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HILL-BURTON FREE CARE PROVISIONS - A FIRST STEP

We all have an ongoing stake in how voluntary non-profit hospitals respond to our needs. Over forty billion dollars is being spent nationwide for hospital care, most of which goes to the non-profit hospitals.

Non-profit hospitals do not make profits; they do not pay dividends. However, this does not mean that they do not make money. Where General Motors describes a line item as "profit", substitute "surplus", where IBM pays high corporate officer and executive salaries, the non-profit hospital does the same. "Profits" in the non-profit hospital sense, become "reserves", "funds", and "trusts". Profits also become capital investments that expand the facility and allow it to acquire bigger and better technology that create even more revenue.

Aside from the generation of revenue and surpluses, expansion and development, hospitals are also the recipients of significant public investment each and every year of their operation as non-profit corporations. Non-profit hospitals are exempt from federal corporate income taxes, state corporate income taxes, state and local property taxes, taxation on endowments and gifts and, additionally, are eligible to receive state and federal subsidies and grants.

In Rhode Island, as in many other states, some hospitals have been built on land ceded by the state. All non-profit hospitals' corporate charters in Rhode Island contain the pledge that no patient will be turned away for lack of ability to pay. Consumers should look at the corporate charters of hospitals in their own communities.

What the public receives for their investment is the continued availability of the facility's service. Yet, it is arguable that if these services are not readily available to all, especially to the most needy, then the community is on the short end of the bargain. After all, persons able to pay or who have sufficient insurance coverage, DO PAY and at quite substantial rates.

Consumer advocates in health care believe that all persons have a right of access to quality health care regardless of race, sex, ability to pay or source of payment. Federal legislation prohibits discrimination in delivery of health care based on race, color or national origin (title #6 Civil Rights Act, 1964). What about women and the poor?

While outrages, like an indigent person lacking the price of admission, bleeding to death on a hospital doorstep, hardly ever seems to occur, the problems have yet to be solved. Many impoverished patients (at least those who overcome their fear of seeking services without funds) may find it possible to enter a hospital but then suffer indifferent treatment and suffer further indignities and harrassment as the hospital seeks to collect.

The uncompensated care provisions of the Hill-Burton Act of 1946 can be the first step toward fulfilling the goal of free care for all Americans under a National Health System.

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CAN HOSPITALS AFFORD FREE CARE?

In Fiscal Year 1974, one of Rhode Island's largest non-profit hospitals listed an operating loss of over $5 million and described this in their Annual Report as "representing the value of Free Service to the Community." At the same time, this hospital held nearly $110 million in unrestricted reserves (which were untaxed and untapped) and total assets approaching $200 million. This facility also received a substantial rate increase during the year. $750,000 in gifts were also received during that year. Special state and federal grants ran many departments within the hospital. Add to this a $2.5 million in Hill-Burton subsidies received during prior years. Under the PROVISIONS OF THE Hill-Burton Act, discussed in more detail later, this facility is obligated to provide $250,144 in "free care" annually.

Other facilities within the state differ from this outline only in scale.

How much is enough?

When a hospital provides a bed to a patient without charge, there is a difference between the value the hospital places on this act of charity and actual cost. Nationally, fixed costs for a hospital bed make a difference in actual cost between a full bed and an empty bed. An empty bed costs two-thirds as much to maintain as a full bed. The average occupancy rate of hospitals in the United States is under 80%.

WHO REALLY NEEDS FREE CARE?

Substantial numbers of low-income people have been consistently excluded from all available health care coverage programs, or find such programs insufficient to meet their needs. The elderly must pay large amounts in Medicare deductibles and co-payments. Medicaid rules contain technical provisions that automatically exclude many working-poor families and the unemployed. People out of work or earning less than a living wage are finding health insurance premiums sky-rocketing out of reach. Finally, state and local cut-backs in medical aid programs and Medicaid have restricted coverage and eligibility.

Between the Recession and the national politics of fiscal conservatism, the pool of individuals and families faced with severely limited access to a most important need, hospital care when they need it. Even assuming that this was the best of all possible worlds and comprehensive national health insurance was passed through Congress and signed by the President tomorrow, such a plan could not be implemented until the 1980's. Some resource must be tapped today if these needs are to be met.

HILL-BURTON ACT OF 1946

Adding to this whirlwind of complexities are the federal government's programs for construction subsidies. Starting in 1946 with the passage of the Hill-Burton Act and continuing into the future through the National Health Planning and Resources Development Act of 1974 (Title XVI), nearly $15 billion in federal subsidies have flowed to non-profit hospitals. This development has been of primary interest to consumer advocates concerned with the access of the poor to hospital care.

