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Mr. Dean A. Zerbe
Senior Counsel and Tax Counsel
Minority Staff
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Mr. David Young
Chief of Staff
Senator Charles E. Grassley, Ranking Member
Senate Finance Committee
135 Hart Senate Building
Washington, DC 20510

Dear Mr. Zerbe and Mr. Young:

The Iowa Health System ("IHS") writes in response to the request by the Senate Finance Committee – Minority Staff ("Committee") for comments on the "Tax Exempt Hospitals: Discussion Draft" proposing reform in the area of nonprofit hospitals. IHS appreciates the opportunity to share our views on this topic.

IHS is a 501(c)(3) nonprofit corporation formed 12 years ago. We are the largest health system in Iowa and western Illinois, serving as the parent organization to the eleven urban hospitals and physician clinics whose governing boards decided to join the health system. These hospital affiliates are Iowa Methodist, Iowa Lutheran and Blank Children's in Des Moines; St. Luke's in Cedar Rapids; Allen Memorial in Waterloo; St. Luke's in Sioux City; Trinity in Fort Dodge; Finley in Dubuque; and Trinity 7th Street, Trinity Terrace Park and Trinity West in the Quad Cities. The physician clinics are located in each of the affiliate hospital's communities. Each of our affiliate organizations has served their communities for over 100 years. The IHS governing board as well as the governing boards of each of the hospital affiliates are comprised of local community leaders. Over 110 community leaders serve on these respective boards of directors.

IHS hospitals and physicians provide nearly thirty percent of all inpatient care received by Iowa residents. Annually, we admit over 100,000 patients to our hospitals. On an average day, approximately 6,500 patients are treated by an IHS provider. As Iowa's second largest employer, IHS and its affiliates employ over 18,000 individuals in coordinating, providing and administering healthcare to those in need. We employ approximately 450 physicians who provide services at our hospitals, and at over 128 clinic

sites in over 70 communities in Iowa, eastern Nebraska and western Illinois. In addition, over 2,600 physicians are on the active medical staffs of our facilities.

We treat all residents who seek care from these providers and facilities regardless of their ability to pay. In 2006, our affiliate hospitals provided approximately $77.5 million of charity care.[1] This charity care represented approximately 4.6 % of the $1.7 billion total operating expenses of IHS in 2006.[2] Our total quantifiable benefit to our communities was approximately $100 million in 2006, representing approximately 5.7% of IHS total

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[1] The $77.5 million of charity care was calculated using the Senate Finance Committee's proposed definition of charity care set forth in the Discussion Draft, pp 7 -8. A portion of this number is made up of patients who initially were billed for healthcare services, but were then rendered charity care once the hospital had the knowledge that the patient did not have the financial resources to pay for the services. Our system hospitals are working toward a process to more effectively identify charity care patients at the time of the initial contact with the hospital.
All IHS affiliate hospitals follow the IHS charity care and financial assistance policy, which in part, provides:

1. Charity care and financial assistance discounts shall be based on the following guidelines:
Hospital Patients

1.1 Full charity care shall be provided to underinsured and uninsured patients earning 200% or less of the Federal Poverty Income Guideline (FPIG).

1.2 For financially needy underinsured or uninsured patients (a) earning between 201% and 1000% of the FPIG, and (b) whose patient account balance exceeds the minimum balance on the table below, discounts shall be provided to limit such patient's payment obligation to the lower of

1.2.1 the equivalent of 7% of the patient's Annual Household Income (as defined below) each year for up to 3 years, or

1.2.2 the amount of the patient account balance after subtracting the percentage discount applicable to the patient's FPIG Household Income provided in the following table.

