September 7, 2007

The Honorable Charles Grassley
Senate Finance Committee
Senate Dirksen 219
Washington, DC 20510

Dear Senator Grassley:

Thank you for soliciting our comments on the Tax-Exempt Hospitals: Discussion Draft released July 19th. We believe the kind of changes proposed in the staff document would help ensure greater accountability for hospitals and ensure the community is obtaining better access to affordable health care. We applaud your efforts, and have specific comments on the following details of your proposal.

Charity Care

We would like further clarification on staff's suggested definition of "underinsured." It is unclear if a health plan deductible is one type of out-of-pocket medical expense, and why a distinction is being made between the two types of medical expenses. A patient is concerned with all medical expenses regardless of the category. We suggest a definition that makes no distinction between different types of medical expenses. (see below)

Consumers Union has developed a Model Fair Accessible Individual Rate (FAIR) Bill (attached). In order to reduce the stigma, and make medical care as accessible as possible, we have specifically chosen to call the charity care program FAIR Care. We have highlighted some of the definitions from the bill below:

Available Assets: The resources, as distinct from Family Income that are taken into account in determining eligibility for Medical Hardship Assistance. Available assets do not include: the residence in which a patient and/or the patient's family resides, automobiles used regularly by a patient or immediate family members, retirement and deferred compensation plans qualified under the Internal Revenue Code, non-qualified deferred compensation plans, college savings accounts, the first ten thousand dollars ($10,000) per family member of a patient's family's monetary assets and 50 percent of a patient's family's monetary assets over the first ten thousand ($10,000) per family member.

Charity Care: No-cost inpatient and outpatient medical treatment and diagnostic service for uninsured or underinsured patients who cannot afford to pay for the care. Such treatment is provided without expectation of payment. Charity Care does not include bad debt or contractual shortfalls from government programs, but may include insurance

co-payments or deductibles, or both. All payments meant to reimburse for the care of low income patients, such as disproportionate care hospital payments and Medicare graduate medical education payments should be netted out prior to calculating the hospital's level of charity care provided; that is, charity care standards should be based on the cost of unreimbursed care. In no circumstances will a patient believed to be eligible for Charity Care be issued a bill. Care provided under a Hill-Burton obligation is not counted as Charity Care under this definition.

Family Income: The sum of annual earnings and cash benefits from all sources after taxes, less payments made for alimony, child support, and student loans.

Patient's Family:
1) For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not.
2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

Underinsured: A patient, including individuals in public insurance programs, whose deductibles, co-payments, spend down, medical, or hospital bills after payment by third –party payers exceeds 5% of patient's income in the prior 12 months.

Uninsured: A patient who does not have health insurance and is not currently covered by any third-party payer program. This includes persons whose coverage is terminated while receiving services at a hospital and is thus individually liable for a portion of the bill.

Appropriate Level of FPL for Charity Care Patients

Medical expenses can overwhelm patients at any income level. We suggest a three tier system where by charity care would be made available to patients at the lowest income levels, below 300% FPL, charity care with an annual reduced price payment fee is available to patients from 300% FPL to 500% of FPL and Medical Hardship Assistance is made available to all patients whose medical expenses exceed 25% of their family income, and they do not have the assets available to cover the medical expenses.

Full Charity Care Eligibility

Charity Care should at a minimum be provided to uninsured and underinsured patients whose family incomes are up to 300% of the FPL.

Staff suggests that hospitals should be allowed some flexibility in deciding on the data necessary to determine eligibility for charity care. The application process for charity care must be kept simple and require as little documentation as possible. Even with those hospitals that currently profess to have charity care policies, we have seen how use of these policies is thwarted by complex, overly burdensome application procedures that are clearly designed to discourage applicants. In the absences of federal requirements to keep this process simple and accessible, we expect that hospitals may use burdensome applications and procedures to discourage use of charity care or reduced price care. The federal government must set the standards for applying for charity care and not merely leave it up to hospitals to come up with standards. If requested documents are not reasonably available, an affidavit signed by the patient shall be sufficient.

