



**Testimony before the
U.S. Senate Committee on Health, Education, Labor & Pensions**

Field Hearing

Chaired by U.S. Senator Al Franken

regarding

**“Ensuring Patients’ Access to Care and Privacy: Are Federal Laws
Protecting Patients?”**

May 30, 2012

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Good morning, Chairman Harkin, Ranking Member Enzi, and distinguished Senators. I am grateful for the opportunity to testify before you today.

My name is Jessica Curtis. I direct the Hospital Accountability Project at Community Catalyst, a national non-profit consumer advocacy organization that has been giving consumers a voice in health and health care since 1997. My organization works to promote pragmatic, consumer-friendly solutions to the obstacles many low- and middle-income people face in staying healthy and accessing the care they need. Medical debt is one such obstacle, and we have been a leading consumer voice investigating its causes and pushing for rational policy solutions for many years.

Through the Hospital Accountability Project, we work with hospital leaders, community groups, public health organizations, and policymakers to improve access to care and protect patients to the greatest extent possible from medical debt arising from hospital bills. Out of this work, we have developed standards and model legislation that hospitals and policymakers can use to craft institutional and public policies, respectively, that make the billing and collections process fair, clear, and transparent for patients. We also track and inform developments in state and federal policy related to hospital financial assistance, billing and collections.

My comments today will aim to provide some context for medical debt by answering: What is medical debt, and how is it unique? In what ways does it impact patients' access to care and financial well-being? Finally, what can be done to address these problems and protect families from its harmful effects?

Introduction

First, though, I'd like to start with a story. In April 2008, the *Wall Street Journal* drew national attention to the story of Texas resident Lisa Kelly, a former school bus driver whose battle with leukemia found her facing an unlikely adversary: the business department of the M.D. Anderson Cancer Center, a non-profit hospital affiliated with the University of Texas and the country's premier specialty hospital for cancer treatment and research at the time.ⁱ When her doctor referred her to M.D. Anderson, Mrs. Kelly tried to schedule an appointment only to be told that the hospital did not accept her insurance.ⁱⁱ From the hospital's perspective, she was uninsured and would have to present a certified check for \$45,000 in order to make her initial appointment.ⁱⁱⁱ Mrs. Kelly managed to meet that deadline and see a hospital oncologist, who wanted to admit her immediately. But the hospital's business office told her that she would need to pay another \$60,000 upfront in order to be admitted, despite the fact that she and her husband were unable to meet that demand.^{iv}

When Lisa Kelly's story went public, it became clear that her experience was the result of a policy to demand upfront payment from uninsured and underinsured patients implemented by M.D. Anderson's business office to reduce the hospital's unpaid patient bills, or bad debt.^v The policy led to interruptions in Mrs. Kelly's care and severely impacted her family's long-term financial future. At the time of the article, the family was making monthly payments of \$2,000 to M.D. Anderson in order to pay off the \$145,000 they accrued in medical bills from Mrs. Kelly's treatment.^{vi}

What happened to Lisa Kelly—the discovery that the insurance policy she could afford was inadequate to cover the costs of her care; repeat encounters with a hospital business office demanding money she did not have; the crushing debt she acquired due to a diagnosis she could neither predict nor control—is part of a larger phenomenon that is being relived daily in hospitals and medical offices around the nation. Similar stories have emerged from North Carolina to California. The question is, what can be done?

Medical Debt: A Special Case

Medical debt is simply “money owed for any type of medical service or product” to a provider or third-party agent, such as a collection agency.^{vii} Medical debt arises when providers classify the money a patient owes for health care services as bad debt—that is, payment for services that a hospital expected to receive but was unable to collect.^{viii} As this definition suggests, classifying a patient’s account as bad debt almost certainly means that the provider or its collection agency has pursued the bill through the collections process.