Percentage Discount & Minimum Guarantor Balance Table

	Minimum Guarantor Balance Based on Family Size					
FPIG	**1**	**2**	**3**	**4**	**5 or >**	**Discount**
< 200%	0	0	0	0	0	100%
201% - 400%	2,000.00	1,500.00	1,000.00	800.00	650.00	80%
401% - 600%	5,000.00	3,500.00	2,500.00	2,000.00	1,500.00	60%
601% - 800%	15,000.00	10,000.00	7,500.00	6,000.00	5,000.00	40%
801% - 1000%	25,000.00	16,500.00	12,500.00	10,000.00	8,000.00	20%

1.3 A minimum balance listed in the table must exist before this policy is applicable.
This policy also provides for waivers or discounts of Medicare or Medicaid co-pays, or deductibles based on financial need, and contains extensive provisions on the method of communicating the availability of charity care and financial assistance to patients. The entire policy can be found at:
http://www.ihs.org/documents/documents/2557_1BR34_financial%20assistance.pdf.

[2] Operating expenses excludes the cost of bad debt.

operating expenses.[3] In 2006, we received approximately $80.5 million of benefit by being tax exempt. This represents approximately 4.7% of IHS total operating expenses.[4]

The Committee has recommended special rules for Section 501(c)(3) nonprofit hospitals to qualify for tax exempt status, in addition to other rules for nonprofit hospitals that seek exemption under Section 501(c)(4).[5] Overall, IHS and its affiliates are in favor of reform that sets forth accountability requirements for hospitals to qualify for 501(c)(3) status. We take seriously the privilege of being tax exempt nonprofit organizations. Our mission is to improve the health of the people and communities we serve. Clear requirements in the area of charity care and community benefit are a reasonable manner for nonprofit hospitals to demonstrate they are mission focused and deserve the benefits of being tax exempt.

Several points in the Discussion Draft, in our view, would not make good public policy. In general, however, we whole-heartedly agree with the majority of the points raised in the Discussion Draft. We will briefly identify both types of issues in this paper and would appreciate the opportunity to discuss these points in detail with the Committee.

Discussion

- **501(c)(3) nonprofit hospitals should be held accountable for provision of a quantifiable amount of charity care and community benefit**

We support additional regulation to hold 501(c)(3) hospitals accountable to provide quantifiable amounts of charity care and community benefit to their communities. Speaking of our system specifically, the quantifiable benefit we give to our communities (5.7% of operating expenses) is greater than the benefit we receive from being tax exempt (4.7% of operating expenses). IHS earns its tax exempt status. We believe it is entirely reasonable to be expected to do so. We believe that all tax exempt organizations should be required to do the same. Accountability accompanies the privilege.

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[3] Our total quantifiable community benefit was calculated using the Catholic Health Association (CHA) definition and reporting guidelines for charity care and community benefit which have been endorsed by Senator Charles Grassley in his September 12, 2006 press release regarding the manner in which nonprofit hospitals should measure charity care and community benefit, and by the Committee in this Discussion Draft, p 13. While it is intended that neither bad debt, as defined by the CHA definition, nor Medicare shortfall is included in these calculations, IHS hospitals are modifying their reporting procedures to comply with the CHA guidelines. When calculating Medicaid shortfall, the difference between cost of service and Medicaid reimbursement was counted, rather than the difference between the charge master and Medicaid reimbursement. This methodology is in accordance with CHA guidelines.

[4] This number represents the tax liability from which IHS and its affiliate hospitals are exempt due to their 501(c)(3) status: property tax, sales tax, federal and state income tax, savings on interest rates and unemployment taxes.

[5] The Discussion Draft suggests that only 501(c)(4)'s be required to provide a minimum quantitative amount of community benefit, while the draft does not identify a quantifiable amount of community benefit to be provided by 501(c)(3) hospitals. See Draft pp 12-13.

Our concern with the Committee's discussion of a 5% requirement for charity care is that the Committee has created a two-tiered system between nonprofit hospitals that will be required to provide a quantifiable amount of charity care (501(c)(3)'s) and nonprofit hospitals that will be required to provide a quantifiable amount of community benefit (501(c)(4's). The Committee suggests that 501(c)(3)'s will provide a set level of free and subsidized care and thereby receive greater tax exempt benefits than 501(c)(4)'s who will provide a quantifiable amount of community benefit other than free and subsidized care. The fundamental premise behind this suggestion is that free and subsidized care given by nonprofit hospitals is more valuable to our communities than other types of community benefit provided by nonprofit hospitals.

