

County Indigency Program.³³ The County Commissioners saw the county's indigency program a source of last resort, to be used only when all other sources of help have been exhausted. The conflict between the county and St. Luke's came to a head when St. Luke's filed its annual request for a property tax exemption with the Ada County Commission. The county responded by denying the hospital's application for property tax exemption, disallowing \$3.5 million dollars worth of tax breaks.³⁴

Following this and subsequent rulings, St. Luke's (along with St. Alphonsus, another Ada County nonprofit hospital) abruptly withdrew from the Consortium and the Consortium's plans for countywide health coverage for low-income families. ICAN community members responded immediately by inviting the press to attend as it delivered a "Get Well" card to St. Luke's ailing charitable mission. This well-publicized and very public shaming finally drove St. Luke's and St. Alphonsus to establish what the hospitals called a "Health Access Program."

While the Health Access Program addressed some of St. Luke's community benefits obligations, it lacked key features of a comprehensive community benefits program. The program, for example, did not perform community outreach or otherwise publicize its existence. As a result, the proclamation by the hospitals that the program would "provide primary medical care to an additional 4,000 people in Ada County who are without insurance and live below the federal poverty level" proved wildly optimistic. In fact, the Program serves only 20-60 patients a month.³⁵ This number is all the more disappointing given that there are 8,600 Ada County residents who are not eligible for Medicaid, are low-income and are uninsured.³⁶ It seems reasonable to speculate that the program's low rate of service is caused in part by the meager funding — \$500,000³⁷ — the hospitals have given the Program as well as the absence of outreach and publicity.³⁸ The Program also fails to offer a sliding fee schedule for prescription drugs — a major medical expense — or to include community representation on its Board.

While ICAN community members applauded the health access program as an excellent first step, they nevertheless continued their campaign to redirect a more significant portion of St. Luke's hefty profits to the unmet health care needs of the community. As this campaign continued, new problems with the community benefits practices of St. Luke's came to light. While conducting a door-to-door outreach campaign, for example, ICAN members met Leanna Rowen, a community resident who had had emergency open-heart surgery at St. Luke's in 1984. Leanna was uninsured and unable to pay for the astronomical cost of the surgery. St. Luke's sent Leanna to collections. The hospital also directed Leanna to apply for the County Indigency Program, telling her that the program would pay off her hospital bills. What they did not tell her was that, while this program would pay part of the hospital bill, it would then turn around and place a lien on Leanna's family home. This was Idaho law. (For Leanna's full story, see next page.)

Research revealed that Leanna was not alone; St. Luke's systematically sent low-income, uninsured patients to collections and then to the County Indigency Program.³⁹ Between 1996-1998, over 3,570 people have had liens placed on their property for receiving health care paid for by the Program.⁴⁰

In June 1999, ICAN leaders released a report, "Public Health or Private Wealth: Who is Cashing in on St. Luke's Riches?" summarizing the problems with community benefits at St. Luke's and proposing concrete solutions.⁴¹ The report called on St. Luke's to create a formal charity care policy and to provide debt forgiveness for families with incomes up to 200% of the federal poverty level.

After releasing the report, ICAN called on St. Luke's CEO, Edwin Dahlberg, to meet with community representatives to discuss the hospital's policies. When he refused, ICAN continued to publicly pressure Mr. Dahlberg to commit to a meeting by holding a candlelight vigil outside his home, with members placing a symbolic "community lien" on Dahlberg's home that would be lifted when he agreed to meet with ICAN. ICAN also distributed flyers at a club where Mr. Dahlberg is

a member, and successfully solicited a letter the Episcopal Bishop, a St. Luke's Board Member, urging Dahlberg to meet with ICAN. In September of 1999, Mr. Dahlberg finally agreed to sit down and negotiate with ICAN on the demands laid out in ICAN's report. ICAN is now working toward similar meetings with St. Alphonsus, the other major nonprofit health care provider in the Boise area.

As the local campaigns developed, ICAN members worked simultaneously to strengthen the state-wide legal framework safeguarding public investments in nonprofit hospitals. In 1998, the group worked with the Attorney General to pass one of the few community benefits laws in the country. That said, the legislation which passed was the product of compromise. Research ICAN has done since its passage has demonstrated that its impact on the community benefits performance of hospitals has been modest. Hence, ICAN members are preparing to introduce stronger community benefits legislation in the next session of the Idaho legislature.