Reduced Price Care Eligibility

In addition reduced price care should be provided to uninsured and underinsured patients from 300% of FPL to 500% of the FPL. The Hospital shall calculate an annual reduced price fee for the patient and the patient will be eligible for Charity Care after he or she has incurred expenses in the amount of the annual reduced price fee. The annual reduced price fee shall equal 5% of the difference between the patient's Family Income and 300% of the Federal Poverty Income Guidelines. Each family shall be charged only one Reduced Price Fee amount per 12 month period. Allowable medical expenses billed by other providers during the same 12 month period shall be counted toward the Reduced Price Fee. It is the patient's responsibility to document expenses incurred from other Providers. Allowable medical expenses billed by the Hospital shall be calculated at the lower: (i) the lowest rate that would be paid by Medicare/Medicaid or (ii) the actual unreimbursed cost to the hospital for such service. The Hospital shall bill a patient only for the Reduced Price Fee amount.

Medical Hardship Assistance Eligibility

Hospitals should provide medical hardship assistance to patients at any income level whose allowable medical have exceeded 25% of the family income and their available assets are insufficient to cover difference. The Hospital shall calculate a patient's Medical Hardship Assistance Fee by adding 25% of the patient's family income to the patient's Available Assets. There is one Medical Hardship Assistance Fee per Family per 12 month period. Allowable Medical Expenses billed by other Providers during the same 12 month period may be counted toward the Medical Hardship Assistance Fee. It is the patient's responsibility to document expenses incurred from other Providers. The patient will remain responsible for all Allowable Medical Expenses to the extent of the Medical Hardship Assistance Fee. The patient is eligible for Charity Care for all expenses for Medically Necessary Services in excess of the Medical Hardship Assistance Fee for the period of Charity Care eligibility. A Hospital shall bill a patient only for the Fee amount at the lower of: (i) the lowest rate that would be paid by Medicare/Medicaid or (ii) the actual unreimbursed cost to the hospital for such service.

Minimum Requirement Nonprofit Hospital for Providing Charity Care

We support a minimum of 5% of annual net patient revenues or expenses to charity care, whichever is greater in accordance with the hospital's charity care policy. Our experience working on these issues in Texas (where the minimum is 4% of net patient revenues) is that whatever level is set becomes a ceiling instead of a floor. Texas nonprofit hospitals hover around the 4% of net patient revenue minimum. Hospitals should be encouraged to meet the needs of the communities they serve, and provide more than the 5% threshold when the needs surpass this level. Appropriate rewards could include greater access to tax free bonds, higher reimbursement levels for Medicare or assistance with capital improvements.

As detailed below, we believe all nonprofit hospitals should have the same requirements. Further, calculations for meeting the charity care standard should be done in a standardized manner (see discussion below on standardized calculations of charity care). We do not support the creation of a separate class of nonprofit §501(c)(4) hospitals with less accountability to the communities they serve and no minimum charity care requirement.

Bad Debt

In response to the suggestion made in footnote 30, we strongly encourage policy makers to not allow hospitals to re-categorize bad debt as charity care. This concept is counter to that of charity care – that is, care for which no payment is expected. If policymakers desire to create some sort of tax adjustment for hospitals in general based on bad debt, it should be done separate from charity care policies. If policymakers decide to provide for a broader allowance for converting bad debt the charity care, hospitals should be prohibited from assigning a patient's debt to external debt collectors.

Standardized calculations of charity care

Calculations made to determine whether a hospital meets the specified level of charity care required to maintain nonprofit status should be done in a standardized manner. We strongly recommend that the Medicare Cost Reports be used as that standard. This will ensure that all hospitals are counting the same direct care expenditures when calculating their charity care. For example, in Texas, the original method for calculating hospital charity care used the Medicare Cost Report as the base for establishing a cost to charge ratio, but through lobbying by hospitals, this standard was changed the next year so that the hospital's annual audited financial statements were used as the base to establish this ratio. This substantively changed the value of the state standard of 4% of net patient revenue. Several years after the change in law we were able to calculate the actual difference in the dollar amount of charity care provided in the state based on this change of calculations. For 1998 and 1999, using the audited financial statements to calculate the cost to charge ratio inflated the amount of charity care provided by more than $195 million statewide. Put another way, in 1999, using the audited financial statement method, hospitals performed $356.9 million in charity care compared to $250.6 million using the Medicare Cost report method.

Audited financial statements serve a specific purpose – to inform about the financial status of the entire hospital financial position (e.g., solvency). The audience includes the government (for bonds), bankers (for loans), investors, donors, board of hospital, etc. Medicare cost reports are statements to the government which is interested in calculating as pure patient costs as possible. The emphasis is on patient cost expenses and revenues. (Capital expenses are also allowed to be included.) This report is a more appropriate process for the purpose of determining charity care because it is more precise and more standardized. For example, a hospital's concierge service would be included in the audited financial statement but not in the Medicare cost reports.