It is this fundamental premise with which we do not agree. It is of substantial value to our communities that our affiliate hospitals provide free and subsidized care. This does not mean that the other services provided by nonprofit hospitals to their communities are less valuable to vulnerable populations. For example, the following services are provided to our communities that are not free care: (1) behavioral health[6]; (2) substance abuse units[7]; (3) a specialty children's hospital[8]; (4) emergency rooms open to all[9]; (5) trauma centers[10]; (6) a poison center; (7) physical rehabilitation units and (8) primary care clinics. These services are offered because they are needed in our community, are not being offered by for profit entities[11], and constitute valued community benefits to those we serve. These services annually operate at a loss, but we provide them because there is a critically high need for these services in our communities. As such, these services should be counted by the government in evaluating the benefits provided by the nonprofit hospital.

Our suggestion is that 501(c)(3) nonprofit hospitals be held accountable for a quantifiable amount of benefit to the community which encompasses both charity care and community benefit. Community benefit can be ascertained by following the CHA guidelines of community benefit categories. The CHA guidelines provide a common yardstick by which all nonprofits can be evaluated. The CHA guidelines provides a clear

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[6] IHS hospitals provide one-fourth of the inpatient mental health care in the state of Iowa. Our care of mental health patients typifies how much of the care we render is compensated care but is serving vulnerable populations. The compensation rate does not cover the cost of offering the service.

[7] IHS hospitals provide 92% of the medically managed inpatient substance abuse care and 50% of the primary/extended residential substance abuse care in the state of Iowa. Our care of substance abuse patients is another example of care that we are reimbursed for that serves a vulnerable population. The rate of compensation we receive for the service does not cover the cost of service.

[8] Blank Children's Hospital was founded in 1944, and is a leader in pediatric emergency services; pediatric intensive care; neonatal intensive care; pediatric cancer care; and many other specialty and primary care areas. Blank is a teaching hospital and is one of only two hospitals in Iowa to train residents in pediatrics. The children Blank serves come from across the state and beyond.

[9] Every IHS hospital offers a 24 hour accessible emergency room open to all members of the public, regardless of the ability to pay.

[10] There are seven designated Trauma Centers among our affiliate hospitals, and one Level One Trauma Center at Iowa Methodist in Des Moines.

[11] In addition to offering compensated services not offered by for profit hospitals, nonprofit hospitals also provide benefits to their communities similar to those provided by the for profit sector. For example, health education and research benefits both the vulnerable populations, and the communities as a whole.

standard to measure a combination of free care and community benefit provided by 501(c)(3) nonprofit hospitals. The adequate level to be obtained under the CHA could be proposed by legislation.

One purpose of the Discussion Draft is to spur regulation that will "ensure that in exchange for the . . . tax breaks nonprofit hospitals [receive they] . . . provide concrete benefits to the community, especially to the most vulnerable in our nation." We caution that the Committee should promote not only the provision of free care, but the provision of all services that benefit vulnerable populations.[12] Only through a measuring standard that takes into account both free care and community benefit can this purpose be properly served.

● All hospitals and health systems should be required to quantify charity care and community benefit

The Committee has exempted critical access hospitals (CAH) from the requirement of providing a quantifiable amount of charity care and community benefit. We do not support this exemption. As indicated above, we believe that every tax exempt hospital or health system, including critical access hospitals, should be required to earn the benefits of tax exemption. Both CAH and urban hospitals serve vulnerable populations. Both are nonprofit organizations. We suggest it is poor public policy to presume that CAH, that receive the same tax benefits of nonprofit hospital status as urban hospitals, are meeting the needs of their communities. This is particularly true in Iowa where many of the urban hospitals are not that much different than "rural" hospitals which have been legislatively designated as CAH. For example, several CAH in Iowa are geographically located approximately 20 to 50 miles from our urban hospitals and serve the same vulnerable populations.