IV. TACTICS AND OPPORTUNITIES FOR COMMUNITY BENEFITS CAMPAIGNS

1. Tactics

Ultimately, action around community benefits is aimed at improving the health care of underserved community members. In the short-term, however, community action is aimed at educating and attracting potential allies and putting public pressure on decision-makers.

A successful public pressure campaign is one that convinces decision makers that a powerful coalition of forces is demanding action and the price of not complying with these demands is too high. A successful public education campaign is one that convinces potential allies that:

- there are serious problems in the community benefits performance of today's health care providers,
- these problems are due to the failure of pow-

A PERSONAL ACCOUNT OF ST. LUKE'S CHARITY CARE POLICIES: LEANNA ROWEN'S STORY

In 1984, Leanna underwent emergency open-heart surgery at St. Luke's Regional Medical Center in Boise, Idaho. Every day since then, for the past fifteen years, Leanna has struggled to pay off overwhelming medical bills.

Prior to her surgery, Leanna had been a stay-at-home mom for over twenty years, caring for her children, one of whom is developmentally disabled. Her husband worked full-time as a tile layer but his employer did not offer health insurance. Leanna was uninsured when she had her emergency surgery. To make matters worse for the family, Leanna's husband was laid off from his job soon after the operation.

Hating the burden of unpaid bills, Leanna volunteered to work her debt off at the hospital, an offer the hospital declined. Next, Leanna's daughter approached St. Luke's to, again, explain the family's financial situation. The hospital was completely unresponsive.

Far from offering help, the hospital began harassing Leanna with phone calls. They wanted the family to commit to specific monthly payments, an impossible request as the family was now barely able to put food on the table. "No matter how many times you tell them you can't pay, they won't leave you alone," said Leanna. "I finally just told her to make an appointment for the hospital to take back the valve they put in my heart."

In order to start paying off the St. Luke's bills, Leanna began working outside the home for the first time in her life. She earned only \$200 a week, but that was enough for her to acquire a credit card. She immediately charged \$1,700 of the medical bills to her new card.

At the hospital's direction, Leanna applied for the County "Indigency Program." She was approved and, through this Program, the hospital received compensation. For Leanna, however, the situation only got more precarious; Idaho law dictates that participants in the Indigency Program must have liens placed on any property they may have. The County now has the title to Leanna's family home.

St. Luke's is a non-profit hospital receiving extensive support from the community. What does St. Luke's give in return? Leanna's story demonstrates how little St. Luke's gives back to the community in return.

erful actors to meet their responsibilities,

- there are solutions to the problems, and
- the ally can make an invaluable contribution to bringing these solutions about.

The tactics that have proved most useful in education and pressure campaigns around community benefits include public demonstrations, distribution of research findings, community outreach, media outreach, and lobbying. These tactics can occur separately or in concert.

Demonstration Tactics: The public demonstration is a staple of community action around community benefits. Demonstrations broadcast two messages, one about the issue itself and another about advocates — namely, that advocates are numerous, committed, solidary, and organized.

Northwest community organizations working on this issue have held a variety of public demonstrations ranging in type from a candlelight vigil outside the home of a hospital CEO to a charity care picket line.

Research and Reporting Tactics: Information is critical to any community benefits campaign. The right data, when distributed widely, will motivate members, attract allies, silence skeptics, and cow opponents. Community organizations in the Northwest have used a variety of research and reporting tactics to uncover and disseminate facts useful to any community benefits campaign. These include:

- surveys and focus groups to assess the unmet health needs of community members
- corporate research, including surveys of hos-

pitals, to determine what hospitals claim to provide and what they actually provide in the way of community benefits

- analyses of current laws to determine which might serve as levers to pressure hospitals, regulators and politicians
- drafting of model legislation

Community Outreach Tactics: A large number of people suffer from the failure of hospitals to provide community benefits. Most, however, feel alone. Through community outreach, organizers bring these people together, so that they draw strength from each other and fight the problem as a group. When the community is united, decision makers are significantly more vulnerable to pressure.

Examples of community outreach tactics around community benefits in the Northwest include:

- locating and organizing meetings among low-income uninsured individuals who had been sent to collections by hospitals or who have had liens placed on their property
- locating and organizing community members concerned about the free care policies of their local hospitals

Action Education Tactics: Community outreach, particularly around complex issues like community benefits, is most successful when combined with action education. In action education, organizers develop tools to help explain difficult-to-understand issues in clear and simple ways. Community members who feel they have mastered the basics principles of an issue in turn feel more empowered to speak up for community needs around that issue.