Hospitals should not be allowed to count the reimbursements from Medicare and Medicaid as charity care. If the reimbursement is less than the cost, hospitals may count this difference between their actual cost and reimbursement as charity care. Certain subsidized health services (burn units, trauma centers) should not be included for purposes of meeting the quantitative test for 501(c)(3), 5% charity care test. These services are already subsidized, and should not supplant charity care. Nor should a nonprofit hospital receive credit toward charity care for having "an emergency room open to all, regardless of ability to pay." This is already required of all hospitals, including for-profit hospitals, under EMTALA.

We are concerned, however, that critical access hospitals are exempted without mention of any requirements. While we understands the reason for this exemption is to ensure

that services continue in areas with low hospital access, such hospitals that can show financial distress should be able to request a lower threshold.

The standards should require systems of nonprofit hospitals, within a 10 mile radius, to meet the charity care requirement together as a group. The hospitals within a group should add together their net patient revenue to determine the 5% standard for the group. The hospitals within the group should keep separate logs on charity care requested and provided and report the amount of charity care provided at each hospital separately.

The standards should also require nonprofit hospitals to make all of their services available to people with Medicaid. Nonprofit hospitals should not only be required to accept Medicaid for payment—which would reduce the need for additional charity care money as well—but they should also ensure that providers at their facilities accept Medicaid for payment. Many low-income people find that a recent hospital stay may have been covered, but are surprised to find that the emergency room doctor and the anesthesiologist do not accept Medicaid. These providers then send expensive bills to beneficiaries who can little afford to pay for this care.

The federal government should also be enforcing all aspects of the Hill-Burton obligations of hospitals that received these funds. While most facilities no longer owe payments on these loans so their obligations to provide free care have expired, these facilities continue to have a community service obligation in perpetuity. This obligation includes acceptance of both Medicaid and Medicare as well as actual services that benefit the community. The federal government has been lax in enforcing these obligations for years, and this would be a good opportunity to renew enforcement.

Physician and Laboratory Billing

Most patients who receive medical care at the hospital are billed for the hospital stay and physician or laboratory services separately. Hospitals are increasingly outsourcing their services, thus the actual hospital bill is a smaller percentage of the total billed to the consumer following a trip to the hospital. Consumers who receive charity care may still be overwhelmed with medical debt from physician charges, and other medical charges for services received that are not billed directly by the hospital. We suggest the committee explore policy options to ensure that patients who receive charity care are not billed from physicians, and other ancillary providers. Some options may include requiring physicians to provide charity care when the hospital provides charity care, and/or creating a pool for physicians and laboratories to be reimbursed for their cost of care.

As noted above, nonprofit hospitals should be required to accept Medicaid and in return require that their contracting physicians accept Medicaid as well.

Emergency Rooms

While there is some reference in the staff memo to emergency room services as a marker for community benefit, we hope that you will consider doing more in this area.

As you know, last year the Institute of Medicine issued a three volume report entitled The Future of Emergency Care, which described the enormous problems in this part of our health care delivery system and offered a number of recommendations. ER capacity and access has become a major issue: on average there is an ambulance on diversion

from the nearest ER room every minute of every day; patients can easily spend a day or more in waiting rooms or on gurneys in hallways, and between 1993 and 2003 we saw the closing of 425 ER rooms while the number of patient visits increased by about 14 million.

Because many ER patients are uninsured or have trouble paying, there is a growing temptation to close these money-losing facilities. The Miami Herald of August 7, 2007, for example, discusses the decline in trauma center burn care beds because these are such
profit-losing centers. Yet as the IOM report made clear, rather than seeing ERs close, the nation really needs to be thinking of some system of surge capacity in the event of terrorist attack or pandemic.

Therefore, we hope you will consider in the final bill a requirement that, *unless there is a State certificate of need (CON) program requiring an ER closure, reduction, or change in location, that a tax exempt hospital that closes, reduces, or moves emergency facilities will be considered to have eliminated an important community benefit and will be required to show why it should not lose its tax exempt status.*

As the IOM report shows, the ER crisis is a complex one that cuts across many issues. It will take all the tools at our disposal, including the tax code, to stabilize the situation and move toward improving it. The Senate Finance Committee, with its Medicare, Medicaid, and tax jurisdiction is unique in being able to look at this problem. For example, one could use Medicare's multi-billion capital payments systems to require that after some date in the future no hospital construction will receive Medicare assistance unless it meets the type of model design and planning features described in the IOM report.