When the Act was passed in 1946, the statute included the requirement that recipient facilities promise "that the facility will furnish a community service

and will furnish below cost or without charge a reasonable volume of services to persons unable to pay therefor." From 1946 until the 1970's, execution lay exclusively with the facility itself on the honor system. As a result of lawsuits, Cook v. Oschner being most prominent, HEW regulations on procedures for free care provision were developed. Subsequent and on-going litigation has forced continued refinement of the federal rules and consumer activism has sparked some state-level response.

PLAYING BY THE RULES

Federal law (which should be embodied into state health facilities plans) establishes a principle of "presumptive compliance". Recipient facilities must specify a formula whereby they will provide free care. The options they have are:

(1) to declare that no person will be denied service for lack of ability to pay and all persons eligible for free care under Hill-Burton eligibility rules will be given that benefit;

(2) that 3% of the facility's operating budget (minus revenue from Medicare and Medicaid) will be devoted to free care;

(3) that 10% of the federal subsidy's value will be provided per annum in free care;and

(4) that the facility, experiencing financial difficulty, cannot choose any of the above and asks the state regulating agency to set the free care obligation.

Until December, 1975, hospitals had no obligation to inform the public of this obligation. Because of the non-existence of state or federal enforcement, many facilities chose the first option. While this appears the most beneficent, actual performance showed an appalling minutiae of free care proportional to the original subsidy being provided by Option #1 facilities. And, in spite of Congressional attention and new HEW rules, we see this picture changing only through consumer activism.

When a hospital reports the total amount of free care it provides, that total can only comprise services charged at "reasonable cost". "Reasonable cost" is considered to be the same fee rate negotiated by the hospital for reimbursement by Medicare (see: 42 CFR 53.111 (b)(6), Fed. Reg., July 22, 1972; also 42 U.S.C. 1395; also 20 CFR 405, 401 et seq.).

This means that a hospital cannot claim that it has met its obligation to provide free care by calling the difference in payments for service to Medicare and Medicaid patients and what they charge private patients, Hill-Burton uncompensated service.

WHO SHOULD GET FREE CARE?

Answering the question of who got free care in the past is a puzzle for even the best of minds. Consumer advocates claimed with some proof in 1974 Congressional hearings that much of the free care being claimed by recipient hospitals was actually a write-off of uncollectible debts, owed by persons with widely varying abilities to pay. The advocates argued that this retroactive benevolence could not

substitute for a coherent and just process for informing, identifying and certifying legitimately eligible persons. As the rules evolved, we can develop a clearer picture of which patient SHOULD be eligible.

(1) Patients generally should not be eligible for any other entitlement which would pay for the cost of care. That is, if the costs could be covered by Medicare or Medicaid, they cannot be written off under the Hill-Burton Act. However, if the Medicaid-eligible patient needs a hospital service that is not covered under Medicaid (as in many states, clinic and accident room services), then the resource of Hill-Burton can be tapped.

(2) Established income guidelines should reflect the poverty line or welfare standard in the state. Some states have chosen as a standard the OEO/CSA poverty line; other states, such as Rhode Island, set the Hill-Burton standard at the Medicaid standard, presumably to account for those persons deemed technically ineligible for Medicaid. Provision should also be included for a "flexible test" of income for persons whose income over the eligibility standard would be consumed by hospital costs.

(3) Finally, and perhaps most significantly, the state plans should include provision for "extenuating circumstances." The Rhode Island Plan states it clearly:

> "Each case must be evaluated on its own merits, as there are numerous persons or families who are otherwise self-supporting but may be unable to pay the full charge for needed services...."
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> "In determination of the liability of the family unit, the hospital's administration shall consider in addition to the income guidelines, the extent of medical insurance coverage, other available resources, the size of the patient's family, and financial obligations, which would impose an unreasonable financial burden upon the responsible party."

Not all state plans carry this provision, despite the apparent mandate of the federal rules.

CONSUMER ACTION FOR FREE CARE

From Tacoma, Washington to Providence, Rhode Island, from Little Rock, Arkansas to Boston, Massachusetts, advocate groups are organizing and mounting vigorous organizing campaigns aimed at enforcing hospital compliance with the law. In every locale, there has been no lack of directly affected persons eager to join the effort.

Starting a Hill-Burton organizing effort requires a systematic approach.

STEP #1: KNOW THE RULES. The federal regulations are less than exhaustive. These rules and the state plan section on free care can be absorbed in a single sitting. Read the several excellent background articles that separate the ideal

from the real, which should be readily available from your local Legal Services Office. A copy of your own state's Hill-Burton regulations, and a list of the hospitals which received funds under Hill-Burton can be obtained from your State Health Department.