One of the most widely-used action education tools in community benefits campaigns in the Northwest is the “Community Benefits *Jeopardy!* Game.” Community members, acting like the players on the television program, *Jeopardy!*, compete with each other to answer a series of questions pertaining to community benefits. The game, created by the Northwest Federation of

Community Organizations (NWFCO), was developed as an interactive education device to explain community benefits in a way that is simple and fun.

Media Outreach Tactics: When the media covers community actions, the effects of these actions are amplified tenfold. The result is the widest possible distribution of the community’s message (including its implied threat to decision makers) as well as an increase in members and allies. To attract the media’s attention, the community must provide it with a compelling “story”; while a basic theme of the story is often “we’re a big, powerful group, we’ve identified a problem and we’re focusing on a remedy,” the story is much more attractive if it contains an entertaining hook.

Examples of media outreach tactics around community benefits in the Northwest include:

- sending a “Get Well” card to a hospital’s ailing charitable mission
- placing a symbolic “community lien” on a hospital CEO to be lifted when he agrees to meet with the organization

Legislative Tactics: In most states, legislation on community benefits is still in its infancy. Hence, community groups face a largely untried field when they pursue such legislative tactics as writing model community benefits legislation; lobbying for reform of current health care laws (such as conversion laws) so that they can be used to regulate the community benefits; opposing legislation which will worsen this performance, and; lobbying for budget increases to underfunded regulators of hospitals.

Examples of such legislative tactics in the Northwest include:

- helping to pass some of the earliest community benefits legislation in the country
- drafting and lobbying for conversion legislation that requires regulators to take community benefits performance into account in evaluating proposed conversions

2. The Timing of Tactics: Special Opportunities for Community Action

Community organizers maximize the effect of tactics when they deploy them at times when decision makers are particularly open to community input or vulnerable to community pressure. In the case of community benefits, these decision makers include hospital administrators and certain government bureaucrats and politicians. (Namely, bureaucrats and politicians whose decisions greatly affect the business of hospitals; these could be county commissioners responsible for granting building or zoning permits or Attorney Generals responsible for determining a hospital's compliance with community benefits legislation.)

Public and Legislative Hearings: Depending on the state, government regulators may be required by law to hold public hearings when hospitals attempt to:

- renew their nonprofit status (so that they can receive tax exemptions)
- convert from for-profit tax status to nonprofit tax status
- sell themselves or a subsidiary
- merge with or buy another health care institution
- obtain zoning permits or variances
- make significant capital improvements

In all states, legislators hold public hearings on bills introduced to the legislature.

In the Northwest, where the fight to hold hospitals accountable to their charitable mission is well underway, community organizers have seized the opportunity hearings present. In Washington state, for example, Washington Citizen Action (WCA) intervened with great success in a public hearing called by regulators to examine the purchase of one hospital by another. Regulators ruled that the sale could go forward only if the newly-purchased hospital significantly increasing its community benefits. Other organizations, such as the Idaho

Community Action Network (ICAN) have used legislative hearings as part of their community benefits campaigns.

Advertising campaigns by decision makers: From time to time, hospitals mount media campaigns to promote themselves. This provides community members the opportunity to mount a counter campaign in which they contrast the hospital's self-portrayal in ads to an uglier reality. The very prominence of the hospital's original campaign attracts the free media to the community's message, particularly if organizers play off the content of the original ad campaign. The media campaigns of certain politicians can be approached the same way.

Opportunities of this kind, and of the two that follow, have not yet been used by community organizations working to improve community benefits, but chances abound for them to do so in future.

Legislative campaigns backed by decision makers: When hospitals and key politicians lobby for a bill dear to their hearts or pocketbooks, a window of opportunity opens for community action. The bill may be about community benefits or it may be about something else entirely. What is important is not the content of the bill, but rather the opportunity for organizers to stop a hospital's achievement of something it wants. By throwing up obstacles to the bill's passage, organizers make hospitals pay attention and may make them rethink their opposition to objectives of importance to the community groups in question.

Public appearances by decision makers: When administrators or politicians appear publicly, they want to please and to look good in front of their audience. When media are present, this desire is amplified tenfold. Community members can use this situation to announce to this same audience that there is a problem and that the source of the problem and of the problem's solution stands before them. Public appearances, in other words, provide another golden opportunity for the community to take action.

V. THE FUTURE OF COMMUNITY BENEFITS: GOALS FOR COMMUNITY ACTION

The Northwest Federation of Community Organizations (NWFCO) recently convened a community benefits roundtable at the University of Washington. At this roundtable, community members, researchers, organizers, and legislators worked together to pinpoint future directions for community benefits campaigns. They identified six goals for community action.

