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VIA ELECTRONIC SUBMISSION AT REGULATIONS.GOV

September 24, 2012

U.S. Department of Treasury  
Internal Revenue Service  
CC:PA:LPD:PR (REG-130266-11), Room 5203  
P.O. Box 7604  
Ben Franklin Station  
Washington, DC 20044

**Re: Notice of Proposed Rulemaking, “Additional Requirements for Charitable Hospitals,” 26 Code of Federal Regulations Part 1, [REG-130266-11]**

Dear Sir/Madam:

The National Immigration Law Center respectfully submits the following comments to the Department of the Treasury, Internal Revenue Service (IRS) in response to the [Notice of Proposed Rulemaking, REG-130266-11; Additional Requirements for Charitable Hospitals](#) (the Notice).

The National Immigration Law Center (NILC) specializes in the intersection of health care and immigration laws and policies, offering technical assistance, training, and publications to government agencies, nonprofit organizations and health care providers across the country. For over 30 years, NILC has worked to promote and ensure access to health services for low-income immigrants and their family members.

Due to a number of unique access barriers, noncitizens, including both undocumented and lawfully present individuals, are three times more likely to lack health insurance than citizens. Since individuals who are not lawfully present are specifically ineligible to buy health insurance for themselves in the affordable insurance exchanges (exchanges) created by the Affordable Care Act (ACA) and remain ineligible for federal non-emergency Medicaid and the Children’s Health Insurance Program (CHIP), that disparity will only grow once the ACA is fully implemented, although citizens will continue be the majority of the uninsured.

The latest estimates from the Congressional Budget Office indicate that while approximately 30 million citizens and lawfully present immigrants will gain health coverage as a result of the ACA’s historic coverage expansions, 30 million U.S. residents are expected to remain uninsured<sup>1</sup> due to a range of factors: about one-quarter will be ineligible for coverage because of their immigration status; others will be eligible for Medicaid but not enrolled; and the remaining will be ineligible for

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<sup>1</sup> Congressional Budget Office, “Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision,” July 2012. Available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>

subsidies but still unable to afford coverage, exempt from the requirement to buy insurance, or choose to pay the penalty rather than purchase coverage.

This remaining uninsured population will continue to rely on the safety net health care system, including charitable hospitals. The requirements for charitable hospitals at Sections 1.501(r)-(1) through 1.501(r)-(7) of the Internal Revenue Code provide critical consumer protections for uninsured individuals who may be a medical emergency away from severe medical debt or even bankruptcy or simply cannot afford to pay their full hospital bill.

Today, too many U.S. residents are losing the battle between physical health and financial security. While several factors contribute to medical debt, aggressive billing and collection efforts used by hospitals and third-party contractors can create significant financial hardships for patients and prevent equitable access to care. Low-income immigrants are disproportionately affected by such practices, as they are more likely to lack health insurance and face unique obstacles accessing care, health coverage and consumer assistance in the health care system. In particular, immigrants face linguistic and cultural barriers, unfamiliarity with and confusion about the U.S. health care system in general, legal barriers to public health insurance programs and private health insurance offered through the exchanges, and concerns about what personal information is required upon registration and at application for financial assistance and how it will be used. Our comments, therefore, focus on the issues we believe are most critical to ensuring that uninsured patients, especially low-income immigrants, are treated equitably and fairly in matters related to hospital financial assistance, billing and collections.

We commend the IRS and Treasury for issuing proposed rules that will more fully implement the patient protections found in the ACA, thereby promoting patient access to care, protecting families from medical debt, and improving hospitals' accountability for the tax benefits they receive. The following comments suggest ways to further strengthen patient protections in the final.

## **I. Establishing a Financial Assistance Policy**

Under the ACA, nonprofit hospitals must establish a written financial assistance policy that clearly outlines what kind of help is available, who is eligible, and how to apply. Nonprofit hospitals must also make sure the policy is widely publicized in the communities they serve. The law takes significant strides forward to connect patients and the general public—particularly those without affordable health care coverage—to basic information about hospital financial assistance programs (FAPs) for which they might be eligible. Our comments address the key points in the Notice that will make implementation of these requirements meaningful for patients.

In general, we strongly support the new standards for transparency and disclosure outlined in the Notice. We are particularly pleased that the Notice explicitly defines the steps nonprofit hospitals must take to “widely publicize” their financial assistance policies, and we recommend that final rules adopt this approach in its entirety. The

Notice provides hospitals with common sense, practical approaches to keep community members informed about financial assistance, in keeping with their charitable missions to promote access to care.