Medical debt is the outcome of a unique type of consumer transaction

Medical debt can be distinguished from other types of consumer debt in several ways. First, consider the circumstances under which it arises. With very few exceptions, patients—or, health care “consumers”—attempting to access health care services do so out of medical necessity. Illness and injury are unpredictable and involuntary. In addition, the stakes for patients are very high: the decision not to seek medical care due to lack of insurance or potential cost could result in disability or death. A patient seeking care in a hospital’s emergency room is in no position to bargain for a better deal, and in that sense starts from a very different place than a person walking into a big-box store to purchase a flat-screen TV. Second, patients have no way of knowing the cost of treatment in advance, making medical care—especially hospital care—very different from normal consumer transactions. Even with perfectly transparent prices, patients do not know in advance what their diagnosis and treatment options will entail, or whether complications (which are not always preventable) will occur.

Medical debt is a widespread problem

The number of Americans struggling to pay medical bills is startlingly high. In the first half of 2011, one in five people in the United States reported that their family had difficulty paying a medical bill.^{ix} One in four reported they were in a family paying a medical bill off over time; remarkably, one in ten reported they or a family member were currently responsible for a medical bill they could not pay at all.^x Families with children and adults under the age of 65 have been hit particularly hard, with a disproportionate burden falling on low-income, Hispanic and black families.^{xi}

Medical debt is a threat to physical and financial health

For patients, the long-term effects of having a medical bill sent through the collections process can be particularly devastating. First, medical debt plays a significant role in driving families deeper into economic distress. One well-known study posited that over 60 percent of all bankruptcies could be traced back to medical debt or illness.^{xii} A 2007 preliminary study of home foreclosures in four states cited medical crises as a contributor to half of home foreclosures.^{xiii} As family finances shrink, many more low- and middle-income families resort to using credit cards to pay down medical debt.^{xiv} However, this strategy leaves them susceptible to high interest rates

and can lead to lowered credit scores.^{xv} In August 2011, the *New York Times* reported that 20 percent of clients seeking financial counseling from Atlanta-based CredAbility, a national non-profit credit counseling agency, cited medical debt as the primary reason they were seeking bankruptcy—up from 12 to 13 percent the previous two years.^{xvi}

Second, medical debt—or the threat of it—can have a chilling effect on patients’ willingness or perceived ability to seek care in a timely way. Skipping recommended follow-up care, not filling prescriptions, and delaying physician or specialist care when medical problems arise are all commonly reported behaviors among families carrying credit card debt.^{xvii} In families that lost insurance coverage due to unemployment, just under three-quarters report using one of these strategies to keep costs down.^{xviii} And in one national survey, about one in ten Americans living with a serious illness, medical condition, injury or disability “report being turned away by a doctor or hospital for financial or insurance reasons at some time during the past 12 months when they tried to receive care.”^{xix}

What Causes Medical Debt? Lessons from the States

Three main factors contribute to medical debt: lack of comprehensive coverage; provider practices to collect on debts that range from the inappropriate to egregious; and a lack of strong public policies and oversight. The result is that too many Americans fall through gaping holes in the very same safety net on which they, of necessity, must rely.

Lack of affordable health coverage

Approximately 50 million people living in America lack health insurance.^{xx} A recent report by the Department of Health and Human Services (HHS) found that hospital charges are simply out of reach for many of these uninsured families, with most families able to afford only 12 percent of the cost of a hospital stay.^{xxi} Even uninsured families with relatively higher incomes (over 400 percent of the Federal Poverty Level) could afford only 37 percent of the stay.^{xxii}

Another 29 million people living in America are underinsured.^{xxiii} This is due in part to rising out-of-pocket expenses—higher premiums, higher co-pays and coinsurance, and higher deductibles—as well as a rise in plans that either limit benefits or cap coverage.^{xxiv}

Uninsured and underinsured patients are more susceptible to medical debt. When compared to people with adequate coverage, both groups forego care due to costs at rates that are twice as high for the underinsured and three times as high for the uninsured.^{xxv} And the uninsured and underinsured struggle with medical debt at higher rates than those with better coverage.^{xxvi} For many, skimpy coverage is just as bad as no coverage. About 76 percent of those in medical debt reported having health insurance when they acquired the debt.^{xxvii}

Despite obligations to provide access to care, many hospitals are using or authorizing billing and collection tactics that contribute to medical debt

Through our work on the Hospital Accountability Project, Community Catalyst has found that hospitals play a significant role in promoting access to care and avoiding medical debt. There are good public policy reasons to look to hospitals to promote care, including:

- Mission. Hospitals often base their organizational missions on core values that expressly articulate a community-focused approach, irrespective of an individual's ability to pay or any external legal obligation to do so.
- Tax Status. By filing for tax-exempt status, non-profit hospitals have covenanted with the public to provide financial assistance and other forms of community benefit in exchange for the highly valuable federal, state, and local tax breaks and other benefits they receive as a result of that tax-exempt status.
- Public subsidies. Many hospitals receive Disproportionate Share Hospital (DSH) payments and money from other public funds that indirectly subsidizes a significant portion of their costs for providing uncompensated care.
- Social and corporate responsibility. All hospitals, non-profit and for-profit alike, have a social responsibility to provide some amount of financial assistance since health care is an "essential service"—particularly in areas where there are few acute care providers.

But in many places, hospitals' financial assistance, billing and collections policies have been shown to be inadequate, inappropriate, or even harmful. Hospitals have been cited for:

- Failing to screen patients for eligibility for public programs or the hospital's own financial assistance policy prior to engaging in more aggressive collection activity^{xxviii};
- Failing to notify patients of the availability of these programs, and even denying that they offer free care^{xxix};
- Deciding to offer financial assistance or payment plans based on a patient's propensity to pay, rather than ability to pay;
- Using credit scores to determine a patient's access to lines of credit;
- Requiring significant up-front payments before providing treatment^{xxx};
- Mounting extremely aggressive collection practices, including placing liens on patients' property or garnishing their wages;
- Selling off patient accounts to third party lenders that charge exorbitant interest rates^{xxxi}; and
- Overcharging the un- and underinsured for care.^{xxxii}

These practices all create obstacles for patients seeking access to care. In Community Catalyst's work with state and local partners, these complaints are common, and the impact on patients is devastating.

What makes these practices even more abhorrent is that they are not necessary for hospitals to remain financially viable. Treating patients fairly and having clear, transparent, and strong policies for financial assistance and billing makes good business sense. In a September 2008 outlook report, Fitch Ratings commented on the apparent correlation between stability in hospitals' median operating margins and some consumer-friendly practices, such as developing strategies to better identify Medicaid-eligible patients and revisiting financial assistance policies.^{xxxiii} Increasingly, industry experts are advising hospitals to implement best practices for financial assistance, billing and collection.^{xxxiv} And in many states, low-income patients who currently qualify for hospital financial assistance programs will be newly eligible for Medicaid, subsidies, or other coverage when Affordable Care Act reforms take full effect in 2014. In Massachusetts, for example, hospitals were able to help the state identify and "flip" patients who received safety-net services into public coverage programs after state-level reforms.^{xxxv} This sped

up enrollment significantly, giving patients more immediate access to comprehensive benefits, which “trickled down” to the hospitals through higher reimbursements.

But government oversight of hospital practices has often been weak or inconsistent

State laws and regulations, like hospital practice, also vary tremendously. For example, California, Maine and Rhode Island have set minimum eligibility standards for hospital financial assistance tied to family income. In Pennsylvania, state regulators have limited what information hospitals can require of patients to determine eligibility for financial help as a condition of receiving certain public subsidies. In Minnesota, prior to pursuing legal action or garnishing a patient, hospitals must verify the debt, confirm that all appropriate insurance companies were billed, offer the patient a payment plan, and offer the patient any cost reduction available under the hospital’s charity care policy.^{xxxvi} In California, hospitals and their affiliates are barred from garnishing a “financially qualified” patient’s wages or placing a lien on his or her primary residence in order to collect a debt.^{xxxvii}

Still, most states lack adequate protections for individuals who cannot afford to pay for their care. Some, such as North Carolina, have no laws on the books that expressly regulate medical debt collection. There, a major public hospital system was found to routinely uses liens to collect debts on very low-income patients’ homes. But even when state laws are strong, oversight and enforcement of these protections can be ad hoc or non-existent. As a result, compliance with existing laws can decay. For patients, this means that the protections available to them vary greatly depending on where they live and the individual policies of the hospitals in their area.