We hope that someday you could dedicate a hearing to the ER problem. Consumers Union has been collecting stories from readers about their ER experiences, and we have received some truly frightening stories that would make excellent testimony.

Charges

Consumers Union supports the suggested standards on billing the medically indigent by all nonprofit hospitals. We suggest this standard be expanded to include all uninsured and underinsured patients regardless of income level, and be applied to all hospitals, including for profit hospitals and public hospitals. No hospital should take advantage of uninsured or underinsured patients and require them to pay "sticker" price while insured patients have negotiated rates well below charges.

Most uninsured or underinsured patients do not understand the complexities of hospital billing and that the initial charges do not reflect the cost of care. Even when they cannot afford to pay a bill, many are reluctant to ask for "charity care." These patients should not be improperly influenced by high "sticker" prices and should instead receive a bill that reflects fair charges.

Conversions

Consumers Union has been monitoring hospital and health plan conversions nationwide for over 20 years. We have provided information and technical assistance to community groups, philanthropic leaders, and legislators, in 43 states faced with hospital and health plan conversions form nonprofit to for profit corporations. Before converting to a for-profit the nonprofit must show that their mission has become impossible or impractical.

As detailed in our Model Act (attached) Consumers Union believes that regulator overseeing al nonprofit conversions or sales must ensure:

- An open transparent process which allows the public the opportunity to participate in a meaningful way.
- The sale or conversion is in the public interest.
- The full fair market value of the nonprofit asset remains dedicated to a mission as close as possible to the original mission.
- The health of the community is maintained.

Many states have uses Consumers Union's Model Act in creating their own legislation in this area. ***We strongly oppose any federal conversion standard that does not specify that states may have their own stronger laws and regulations governing the conversion process.***

Special Rules for Hospitals Exempt Under §501(c)(3) and §501(c)(4)

Consumers Union opposes creating a separate category of nonprofit hospitals with 501(c) (4) status and lower standards required for charity care. It is unclear what benefit if any the community would receive from allowing hospitals to become a 501(c)(4), or why a hospital would convert except to avoid these requirements

At this time we are not aware of any hospital that has sought exemption under §501(c)(4). Though we appreciate that there are less tax benefits for §501(c)(4) hospitals, we feel that adopting a two-tiered system where there is currently only one, creates an undesirable incentive for hospitals to convert from §501(c)(3) to §501(c)(4) status in order to take advantage of lesser requirements. Nonprofit hospitals already too closely mimic the for-profit models. The community benefits standard, as you mention on page 5 of the draft, "is a facts and circumstances test without any clear lines." Though community benefits are valuable contributions to the public welfare, Consumers Union feels that, in exchange for their tax benefits, all hospitals should be required to provide direct medical services to those in the community that are in dire need. Creating a second, lesser standard, allows hospitals the choice to do otherwise.

In addition, this two-tiered system will create a influx of voluntary conversions from §501(c)(3) to §501(c)(4) that will necessarily require additional oversight on behalf of IRS and state attorneys general. The assets of a §501(c)(4) are not necessarily charitable and so full conversion proceedings would have to take place if a hospital wants to change its tax status. The same problems will arise with these conversions, as with conversions from nonprofit to for-profit hospitals and therefore the same rules should apply to a change of tax status. The draft does not address this issue in its discussion of the termination tax.

If staff does decide to recommend a two-tiered tax exempt status for nonprofit hospitals, we urge this committee to examine whether a new 501 category should be established which specifies that nonprofit hospitals are public charities with charitable obligations. At a minimum, the same standards for developing and posting a written charity care policy, and reporting the amount of charity care provided annually should apply to all nonprofit hospitals.

If a hospital converts from a § 501(c)(3) to either a § 501(c)(4) or a for-profit hospital, regulation should require notice to both federal and state regulators. Often state regulators are caught off-guard and do not become aware of the conversion until long after the fact. Opportunities for securing assets dedicated to the nonprofit mission may be lost.

Termination Tax

We oppose any government exaction that will divert assets away from any charitable trust.

When a nonprofit hospital decides to convert to for-profit, either a state conversion law applies, or if there is no law, the cy pres doctrine is applied by the state court. In both cases, the assets of the nonprofit continue to be used in accordance with the nonprofit mission if the nonprofit ceases to exist. The proposed termination tax would in essence be providing a federal statutory requirement in place of state law, where it exists, and common law cy pres doctrine where it doesn't. In this case, we recommend that a federal conversion standard is put in place, which requires any nonprofit intending on converting to a for-profit to notify the IRS.