While it is important for a hospital to publicize its financial assistance policy (FAP) with its existing patients, by posting information in public areas of the facility and in all communications to its patients, measures aimed at publicizing the FAP with the surrounding community and public, such as through local news media, social service agencies, and physicians and community health centers in the community, are equally important. Uninsured patients, and immigrants in particular, tend to delay and avoid medical care because of costs. Efforts to educate the community about the hospital's FAP, such as those described in the Notice, may ease potential patients' concerns about cost and encourage them to seek needed care and apply for financial assistance.

**Scope of the Financial Assistance Policy - § 1.501(r)-4(b)**

We strongly support the proposed requirement that hospital financial assistance policies be applicable to all emergency and medically necessary care provided by the hospital facility.

We recommend the IRS issue specific guidance that a nonprofit hospital's financial assistance policy apply to all other providers a patient might encounter in the course of treatment at a hospital, such as hospital-owned physician practices, non-employee physicians, and other providers, as well as laboratory and radiological services, pharmacy services located within or operated by a hospital facility, and outpatient clinics affiliated with or run by the hospital. From a patient's perspective, these providers are indistinguishable from the hospital itself. The patient should have the security of knowing that a single FAP will cover all services provided at the hospital in the course of treatment of a medical emergency or medically necessary care.

**Widely Publicizing the Financial Assistance Policy - § 1.501(r)-4(b)(5)**

We recommend that final rules retain the requirement that nonprofit hospitals make free copies of the full financial assistance policy (FAP), application form, and a plain language summary available upon request and on the Web. The final rule should also clarify that the plain language summary must include notification that the full FAP is available, and how to obtain it. As mentioned above, we strongly support the requirement that nonprofit hospitals "inform and notify" hospital visitors as well as the general public and community served by the hospital, with special emphasis placed on hard-to-reach communities most likely to need financial help, such as immigrant and limited-English proficient (LEP) communities. Finally, we also recommend that the IRS work with HHS to link hospital policies on a national, searchable format, such as [www.healthcare.gov](http://www.healthcare.gov).

**Language Access - §§ 1.501(r)-(4)(A)(v), 1.501(r)-4(b)(5)(i)(B), 1.501(r)-4(b)(5)(iii), and 1.501(r)-4(b)(5)(v)**

Almost 20% of the population speaks a language other than English at home. Over 24 million, or 8.7% of the population, speak English less than very well and should be

considered limited English proficient (LEP) for health care purposes.<sup>2</sup> This includes 47% of Spanish speakers, 33% of speakers of other Indo-European languages, 49% of speakers of Asian and Pacific Islander languages, and 30% of speakers of other languages.

Hospitals need to assist LEP individuals to ensure compliance with ACA § 1557 and Title VI of the Civil Rights Act and identify any potential discrimination or health care disparities. Given existing requirements for providing language services under Title VI, we believe IRS' regulations should adopt the same thresholds these hospitals should already utilize for translating "vital documents"<sup>3</sup> as the FAP certainly is a vital document for individuals who are uninsured and need assistance paying their medical bills.

To meet the requirement in section 1.501(r)-(4)(A)(v) of the Internal Revenue Code that Financial Assistance Plans (FAPs) be "widely publicized" within the community served by the organization, charitable hospitals must ensure that limited-English proficient (LEP) individuals know of and understand the benefits of the hospital's FAP and related documents. IRS should require that hospitals do this for patients currently served by the charitable hospital, as well as for potential patients in the hospital's community.

- ***Definition of Community Served***

We request that IRS define "community served by the hospital" in greater detail. IRS should define the term in a way that leads to an accurate representation of both the actual demographics of individuals who use the hospital facility as well as demographics of individuals that are in the hospital's community but may not currently use the hospital.

Individuals may live or work within the hospital facility's service community but not use the facility because the hospital lacks adequate language access services. Therefore, it is critical that the hospital facility assess the language needs of both its existing patients as well as its potential patients in its community. This concept is outlined in HHS' Office for Civil Rights' "LEP Guidance" which says that a hospital receiving federal financial assistance must take reasonable steps to provide meaningful access to LEP individuals. As part of the analysis of what services to provide, the hospital should undertake a self-assessment that balances

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<sup>2</sup> American Community Survey, 2006-2008, *Selected Social Characteristics in the United States: 2006-2008*; also American Community Survey, 2008, *Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over*, Table B16001, available at <http://factfinder.census.gov>.