● Charges to the uninsured or underinsured should reflect actual cost and negotiated private insurance reimbursement

The Committee has suggested that a hospital may not charge a medically indigent patient who is uninsured or under-insured a rate that exceeds the lower of: (i) the lowest rate that would be paid by Medicare/Medicaid or (ii) the actual cost to the hospital for such service. For the majority of hospital services provided in Iowa, this will mean that hospitals will not be able to charge over the Medicare or Medicaid rate, because in most instances

[12] The community services described above, which are provided at a financial loss, are worthy of measurement by the government in evaluating nonprofit hospitals' worth to their communities. By excluding these critically needed services from this calculation, the Committee discourages nonprofit hospitals from continuing to provide these services, services which have already been marginalized by reimbursement decisions by the government. Many services that the governing hospital boards have decided to continue to provide, even though government sponsored health benefits do not pay the cost of providing the services, create a tension with the board member's fiduciary duties who have a legal obligation to maintain their hospital's finances so the hospital can continue to provide services to constituents. The hospitals' missions, as defined by these local leaders, are to provide these services because they are needed. If the standard suggested by the Committee becomes legislation, these leaders will need to understand that these services will not be counted by the government in evaluating the amount of community benefit provided by the hospital.

these rates are considerably lower than the actual cost to the hospital for providing the services. We suggest that rather than using the governmental reimbursement rate as the set charge for a medically indigent patient who is uninsured or under-insured, a charge that reflects a combination of both negotiated insurance reimbursement rates and actual cost be used.

● Further regulation of joint venture relationships may drive private joint venture partners from the market and create a for profit system of health care services in Iowa

IHS has several physician joint venture relationships that we believe serve the community by better integrating the physician and health system resources and by better aligning financial incentives. These partnerships focus primarily on providing specialty surgical or clinical services. To some extent, the health care market in our communities have encouraged nonprofit hospitals to enter into joint venture relationships with physicians to ensure that certain services can be most effectively coordinated for our communities. As the Committee is aware, substantial regulation of joint venture relationships with nonprofit hospitals and for profit physician partners exists today. Because these joint venture relationships are highly regulated, for profit partners are often hesitant and reluctant to enter into partnerships with nonprofits hospitals. Our concern is that further regulation of joint venture relationships between for profit partners will make relationships with a nonprofit hospital even less attractive to specialty providers. This policy would likely drive physicians to provide the specialty services on their own, without the benefit of integrated and coordinated delivery with a hospital partner. This would create a duplication of the same services in the community and would put the hospitals in direct competition with specialty clinics or hospitals.

This is not in the best interest of patient care and our communities. For profit surgery centers or physician-owned specialty hospitals do not seek to provide charity care. Charity care and community benefit would be reduced in these specialty areas of care if for profit providers were further incented to avoid joint ventures of care delivery with nonprofit hospitals.

● Good governance is essential for 501(c)(3) nonprofit hospitals. Independent Directors (not political appointees) is the factor most critical to good governance

IHS follows the majority of the governance practices set forth by the Committee in its discussion of Governance on pp14-15 of the Discussion Draft.[13] Our suggestion is that

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[13] The IHS board of directors is made up of 19 individuals either appointed by the boards of directors of the hospitals from the seven communities previously mentioned, or elected by the IHS board of directors. We have devoted substantial effort to identify and implement "best practices" in the area of corporate governance. In 2003, shortly after the Sarbanes-Oxley Act was passed by Congress in response to corporate scandals and financial collapses, IHS voluntarily adopted over 40 changes to policies and governance requirements. IHS takes its governance very seriously. Accordingly, we strongly believe IHS is governed well, and that we are administering the business of healthcare in a responsible and appropriate manner.

board members continue to be chosen based on their experience in the healthcare field, business acumen or community background. We do not believe that requiring public officials to control the hospital governing boards would enhance oversight beyond the level of oversight provided by independent community leaders.