Goal 1: Continue to Ensure that Nonprofit Hospitals Meet their Community Benefits Obligations

Current campaigns to ensure that nonprofit hospitals provide community benefits in exchange for their tax exemptions have begun to show returns. These campaigns are on the right track and should continue.

Goal 2: Improve Existing Legislation and Pass New Legislation in Currently Uncovered States

Some hospitals have proposed reporting voluntarily on their community benefit policies and performance. Unfortunately, as with the proverbial fox guarding the chicken coop, this “solution” is problematic. In reality, the burden of oversight effectively remains with community groups, which often do not have the means to verify a hospital’s claims.

Strong legislation is necessary to assure that hospitals and other health providers meet their community benefits obligations. Current legislation important to community benefits, however, does not do the job. A large number of states have no such legislation and, in those states that do, the law is often weak and inadequately enforced. Communities should:

1. Improve the quality of existing legislation.
2. Expand the number of states with (a) community benefit laws, and (b) laws which include community benefits provisions — laws regulating conversions, mergers and acquisitions,

capital improvements, zoning, and tax exemptions.

3. Ensure that all legislation includes enforcement provisions and that adequate resources are appropriated for enforcement efforts.

Goal 3: Ensure that All Health Care Institutions Provide Community Benefits

At the moment, in most states, nonprofit hospitals are among the main providers of community benefits. In the future, all health care providers should provide such benefits. Like nonprofits, for-profit hospitals and HMOs must also be accountable to the communities they serve. Many for-profit hospitals were originally jump-started by government Medicare contracts and continue to benefit from public monies via local property tax exemptions. In addition, they, along with HMOs, receive highly profitable contracts from state governments to provide care for government employees.

Treating for-profit businesses as legally responsible for community benefits is an accepted practice in other industries. Banks, for example, under the Community Reinvestment Act, must make basic checking services available to all areas regardless of median income and must reinvest a certain amount of profits into the communities they serve. Likewise, utility companies must serve all geographic areas regardless of how unprofitable.⁴²

Goal 4: Move Community Members to the Center of Decision Making

Today, community members are among the most dedicated and effective watchdogs of community benefits norms, policies and laws. They do not, however, have the direct authority to make decisions about the community benefits policies of the health care institutions in their own cities and towns.

Both the most efficient and the most fair community benefits system is one in which community members hold seats at the table where decisions

about community benefits get made — specifically, seats on hospital boards, county health commissions, and similar bodies.

In addition, hospitals should collaborate with community members to conduct thorough health needs assessments of the communities they serve. Input from all community members is necessary to identify health concerns and set priorities among health care needs.

Goal 5: Ensure That Community Benefits Include But Also Go Beyond Free Care

So far, community benefits campaigns have focused largely on the issue of hospitals and free care. This is due in part to strategic considerations; when doing outreach to the community, organizers have found that community members understand immediately that hospitals which fail to provide free care to certain community members have violated their social contract with the community.

This immediate understanding and the strong feelings of injustice it arouses make the free care issue a good place to start when organizing a community benefits campaign. As these campaigns mature, however, they must include demands around the full range of community benefits including health education campaigns, free health screenings or flu shots, premium subsidies by insurers or HMOs, and subsidies for operation of health care clinics within local communities.

Goal 6: Shift Public Discourse from a Language of Charity to a Language of Obligation

Currently, public discourse around community benefits is filled with concepts and language that suggest health care providers are giving community members “charity” rather than paying off a debt they owe the community.

A “charity” approach to community benefits implies that health care providers have received

nothing from the people to whom they provide these benefits. Where community benefits care concerned, nothing could be further from the truth. The very core of the community benefits argument is that the community gives health care providers enormous benefits — via tax exemptions, etc. — with the understanding that these entities will, in return, provide the community with something of added value. The hospitals get benefits outside the market and are expected, *in return*, to provide something outside the market.

VI. CONCLUSION

Communities have had many successes holding their hospitals accountable to their community benefit obligations. Even so, 43 million people continue to be without health coverage in the U.S. The challenge for consumers, then, is to use their collective voices to ensure that all health care providers are contributing to the health and well being of their communities.

Community groups can look to the experiences of consumer advocates throughout the country, particularly in the Northwest, to learn of creative ways to bring the voice of consumers into the forefront of the community benefits discussion. The campaigns of the Northwest also serve to illustrate the impediments communities face under our current piecemeal health care system that does not uniformly address the notion of health care providers’ community benefit obligations.