<sup>3</sup> HHS' "LEP Guidance" states "Whether or not a document (or the information it solicits) is "vital" may depend upon the importance of the program, information, encounter, or service involved, and the consequence to the LEP person if the information in question is not provided accurately or in a timely manner." See, HHS, Office for Civil Rights, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, <http://www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf>.

factors including “(1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee.”<sup>4</sup>

We further request that IRS define “community served” in a manner that does not exempt hospitals from translating FAP documents for many LEP individuals because IRS uses too broad a geographic area for LEP populations to ever meet the thresholds for translation. The definition of “community served” has wide ranging implications for whether an LEP person will receive translated FAP documents. For example, if IRS’ proposed 10% threshold is applied on a county level, hospitals in 27 states would likely be excluded from translating any documents because no counties contain 10% LEP individuals. Only 255 counties in the entire country (78 of which are in Puerto Rico) meet the 10% threshold that would require hospitals to translate FAP materials for LEP populations.<sup>5</sup> If IRS adopted a stricter definition of “service area,” hospitals applying the 10% threshold to smaller geographic areas may be more likely to constitute a high enough percentage of the population to trigger translation. Yet we strongly urge IRS to adopt a numeric threshold in addition to the percentage threshold (regardless of what the percentage is) to ensure that millions of LEP individuals are not left out of receiving critical information.

The proposed rule only includes a percentage threshold for requiring charitable hospitals to translate FAP materials. It merely requires translation of notices when 10% of the community served by the hospital population is LEP. First, we believe a 10% threshold is too high, especially when many hospitals are already subject to guidance from HHS’ Office for Civil Rights that expects translation when a language group is 5% or 1,000 individuals.<sup>6</sup>

As noted above, a 10% threshold used in conjunction with a county-level service area would lead to an exemption from translating FAP materials for every nonprofit hospital in 27 States. Only 177 counties in the mainland United States would contain hospitals required to translate materials. This is woefully insufficient. For instance, no hospital in the city of Chicago—a diverse metropolis and the third largest city in the United States—would be required to translate FAP materials using a ten percent threshold. Yet there are 461,000 LEP Spanish speakers in Chicago alone.

We thus request that IRS adopt a dual threshold with both a numeric and percentage alternative, requiring translation when either is met, for translating charitable hospital's financial assistance plan documents. Hospitals should translate FAP materials for each LEP language group that constitutes **five percent or 500 of the individuals** eligible to be served. The proposed rule cites 26 CFR 54.9815—2719T(e) as an example of a similar federal regulation requiring notices or summaries

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<sup>4</sup> HHS, Office for Civil Rights, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, <http://www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf>.

<sup>5</sup> See <http://allianceforajustsociety.org/wp-content/uploads/2011/09/Left-in-the-Dark-FINAL.pdf>

<sup>6</sup> See *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (LEP Guidance) available at <http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.php>.

to be issued in non-English languages. That regulation uses a 500 person numerical threshold in addition to a percentage of the community served threshold, a policy we strongly support.<sup>7</sup>

We do understand that certain circumstances may occur for an exception to translating vital documents for small language groups. The HHS LEP guidance addressed this issue by noting that if there are fewer than 50 people in a language group that reaches the five percent threshold, the hospital must provide written notice of the right to receive competent oral interpretation of the written materials, free of cost. We suggest IRS could adopt a similar requirement.

- **§ 1.501(r)-6(c): Reasonable Efforts**

The final rule should also address language access issues in regard to follow-up communications with LEP individuals once they have submitted a financial assistance application. We request that the rule require that all future communications with the individual regarding their financial assistance application be provided in the same language as the submitted application. This provision is necessary to achieve the purpose of the proposed rule.

- **Oral Language Assistance**

The proposed rule on charitable hospitals does not address the provision of oral language assistance which is an essential method for ensuring effective communication with LEP individuals, especially if translated materials are unavailable or LEP individuals have questions about translated materials. We request that the provision of oral language assistance be addressed in rulemaking in a way that is consistent with previous HHS guidance.