● Reasonable sanctions are appropriate for 501(c)(3)'s who do not meet standards and those who exceed standards should be rewarded

The Committee has stated one goal of the Discussion Draft is to increase care to vulnerable populations. Requiring nonprofit hospitals to contribute their fair share to this goal makes good public policy. However, regulating the operation of nonprofit hospitals to the extent that they are inordinately burdensome to operate could result in significant negative impact to our communities. We strongly urge a cautious approach to fully develop the understanding of this potentially severe adverse impact. Over regulation could discourage hospitals and health systems from seeking or maintaining nonprofit status and potentially from being providers of governmental reimbursed services. If our Iowa nonprofit hospitals operated as for profit entities, it would result in a loss of services provided to vulnerable populations. It has been suggested by Senator Grassley that some for profit hospitals provide "as much if not more charity care than some nonprofit hospitals."[14] Not true in Iowa where all of the hospitals are nonprofit. Iowa Health System believes this contributes to Iowa's rate of uninsured persons in Iowa which is among the lowest in the United States.[15] The potential savings to the U.S. Treasury that are realized when the rate of uninsured individuals is low, is more than off-set by creating over-regulation that results in the decision of tax exempt hospitals to convert to for profit status, withdraw from the provision free care and essential community services, and have the resultant burden fall on the government. The Committee reform proposals should seek to enhance local, independent governance and the continued provision of these critical healthcare services.

IHS suggests that hospitals and health systems that meet or exceed congressional standards set for quality; charity care; community benefit; transparency and governance should be recognized by the federal government for their contributions and achievements. These hospitals and health systems should receive additional reimbursement for the provision of services that will allow such nonprofit entities to remain financially viable and

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Our Board ensures the organization fulfills its charitable mission. The Board has established independent standing committees of the Board which govern director independence, the compensation of the organization's executives, and the finances of the organization. We have established an effective corporate compliance program and conflict of interest policies.

[14] Quote of Senator Grassley, *Hospital Charity Care Is Probed*, Washington Post p.D2 September 13, 2006

[15] Approximately 9.1 percent of Iowans do not have insurance coverage. Approximately 5 percent of Iowa children are uninsured. Iowa ranks 3rd among the states, in number of residents, who have health insurance coverage. Statement of Susan Voss, Insurance Commissioner of Iowa, Iowa General Assembly 2007 Committee Briefing, Affordable Healthcare Commission Meeting, June 20, 2007.

competitive with for profit services. In this way, the federal government promotes the provision of high quality care to vulnerable populations by well run entities.

● Nonprofits should not engage in unfair billing and collection practices

We support the expansion of the FDCPA to internal hospital billing and collection practices. Further, we recommend hospitals establish their own internal billing and collection practices.[16]

● Transparency in executive compensation and other matters

We practice transparency in all facets of our organization. IHS believes this is a fundamental practice that should be required of 501(c)(3)'s. For example, in regard to executive compensation,[17] we have published the total compensation of our Health System and hospital chief executives on our website for over two years.[18] Additionally, we report an executive's total compensation on the Form 990 filed by the Health System and each of our hospitals. Our executives' W-2 compensation is the same as the amounts seen by the public on our website and on our Form 990's.

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[16] IHS has developed the following guidelines for billing and collections:

- Standards and scope of practices to be used in any collection efforts have been defined and collection agencies are instructed to adhere to such standards and scope of practices.
- Bills to patients include a) a statement that indicates that, if the patient meets certain income requirements, the patient may be eligible for financial assistance; and b) a statement that provides the patient with the name and telephone number of a facility employee or office from whom or which the patient may obtain information about the financial assistance policies for patients and how to apply for such assistance.
- Collection efforts do not include seizure of real estate.
- Extended payment plans offered to patients in settling past due outstanding hospital bills is interest-free.
- Board of director involvement in administration and oversight of financial assistance policies and CFO approval of collection activities. Multiple follow-ups w/patient before collection activity goes to litigation.