There are many opportunities for advocates to change the way health providers look at their responsibilities to the people of this country. Community members can and should become active partners with health providers, together determining how to address the many unmet health needs of local residents. While some partnerships may be created in an open and welcoming environment, there still remains the chance for success in areas where advocates must use public pressure tactics to achieve their goals.

ENDNOTES

¹ Marcelene Edwards, "St. Luke's Has History of Compassion: Hospital Once Was Known for Never Turning Away a Sick Person Who Couldn't Pay for Health Care." *Idaho Statesman*, July 18, 1997, p. 1A.

² St. Luke's, for example, "receives thousands of donations averaging nearly \$2 million per year." Bill Bodnar, St. Luke's Vice President of Corporate Development, Memo to "Interested Parties," on March 26, 1998. The national average for donations to community hospitals is 0.75-1.5% of net hospital revenues. See also *Selling Out? How to Protect Charitable Health Dollars and Services*, San Francisco, CA: Consumers Union, and Boston, MA: Community Catalyst, October 1998, p. 11.

³ The Access Project, *Defending Community Benefits in a Changing Health Care World*. <http://www.accessproject.org>.

⁴ *The Wall Street Journal*, July 14, 1997.

⁵ Joel Weissman, "Uncompensated Hospital Care: Will It Be There If We Need It?" *Journal of the American Medical Association*, September 11, 1996, vol. 276, no. 10, cited in *Health Focus*, March 1997, p. 4, a publication of the American Federation of State, County and Municipal Employees (AFSCME) Public Policy Department, Washington, D.C.

⁶ "Community Care," *The Newshour with Jim Lehrer*, February 2, 1998.

⁷ IRS Ruling 83-157. In this ruling, the IRS declared that "an entity engaged in the promotion of health *for the benefit of the community* pursuing a charitable purpose is tax exempt" (italics added). The ruling does not, however, specify in any systematic way what actions constitute "promotion of health for the benefit of the community." See also comments of Kathleen Nilles, specialist in tax-exempt organizations, in Ken Miller, "St. Lukes: From Tax Exempt to Tax Payer," *The Idaho Statesman*, July 16 1997, p. 8A.

⁸ *Health Care Institution Responsibility Model Act: A Summary*, Boston, MA: Community Catalyst, Inc., 1999, with some modifications by the Northwest Federation of Community Organizations (NWFCO).

⁹ Monica Langley and Anita Sharpe, "Acute Reaction: As Big Hospital Chains Take Over Nonprofits, a Backlash is Growing," *Wall Street Journal*, October 18, 1996, p. A1.

¹⁰ This precedent was set in *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah, 1985). In this case, the Utah Supreme Court revoked the property tax exemption of two nonprofit hospitals because they failed to provide sufficient charitable services.

¹¹ Raymond F. Crerand, "Critical Hospital Services Shouldn't Be Victim of Profit," *The Seattle Times*, April 29, 1998.

¹² Except where otherwise noted, information in this subsection was derived from an interview with Barbara Barron Flye, Executive Director, Washington Citizen Action (WCA), October 1999.

¹³ Washington Administrative Code (WAC) 246-453-030 and 246-310-210, respectively.

¹⁴ "After reviewing your comments and discussing your concerns with the applicant, the department has scheduled a public hearing..." Letter from Karen Nidermayer, Analyst, Certificate of Need Program, Office of Health Systems Development, Washington State Department of Health, to Eleanor Hamburger, Health Policy Director, Washington Citizen Action (WCA), dated April 1, 1998.

¹⁵ Letter from Eleanor Hamburger, Washington Citizen Action, to Karen Nidermayer, Department of Health, dated April 17, 1998, re: Certificate of Need Application by New American Healthcare Corporation to Purchase Puget Sound Hospital.

¹⁶ Letter from Kathy Stout, Office of the Assistant Secretary, Washington Department of Health, to Neil G. McLean, Vice President, New American Healthcare Corporation, May 26, 1998.

¹⁷ Except where otherwise noted, information in this subsection was derived from an interview with Derek Birnie, Executive Director, Montana People's Action (MPA), October 1999.

¹⁸ Julio Mateo, Jr. and Jaime Rossi, *White Knights or Trojan Horses? A Policy and Legal Framework for Evaluating Hospital Conversions in California*. San Francisco, CA: Consumer's Union, 1997, p. iv.