Recommendations for Preventing and Addressing Medical Debt

We have discussed the ways in which medical debt is unique, its impact on families, and the factors that have contributed to its proliferation. Accordingly, special rules need to be in place to protect patients. We suggest a three-pronged federal solution, as follows.

1) Prevent medical debt by implementing the coverage expansions found in the Affordable Care Act

The growing problem of medical debt lends an additional perspective to how America’s health care system fails many uninsured and underinsured people precisely when they need to rely on it most. But an exclusive reliance on the hospital safety net is neither financially sustainable over time; nor is it a suitable replacement for comprehensive health benefits in terms of guaranteeing access to care. Expanding access to care therefore requires making affordable, comprehensive coverage a reality for the millions of Americans who are currently un- or underinsured, and implementing the coverage provisions found in the Affordable Care Act is the best strategy for making affordable coverage a reality.

2) Implement rules that clarify hospitals’ obligations to observe fair billing and collections practices

Even with full implementation of the Affordable Care Act, some Americans will remain uninsured or underinsured, or suffer a medical catastrophe that could otherwise destroy their

financial security. The second remedy for addressing medical debt is to put adequate protections in place by regulating and monitoring hospital billing and collections practices.

Section 9007 of the Affordable Care Act includes new requirements for tax-exempt hospitals that would curb some of the worst practices noted above.^{xxxviii} First, Section 9007 requires tax-exempt hospitals to have a written financial assistance policy that includes eligibility and application requirements and outlines the steps the hospital will take to notify the public that financial help may be available. Second, it requires these hospitals to make a “reasonable effort” to qualify patients for financial assistance prior to engaging in “extraordinary collection actions.” Third, patients who qualify for financial assistance may only be charged the amounts generally billed to an insured patient, ending the industry’s standard practice of price-gouging the uninsured and underinsured. Fourth, it requires hospitals to undertake a regular community health needs assessment and develop strategies to address some of the unmet needs.

These requirements are already in effect for tax-exempt hospitals. As recent media stories have demonstrated, however, they have not yet had an impact on the behaviors of some of these hospitals. Part of this may be due to the fact that we have yet to see implementing regulations from the Department of the Treasury that will further define what behaviors are acceptable under the statute. We believe strong regulations are necessary to fully protect consumers from medical debt, as Congress intended, and we strongly urge members of this Committee to weigh in with the Department accordingly.

While we believe that strong regulations and oversight pursuant to Section 9007 of the Affordable Care Act are the best way to improve hospital behavior, we recognize Section 9007’s limitations. It applies only to tax-exempt hospitals (though for-profits often adopt industry norms) and works primarily by addressing the “upstream” behaviors of providers that contribute to medical debt. Because the statute leaves the scope and breadth of their financial assistance policies up to hospitals’ discretion, uninsured and underinsured patients may still find themselves excluded from many of the protections offered by Section 9007. What can be done to protect people from the downstream behaviors that providers and collection agents are using?

3) Expand consumer protections against aggressive collection practices by initial creditors, such as hospitals, and debt collectors

The third remedy for alleviating medical debt is to expand consumer protections available to patients. We recommend that this Committee investigate opportunities to expand federal debt collection laws that would increase transparency by placing debt collectors on the hook for providing people with the information they need to understand their rights and take appropriate action. Patients who qualify for financial assistance or are eligible for public programs such as Medicaid should be exempted from debt collection activity. In general, hospital debts should not be referred to collections or reported to credit bureaus until the patient is screened for financial assistance or public programs. In no case should a hospital engage in or authorize collection lawsuits, garnishing wages, freezing bank accounts, body attachments or capias, or placing liens on patients’ homes or cars without the express approval of its governing board. Practices such as selling patient debts to third parties or charging interest on outstanding patient debts should be prohibited outright. Medical collections actions—again, because of the unique

circumstances under which the debts arise—are not predictive of creditworthiness, yet they appear on credit reports even after a medical debt has been settled. Each of these practices creates tremendous hardship for families, with long-lasting effects that spill over into the financial well-being of whole communities.