[17] IHS believes that it complies with the regulations issued by the IRS under the Taxpayer Bill of Rights 2 ("TBR2") concerning executive compensation. The IHS Board of Directors has delegated to its Executive Committee the authority to oversee the setting and adjustment of executive compensation and benefits. The Executive Committee consists entirely of disinterested board members. These board members review extensive market data compiled by an independent national compensation consulting firm for each executive position – data that is derived from health systems and hospitals of a similar size to the organization for which each Iowa Health executive works. These board members meet several times each year in extensive meetings to review the data, to understand the competitive market, to ask questions of the consultant, to make sure that the data results in an "apples to apples" comparison, and to decide on what the committee considers to be reasonable compensation for each executive. The Committee receives expert legal advice to help assure compliance with this law. IHS believes its process compiles with the IRS regulations and that it would receive the benefit of the rebuttable presumption of reasonableness provided in the regulations.

[18] Website: http://www.ihs.org/body.cfm?id=1048

To avoid transparency, we understand that some tax exempt organizations choose to split an executive's compensation among related entities which receive services from the executive. As a result, the compensation reported on that organization's 990 will be less than the executive's W-2 income, because the amounts paid to the executive by the other related entities do not appear on the 990 of the reporting organization. Nor does it appear necessarily on the 990s of the related organizations because only the top five salaries need to be disclosed on the 990. Not so with IHS – the executive's total W-2 compensation, is reported on the applicable, single 990, and is on our website as well.

We are also working on a pricing model that will allow potential patients to assess what the cost of their clinical or surgical services will be if they obtain the healthcare service from our facility—the cost they will pay out of their own pocket. This model will allow potential patients to make informed choices regarding their financial liability for healthcare services.

Conclusion

The Committee has stated that the reforms contemplated for nonprofit hospitals are not a "cure-all" to improve healthcare for low income families.[19] Picking up on this note, we remind the Committee that nonprofit hospitals operate in a complex environment.[20] While performing the duties of a charitable organization, nonprofit hospitals deal with the reality that their ability to provide compensated and uncompensated care to their communities, in addition to community benefits, depends on transactions with many for profit entities such as insurance companies, pharmaceutical companies, healthcare supply vendors and physicians. A "cure-all" will not come through reform of the nonprofit hospital alone. In seeking ways to reform our healthcare system, we encourage Senator Grassley and the Committee to maintain the parts of the system that work to provide quantifiable benefit to our communities and its vulnerable populations, and to also look to the other parts of the healthcare delivery market place to consider a more global reform instead of focusing on one facet of the system.

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[19] Discussion Draft, p. 4.

[20] The changes in healthcare in the recent past and those that lie ahead of us have been and will continue to be great. Peter Drucker, a well known management expert and a man *BusinessWeek* called "the most enduring management thinker of our time," said that a "large healthcare organization may be the most complex organization in human history."

The past three decades have seen unprecedented change in our system of health care: new financing mechanisms, accelerating technology innovations, and new paradigms for care. Experts predict these changes will pale in comparison to the investments providers must make. If the health system cannot consistently deliver today's science and technology, we may conclude that it is even less prepared to respond to the extraordinary scientific advances that will surely emerge during the first half of the 21st century. *Mission Critical: The Essential Role of Not-For profit / For profit Community Hospitals to California's Health Care Delivery System*.

We appreciate the opportunity to share our thoughts on this proposal. IHS is committed to the principals of accountability to our communities, good governance and transparency, and supports reasonable legislation promoting these principles. We recognize that a significant amount of time and effort has been put into the research, examination and recommendations in the discussion draft, and look forward to discussing these issues further.

Sincerely,

Sabra Rosener