¹⁹ Pat Bellinghausen, "St. V Joins Hands With Blue Cross," *Billings Gazette*, March 20, 1998.

²⁰ MCA 33-31-202.

²¹ Associated Press, "Lobbying List I," June 29, 1999.

²² Pat Bellinghausen, "Health Needs of Uninsured Mushrooming," *The Billings Gazette*, May 20, 1999, p. 1A.

²³ Except where otherwise noted, information in this subsection was derived from a personal communication with Ellen Pinney, Executive Director, Oregon Health Action Campaign (OHAC), November 1999.

²⁴ Some community members called and visited hospitals posing variously as English speakers or monolingual Spanish speakers with low incomes and without health insurance and in need of hospital services and bilingual social service workers seeking assistance for similar clients.

²⁵ Except where otherwise noted, information in this subsection was derived from an interview with Kevin Borden, Lead Organizer, Idaho Community Action Network (ICAN), October 1999.

²⁶ Idaho Code 35.31-3504.

²⁷ St. Luke's Regional Medical Center, *IRS Form 990*, 1995.

²⁸ Candice Chung and Ken Miller, "County: Not 'Charitable'? You Pay," *The Idaho Statesman*, July 16, 1997, p. 1A.

²⁹ Idaho Community Action Network (ICAN), "St. Luke's Campaign," mss., n.d. [1999], p. 1.

³⁰ St. Luke's Regional Medical Center, *IRS Form 990*, 1995.

³¹ Representatives included members of ICAN, St. Alphonsus, St. Luke's, Planned Parenthood, Central District Health, Terry Reilly Health Services, Family Practice Residency, City of Boise, Ada County, United Way, and the Idaho Primary Care Association.

³² Marcelene Edwards, "Hospital is Expanding in Ada County, Elsewhere," *The Idaho Statesman*, September 1997, p. 1A.

³³ "State law requires that charitable organizations provide a gift to the community. St. Luke's fails to meet that requirement because Ada County taxpayers bear the burden of the medical costs....In the interests of Ada County tax payers, the County Board of Commissioners determined it was no longer fair, in light of disclosures, to continue the St. Luke's tax exemption." Idaho Board of County Commissioners, "St. Luke's Hospital Will Pay Property Taxes Like Other Profitable Businesses," Press Release, July 14, 1997. The Idaho legislature later passed a bill which redefined the criteria for tax-exempt organizations in the state and thereby eliminated the basis for the county's action. Idaho Code 63-602D.

³⁴ Kathleen Ackley and Kevin Borden, *Public Health or Private Wealth: Who is Cashing in on St. Luke's Riches?"* Boise, ID: Idaho Community Action Network (ICAN), 1999, p. 20.

³⁵ *Ibid*, p. 19.

³⁶ James Owens, *Primary Care Consortium Business Plan*, Boise, Idaho, 1995.

³⁷ Letter to "Dear Friends" by Sandra Bennett Bruce, Ed Dahlberg and Todd Swanson, dated July 20, 1998.

³⁸ Kathleen Ackley and Kevin Borden, *Public Health or Private Wealth: Who is Cashing in on St. Luke's Riches?"* Boise, ID: Idaho Community Action Network (ICAN), 1999, p. 19.

³⁹ The County Indigency Program is mandated by state law but is run by each county. The county program pays approved medical expenses up to \$10,000. On a yearly basis, Ada County doles out around \$2.5 million to St. Lukes and St. Alphonsus. Ada County Auditor's Department, *Ada County Budget*, 1998, cited in Kathleen Ackley and Kevin Borden, *Public Health or Private Wealth: Who is Cashing in on St. Luke's Riches?*, Boise, ID: Idaho Community Action Network (ICAN), 1999, p. 13 n.33.

⁴⁰ Kathleen Ackley and Kevin Borden, *Public Health or Private Wealth: Who is Cashing in on St. Luke's Riches?*, Boise, ID: Idaho Community Action Network (ICAN), 1999.

⁴¹ *Ibid*, p. 15.

⁴² The Access Project, *Defending Community Benefits in a Changing Health Care World*. <http://www.accessproject.org>

⁴³ Only a small number of Idaho hospitals are this size.