Finally, policymakers should continue to support transparency initiatives, such as the Internal Revenue Service Form 990, Schedule H, that require hospitals to report the practices they use or authorize agents to take in order to collect patient debt. By giving communities access to detailed information about local hospitals' practices, these initiatives offer an important check on hospital practices that contribute to medical debt.^{xxxix}

Conclusion

In conclusion, medical debt has an increasingly profound effect on families, even those with private insurance coverage and middle-class incomes. But behind the data lies the human element involved in every case of medical debt: in hospital rooms and medical offices around the nation, families facing the specter of medical debt are forced to choose between placing their loved ones' lives or the family's financial future at risk.

We have been here before. Concerns about aggressive collections tactics that impact patient access to care surfaced as recently as the early 2000's. At that time, the response from the hospital industry was to publish and update voluntary standards. While such standards are welcomed, they are clearly not enough to staunch the wide range of behaviors and tactics currently being used to collect debts that many Americans simply cannot pay.

One thing is clear: hospitals that make a practice of healing patients' bodies while bankrupting them—or authorize third parties to do the same on their behalf—have missed the mark. They run the risk of compromising individual and public health; eroding individual, community, and national economic security; and destabilizing their own financial well-being by ignoring industry best practices. Those are risks that we can ill afford to take.

On behalf of the 79 million people who are uninsured or underinsured in America today, I thank you for the opportunity to testify and welcome your questions.

ⁱ Barbara Martinez, "Cash Before Chemo: Hospitals Get Tough," *The Wall Street Journal*, April 28, 2008, at A1. For M.D. Anderson Cancer Center's national ranking, see "America's Best Hospitals 2008," *U.S. News and World Report* (2008).

ⁱⁱ Martinez, *supra* note 1.

ⁱⁱⁱ *Id.*

^{iv} *Id.*

^v *Id.*

^{vi} *Id.*

^{vii} Statement of Mark Rukavina before the U.S. House of Representatives Committee on Financial Services, Subcommittee on Financial Institutions and Consumer Credit, on "Use of Credit Information Beyond Lending: Issues and Reform Proposals," May 12, 2010.

^{viii} See American Institute of Certified Public Accountants, *Audit and Accounting Guide: Health Care Organizations* (2006); American Hospital Association, *American Hospital Association Uncompensated Hospital Care Cost Fact Sheet*, October 2006; Catholic Hospital Association, *A Guide for Planning and Reporting Community Benefit*, 2006.

Bad debt should be contrasted with charity care, or financial assistance, that is written off due to a patient's inability to pay.

^{ix} Robin A. Cohen, Renee M. Gindi, Whitney K. Kirzinger. *Financial Burden of Medical Care: Early Release of Estimates from the National Health Interview Survey, January-June 2011*. Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention, March 2012.

^x *Id.*

^{xi} *Id.*

^{xii} David U. Himmelstein, Elizabeth Warren, Deborah Thorne, & Steffie Woolhandler, *Illness and Injury As Contributors to Bankruptcy*, Health Affairs Web Exclusive, February 2, 2005 [hereinafter Himmelstein et al].

^{xiii} Christopher Robertson, Richard Egelhof, & Michael Hoke, *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, Harvard Law School, August 2007.

^{xiv} One survey report found that medical bills and unemployment were among the leading contributors to credit card debt for low- and middle-income families, with 55 percent of survey respondents with poor credit citing medical debt as a contributing factor. Amy Traub and Catherine Ruetschlin, *The Plastic Safety Net: Findings from the 2012 National Survey on Credit Card Debt of Low- and Middle-Income Households*, Demos, May 22, 2012.

^{xv} *Id.*

^{xvi} Ann Carrns, "Medical Debt Cited More often in Bankruptcies," *New York Times*, August 8, 2011.

^{xvii} See *Plastic Safety Net*, *supra* note 14, at Table 7.

^{xviii} Michelle M. Doty, Sara R. Collins, Ruth Robertson, and Tracy Garber. *Realizing Health Reform's Potential: When Unemployed Means Uninsured: The Toll of Job Loss on Health Coverage, and How the Affordable Care Act Will Help*. The Commonwealth Fund, August 2011.

^{xix} NPR/Robert Wood Johnson Foundation/Harvard School of Public Health, *Poll: Sick in America Summary*, Released May 2012.