STEP #2: UNDERSTAND YOUR HOSPITAL. Find out as much as you can about the hospital(s) in your community. How much have they received in federal subsidy? Which compliance option have they chosen? How much free care have they provided? Do they comply with federal rules regarding the posting of Hill-Burton free care notices? This information should be available by inspection and through the state regulating agency. Look at the hospital's financial reports. Find out the background of hospital board members. Try to find out the salaries of the top officials.

STEP #3: ASSESS THE PROBLEM IN THE COMMUNITY. Find real people who are directly affected. Leaflet the unemployment offices. Enlist the support of community health and welfare services, especially the neighborhood health centers. Initially, concentrate on people who should be eligible for Hill-Burton free care but were not able to get it.

STEP #4: DEVELOP STRATEGY WITH THE PEOPLE. Just as free care is not an issue unless people are affected by it, a campaign is not a community effort unless the people who are affected determine the strategy. Help develop leadership among the people-- the health advocate's role should be one of technical support that lets the people make it happen.

STEP #5: EXECUTE THE STRATEGY. The most common strategy adopted is to develop a list of demands not usually merely restricted to those mandated under the Hill-Burton statute. For example, several Rhode Island groups have demanded and won hospital consent to hire interpreters and to coordinate hospital social service staff efforts with those of community agencies. Executing the strategy effectively usually requires two elements: (1) a strong and well-organized group and (2) the discovery of several instances of hospital violations. Examples of the latter can include: failure to post required notices, the lack of a written policy by the hospital, no established application process in the hospital, instances of misinformation being provided to patients and unjust determination of ineligibility.

STEP #6: CARRY OUT CONTINGENCY PLANS. As part of the overall planning of the effort, play out all of the possible responses the hospital might make to your demands. Have formal complaints prepared for filing on the state and HEW Regional level. Have public interest attorneys waiting in the wings to file litigation. Be prepared to support such action as picketing the hospital, its officials and board members. One organization in Rhode Island, the Rhode Island Workers Association, actually occupied a hospital administration building.

STEP #7: KNOW HOW TO BE GOOD WINNERS. If after Steps #5 or #6, the hospital accedes to your demands, know how to get the most mileage out of it. Among some successful demands were: the establishment of joint community/hospital policy committees which would write hospital free care policies; linkage between community agencies and the hospital staff; distribution of community-prepared informational packages for patients within the hospital and community agency pre-screening of potential Hill-Burton applicants. Be sure that any demand that requires an action on the part of the community can actually be carried out.

SOMETIMES BAD NEWS

Every effort is bound to run into problems. Free care provision under the

Hill-Burton Act is certainly not a limitless resource. Recognize its limitations. For example, advocates must recognize that hospitals can legally limit their obligation by choosing limiting options. Once they reach that level, they can legally restrict the provision of free care.

Hospitals can seek to have the courts intervene by arguing that what the community is demanding in free care is more than "reasonable".

State agency and federal enforcement of compliance has been a continuing problem. In Rhode Island, the State Health Department has responded to formal complaints as an advocate for the hospitals. Regional HEW has maintained a public silence.

State agency officials who side with hospitals, and the legal counsel to the hospitals themselves, will show resourcefulness in finding loopholes and exemptions to free care obligations. In Rhode Island, the state agency ruled that federal subsidies received by hospitals under programs similar to, but not exactly the same as Hill-Burton, should not be used in determining free care obligations. This resulted in a reduction of obligations at seven hospitals and the dismissal of complaints. After several months of high-level negotiations by Marilyn Rose (Center for Law and Social Policy, Washington), this ruling was reversed, but not without harm having been done.

Hospitals can seek waivers from their free care obligations. Without strong fiscal expertise, community groups may find themselves out-classed at public hearings that could be dominated by the hospital's accountants. Many states have chapters of Accountants in the Public Interest who could be enlisted to defeat such an attempt by the hospitals.

All these problems aside, consumer advocates for health care are faced with an opportunity to effect some startling short term benefits for low-income people. The current structure of Hill-Burton rules are such as to be of optimal benefit to persons traditionally excluded from protection from hospital costs. The greatest tool in the use of this resource is public knowledge and strong advocate support.

FURTHER READING

Marilyn G. Rose. "Federal Regulation of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls,"Northwestern Law Review, 70:1, 1975.

Allan Crimm. "Access by the Poor to Health Care in Southern Hill-Burton Hospitals," Southern Governmental Monitoring Project (52 Fairlie St., Atlanta,Ga.30303) 1974.

"Implementation of Hill-Burton Amendments, 1974," Senate Committee on Labor and Public Welfare, Health Sub-Committee, 11/25/74.

"Axelrod, Butler and Wing. "Representing of Clients in Matters Relating to Hospital Bills," Legal Services Clearinghouse, Dec., 1974.

"A Citizen's Guide to Enforcing the Hill-Burton Act," Phil. Unemployment Project (1321 Arch Street, Philadelphia, Pa. 19107).

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