APPENDIX

FACT SHEETS ON LEGISLATION IN THE NORTHWEST

Idaho Community Benefits Bill (I.C. 9-350) (1998)	Page 21
Oregon Conversion Law (Or. Laws 291)	Page 22
Montana Conversion Bill (SB 322) (1999)	Page 23
Washington Certificate-of-Need Law (RCW 70.45.020-.070) (1997)	Page 24

FACT SHEET

Idaho Community Benefits Bill

I.C. 9-350 (1998)

Rule: Each 501(c)(3) nonprofit hospital seeking property tax exemption must prepare an annual community benefits report describing the amount of community benefits it has provided and the needs evaluation process it has employed.

Scope: All private nonprofit hospitals with at least 150 beds.⁴³ Includes acute care hospitals, outreach and satellite hospitals, and the outpatient and support facilities of any hospital.

Reporting Requirements on Community Benefits and Other Services: The hospital must report to the County Board of Equalization:

- The amount of charity care provided;
- Bad debt (i.e., unpaid bills by patients who are able but unwilling to pay);
- Unreimbursed government-sponsored health care;
- Services and programs provided by the hospital below cost;
- Donated time;
- Subsidies and in-kind services.

Community Needs Assessment Required? No.

Annual Report Detailing Efforts Required? Yes.

Community Benefits Reports Are Public Information? Yes.

Penalty for Noncompliance? No.

Power of Regulatory Agency: Any tax-exempt hospital which spends more than 3% of the value of its property on business not directly related to tax-exempt purposes may be taxed on the value spent.

Analysis: The law contains no enforcement provisions. Even were enforcement requirements included, however, the law would be overly-limited in scope. A comprehensive community benefits statute should go beyond reporting requirements to *ensure* that health care institutions provide community benefits that improve the community's health and address the unmet health needs of the community. Such legislation must mandate both goals and timelines for achievement of these goals. It must also require hospitals to collaborate with community members to conduct periodic community-based needs assessments and to devise community benefit plans. The Idaho law falls short of these basic requirements.

Website: <http://www.idwr.state.id.us/oasis/H0154.html>

FACT SHEET
Oregon Conversion Law
Or. Laws 291 (1997)

Rule: Requires public benefit or religious (nonprofit) corporations that operate hospitals to notify and obtain approval from the Attorney General before conducting a sale or other transaction involving significant hospital assets.

Scope: Applies to public benefit or religious (nonprofit) corporations. Covers nonprofit-to-for-profit conversions and nonprofit consolidations or mergers.

Regulator: Attorney General.

Provision Requiring Public Input into Merits of Proposed Transaction? No.

The Attorney General may choose to hold a public hearing on the proposed transaction, but such a hearing is not required. If the Attorney General decides to hold a public hearing, she or he must, at least 14 days prior to the hearing, announce the time and place of the hearing in one or more newspapers of general circulation servicing the affected community. She or he must also notify the governing body of the county in which the hospital is located. If the Attorney General decides not to hold a public hearing, he or she must notify any person or organization which has made a written request to be informed of any such transactions.

Terms of Approval of Conversion include Impact on Health? Yes.

The Attorney General may disapprove the transaction if she or he determines that it reduces the availability and accessibility of health care in the community.

Requires Independent Expert Analysis of Health Impact? No.

The Attorney General may contract for expert analysis of the proposed transaction but is not required to do so.

Requirement that Converting Entity Maintain/Exceed Current Level of Free Care? No.

Formal Process for Monitoring New Owner Compliance with Commitments to Community Care?
No.

Analysis: The Attorney General is not required to hold public hearings prior to approving the conversion. In conversion legislation, public hearings should be mandatory so that the community may express its opinions and offer its expertise in transactions which involve substantial public assets.

Website: <http://gopher.leg.state.or.us>

FACT SHEET

Montana Conversion Bill SB 322 (1999)

Scope: Conversions of health care facilities from nonprofit to for-profit status. Health care facilities include nonprofit hospitals, HMOs, service corporations, insurers, mutual benefit corporations holding assets in charitable trusts, and any entities affiliated with the above through ownership, governance or membership, such as holding companies or subsidiaries.

Regulator: Attorney General.

Provision Requiring Public Input into Merits of Proposed Transaction? Yes.

Prior to issuing a decision on the proposed transaction, the Attorney General must conduct at least one public hearing. At least 14 days prior to the hearing, she or he must announce the time and place of the hearing in one or more newspapers of general circulation servicing the affected community. She or he must also notify the governing body of the county in which the hospital is located and, if applicable, notify the city council of the city to which the assets of the nonprofit health care entity are to be transferred. At the public meeting, the Attorney General must receive written and oral comments from interested persons and issue a written response to these comments.