The discussion draft lacks details about where the termination tax goes, once assessed. We do not support a "tax" that takes money from a nonprofit charitable organization and places the assets in governmental funds. Charitable assets are dedicated to the mission of the nonprofit organization. We would like to see greater detail about who administers the "tax", where the money goes and specifically how this tax will be used to ensure charitable assets are protected for the mission of the nonprofit organization. We encourage you to provide more details, and to not call this a "tax" as this implies a payment to the government.

Sanctions for Failure to Meet Requirements

Intermediate Sanctions

It is important that the IRS have the means to enforce these new requirements, and as such we support the recommendation to impose an assessment as an intermediate sanction on hospitals that do not meet the annual charity care requirements. (We oppose calling this sanction a "tax." We concerned that "tax" implies money will leave the nonprofit sector and be placed into government funds.) We agree to the suggestion that the assessment be in an amount at least equal to twice the hospital's shortfall, but ask for clarity about where this assessment money is allocated.

We suggest that the assessment collected should be allocated to a hospital, in the local area if possible that has met its charity care requirements, or other charitable health care service with the instruction that it be spent on providing additional free care to the community. The rationale is as follows. If a hospital succeeds in meeting its charity care requirements, the money spent stays in charitable nonprofit sector through donated hospital services rather than going to a "tax." For this reason, any sanction or "tax" imposed due to lack of compliance, means that the public has been shortchanged and is owed the charity care it is due. As we mentioned earlier, we do not support a "tax" that converts charitable nonprofit assets into governmental assets.

We disagree with the suggestion that the IRS look at the average over a three-year period to determine whether a hospital has met its requirements. Because nonprofit hospitals receive tax benefits each and every year, we feel that they should be required to meet these requirements each and every year. We see the 5% requirement to be a minimum. Though we commend hospitals that go above and beyond the minimum requirements, we don't want to discourage hospitals from meeting this minimum just because they exceeded it the previous year. The need within the community doesn't change because a hospital has already "technically" met it statutory obligations.

We understand that there are some hospitals that may not meet their requirements because of lack of demand. If the IRS is given the authority to reduce the excise tax in these circumstances, the law must provide clear guidance regarding what the hospital must show to receive a reduction. We agree that the reduced tax should be no less than the amount of the hospital's shortfall and, as mentioned above, should go to a hospital, in the local area that has met its charity care requirements, or other charitable health care service with the instruction that it be spent on providing additional free care to the community. [In Texas the hospital can donate the money to a charitable health care service in the community if it does not have enough business from eligible patients]

Revocation of Exempt Status
Revocation should not be left to the discretion of the IRS. It is important that there be detailed criteria for when the IRS is *required* to revoke the tax exemption of a nonprofit hospital that has failed to meet its requirements. The committee should also be aware that revoking the federal exemption from a nonprofit hospital will necessarily force the hospital to convert to for- profit. For this reason, it will be necessary to adopt conversion standards at the federal level that detail the procedures by which a nonprofit can convert and order the attorney general from the relevant state to begin official conversion proceedings. This need for federal conversion legislation arises again with respect to the proposed termination tax (see discussion above). We are concerned about pre-emption and urge that any federal policy allow states to have more aggressive policies to preserve charitable assets and maintain the health of their residents. We have attached the Consumers Union Model Conversion Act as guidance for the committee in developing these federal standards.

<u>Reporting</u>
All hospitals, nonprofit and for profit, should report charity care numbers. Our Model FAIR Care Policy details the external reporting and publication requirements we recommend to provide the greatest amount of transparency and accountability. At the federal level these numbers should be reported to the IRS or to HHS and published annually. This will enable the public and policymakers to see the full extent of charity care being provided in their community. Texas currently requires such reporting. The public and for-profit hospitals report for disclosure only, rather than meeting a standard.

<u>Collections</u>
Consumers Union supports applying FDCPA to all hospitals, including for profit. We suggest further research to ensure that this policy does not pre-empt any state laws that provide greater protections to consumers.

We have attached Consumers Union Model FAIR Care Policy which includes model collection standards for patients. This model includes restrictions on referring the debt, requirement for creating an equitable payment schedule with no interest, timing of

charity care eligibility, prohibiting any notation in the patient's medical record regarding financial matters, and sending charity care application packets to patients with existing unpaid medical bills.

Again, thank you for your efforts to improve charity care. We appreciate your consideration of our comments, and look forward to offering additional comments as your proposal takes shape.

Sincerely,

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