^{xx} *Overview of the Uninsured in the United States: A Summary of the 2011 Current Population Survey*. Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, September 2011.

^{xxi} *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills*, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, May 2011.

^{xxii} *Id.*

^{xxiii} See Schoen, C., Doty, M., Robertson, R., and Collins, S. *Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent*. Health Affairs vol. 30 no. 9 (1762-1771), September 2011.

^{xxiv} Examples of such plans include hospital-only plans, plans that do not cover prescription drugs or mental health services or cap coverage for these services, or those that set lifetime or annual caps on what the plan will pay.

^{xxv} Schoen, et al, *Affordable Care Act Reforms...Underinsured*, *supra* note 23.

^{xxvi} To give one summarizing statistic, 52 percent of the underinsured and 58 percent of the uninsured report medical debt or problems paying medical bills, compared to 27 percent of those with insurance. *Id.*

^{xxvii} Himmelstein et al, *supra* note 12.

^{xxviii} In a random national survey of 99 nonprofit hospitals conducted in 2009, researchers found that fewer than half of hospitals surveyed (42) provided charity care application forms; only a quarter (26) gave information about eligibility criteria; and just over a third (34) offered information about charity care in languages other than English. C. Pryor et al. *Best-Kept Secrets: Are Non-Profit Hospitals Informing Patients About Charity Care Programs?*, The Access Project and Community Catalyst, May 2010. See also, e.g., Ames Alexander, Karen Garloch & Joseph Neff, *Prognosis: Profits*, Charlotte Observer and Raleigh News & Observer, April 22-26, 2012; Nina Bernstein, *Hospital Flout Charity Aid Law*, New York Times, February 12, 2012.

^{xxix} *Id.*

^{xxx} Jessica Silver-Greenberg, *Debt Collector Faulted for Tough Tactics at Hospitals*, New York Times, April 24, 2012.

^{xxxi} Brian Grow and Robert Berner, *Fresh Pain for the Uninsured*, Business Week, November 21, 2007.

^{xxxii} Hospitals charge self-pay patients, including the uninsured and underinsured, 2.5 times the rates insurers paid and three times the hospital's Medicare-allowable costs for the same services. Gerard F. Anderson, *From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing*, 26 Health Affairs 3 (2007).

^{xxxiii} *2008 Median Ratios for Nonprofit Hospitals and Health Care Systems*, Fitch Ratings, September 25, 2008.

^{xxxiv} See, e.g., Ron Shinkman, *Five Much Better Ways to Collect Patient Deb*, FierceHealthFinance, May 8, 2012; *Acts of Charity: Charity Care Strategies for Hospitals in a Changing Landscape*, PricewaterhouseCoopers' Health Research Institute, 2005; Catholic Hospital Association, *A Guide for Planning and Reporting Community Benefit*, 2006.

^{xxxv} Stan Dorn, et al, *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage*, State Health Access Reform Evaluation , The Urban Institute and Robert Wood Johnson Foundation, November 2009.

^{xxxvi} Pursuant to a binding agreement between the Minnesota Attorney General and the Minnesota Hospital Association.

^{xxxvii} Calif. Health & Safety Code § 127425(f).

^{xxxviii} Section 9007 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (2010). For a fuller discussion of Section 9007, see Corey S. Davis, Jessica Curtis, & Anna Dunbar-Hester, *Leveraging the Patient Protection and Affordable Care Act's Nonprofit Hospital Requirements to Expand Access and Improve Health in Low-Income Communities*, Clearinghouse Review, January-February 2012; and *Protecting Consumers, Encouraging Community Dialogue: Reform's New Requirements for Non-Profit Hospitals*, Community Catalyst.

^{xxxix} However, the Internal Revenue Service has buckled under pressure from some within the hospital sector and made these reporting requirements optional in the past. See *Letter to the Honorable Timothy Geithner, Secretary, U.S. Department of the Treasury, re: Internal Revenue Service Announcement 2011-37 ("Portion of Form 990 Schedule H Optional for Tax-Exempt Hospitals for Tax Year 2010")*, Community Catalyst, June 20, 2011.