Terms of Approval of Conversion Include Impact on Health? Yes.

Prior to issuing a decision on the proposed transaction, the Attorney General must determine whether the transaction would have a significant adverse effect on the availability and accessibility of health care for the affected community. As part of determining this, the Attorney General must assess whether, as part of the terms of the transaction, the proposed for-profit owner has committed to providing access to affordable health care to the disadvantaged, uninsured and underinsured members of that community in a manner comparable to the commitment to access of the current nonprofit owner.

Requirement to Use Independent Expert Analysis of Health Impact? No.

The Attorney General may contract for expert analysis of the proposed transaction but is not required to do so.

Requirement that Converting Entity Maintain/Exceed Current Level of Free Care? Yes.

Formal Process for Monitoring New Owner Compliance with Commitments to Community Care? No.

Penalty for Noncompliance: Yes.

Bill specifies penalties for transactions entered into in violation of the notice, review and approval provisions. In cases of violation, the transaction would be void and the Attorney General could initiate proceedings against board members, officers, and employees of the transacting parties and could impose civil penalties on these violators.

Analysis: This proposed legislation serves as a very important step toward the protection of the public investments that Montanans have made in their health system. The bill would be even further strengthened were it to include language directing the Attorney General to review “creeping conversions,” transactions in which a nonprofit health care entity transfers its assets to for-profit subsidiaries in a series of steps spread out over time.

Website: <http://161.7.127.14/bills/html/SB0322.htm>

FACT SHEET

Washington Certificate-of-Need Law

RCW 70.45.020-070 (1997)

Rule: Regulator approves applications submitted by a for-profit seeking to acquire a nonprofit hospital after taking proper steps to ensure the acquisition will not detrimentally affect the continued accessibility or affordability of health care.

Scope: Covers acquisitions of nonprofits. An “acquisition” means any purchase, merger, lease, gift, joint venture or other transaction that results in a change of ownership or control of twenty percent or more of the hospital assets, or results in a person acquiring fifty percent or more of such assets.

Provision Requiring Public Input into Merits of Proposed Transaction? Yes.

In addition, regulator publishes notice of the application in a newspaper of general circulation in the county where the hospital is located. By mail, email, or fax, regulator also notifies any person requesting notice of the filings of such applications. Notice must state that the application has been received, state the names of parties to the proposed transaction, the contents of the application, and the date by which people may submit written comments about the application to the regulator.

The regulator must conduct one or more public hearings, at least one of which is in the county where the hospital is located. At the hearings, individuals may make verbal statements and file written comments and exhibits. The regulator may subpoena information of witnesses, take depositions, require and administer oaths, take sworn statements, and use discovery procedures prior to making a decision on the application.

Terms of Approval of Transaction Include Impact on Health? Yes.

The proposed new owner must prove that it is committed to providing health insurance to the disadvantaged, the uninsured and the underinsured, and to provide benefits which promote improved health in communities affected by the transaction.

Requirement to Use Independent Expert Analysis of Health Impact? No.

Requirement that Converting Entity Maintain/Exceed Current Level of Free Care? Yes.

The regulator may approve an application only if sufficient safeguards are included to assure that communities affected by the transaction continue to access affordable care and that alternative sources of care are available in the community, if the acquisition results in elimination of particular health services.

Formal Process for Monitoring New Owner Compliance with Commitments to Community Care? Yes.

The regulator must require periodic reports from the new owner to ensure compliance with commitments made in the transaction. The regulator may subpoena information and documents and may conduct on-site compliance audits at the new owner’s expense. If the regulator receives information indicating that the new owner is not fulfilling its community commitments, the regulator will hold a hearing, with ten days notice to the parties to the transaction. If the regulator determines that the information is true, it may suspend or revoke the hospital’s license, refer the matter to the Attorney General, or both.

Website: <http://search.leg.wa.gov/pub/textsearch>

About the Northwest Federation of Community Organizations (NWFCO)

The Northwest Federation of Community Organizations (NWFCO) is a regional federation of five statewide, community-based social and economic justice organizations located in the states of Idaho, Montana, Oregon and Washington: Idaho Community Action Network (ICAN), Montana People's Action (MPA), Oregon Action (OA), Washington Citizen Action (WCA) and Coalition of Montanans Concerned with Disabilities (CMCD). Collectively, these organizations engage in community organizing and coalition building in fourteen rural and major metropolitan areas, including the Northwest's largest cities (Seattle and Portland) and the largest cities in Montana and Idaho.

For more information contact:

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