The Department of Health and Human Services LEP Guidance under Title VI built upon Executive Order 13166, which required federal agencies to publish guidance on how their recipients can provide meaningful access to LEP persons. In that Guidance, HHS recognized that “The more frequent the contact with a particular language group, the more likely that enhanced language services in that language are needed.”<sup>8</sup> The Guidance provided a safe harbor for compliance with Title VI for oral assistance in addition to the one provided for translations: if there are fewer than 50 people in a language group that reaches the five percent threshold, the recipient can provide written notice of the right to receive competent oral interpretation of the written materials, free of cost.<sup>9</sup> If these criteria were practicable for all recipients of Federal financial assistance for more

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<sup>7</sup> See subparagraph (ii) – “For a plan that covers 100 or more participants at the beginning of a plan year, if the plan and issuer provide notices upon request in a non-English language in which the lesser of 500 or more participants, or 10 percent or more of all plan participants, are literate only in the same non-English language.” 26 CFR 54.9815—2719T(e)

<sup>8</sup> HHS, Office for Civil Rights, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, <http://www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf> at 47314.

<sup>9</sup> *Id.* at 47319.

than eight years, likely including all hospitals subject to this rule since they receive federal financial assistance, why are they suddenly impracticable for charitable hospitals regarding a FAP which offers a vital lifeline for many low-income individuals from medical costs and bankruptcy? Further, the LEP Guidance recognizes that all LEP individuals, regardless of meeting a threshold for translating written documents, must be afforded oral language assistance when needed.<sup>10</sup>

- **§ 1.501(r)-4(d)(5)(D)(iii): Meaning of Reasonably Calculated**

The definition of “reasonably calculated” does not establish any thresholds for when hospitals must translate notifications within and outside of the hospital into non-English languages for LEP populations. We request that IRS adopt the same dual threshold for FAPs. Hospitals should translate notices for LEP language group that constitutes **five percent or 500 of the individuals eligible to be served**.

It is critical that hospitals translate notices into non-English languages for LEP populations. LEP populations will not know the FAP exists if they are unable to read the notices posted throughout the hospital or in the community, and they will not know to ask hospital staff for a written copy of the FAP. The FAP notices are a necessary link between the LEP population and the FAP materials, therefore hospitals must translate the notices along with the FAP materials.

In addition, we request that the IRS require hospitals to provide tag lines in the top 15 most common languages spoken by LEP individuals on the plain language summary of the form that provide contact information for whom an LEP individual can call for assistance in their language.

- **§ 1.504(r)-4(a)(4)(C)(ii): Separate billing and collections policy.**

The proposed rule does not require hospitals to translate the separate billing and collections policy for LEP populations. We request that IRS adopt the same standard for translating the billing and collections policy documents as for the FAP and the conspicuous public displays; hospitals should provide translations for each eligible LEP language group that constitutes **five percent or 500 individuals eligible** to be served, whichever is less, of the population of persons eligible to be served. Doing so will satisfy the intent of the regulation, which is that hospitals take reasonable measures to inform individuals about the FAP. The billing and collections policy contains information that is important to FAP applicants and therefore must be translated in order for LEP individuals to fully understand their rights and obligations.

### **Content of Financial Assistance Policies**

#### ***Eligibility Criteria - § 1.501(r)-4(2)***

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<sup>10</sup> *Id.*

We recognize that establishing minimum eligibility standards for financial assistance goes beyond the scope of the ACA statute. Rather, the ACA—and the Notice—requires nonprofit hospitals to disclose key information about their financial assistance policies. Hospitals retain full flexibility and discretion in establishing who is eligible for assistance, including whether their policies will:

- Extend eligibility to the underinsured and “medically indigent,” as well as the uninsured
- Tie eligibility to family income and/or assets
- Count or exclude certain assets in eligibility determinations

Because these are critical issues for many patients, we appreciate that the Notice cites examples of hospital policies that do address these issues and support the inclusion of these examples in final rules.<sup>11</sup>

***Requiring Community Input on the Financial Assistance Policy***

We believe that hospital facilities should be required to consult with members of the community, including representatives of vulnerable, disadvantaged, or hard-to-reach community members, as they develop, implement and revise their financial assistance policies. Working with community partners in developing materials, reaching out to vulnerable populations, and identifying areas for improvement can help hospitals more effectively connect patients to care. Community input on financial assistance could be incorporated as part of the overall framework for community health needs assessments, or at other points as hospitals review their financial assistance policies.

***Method for Applying for Financial Assistance - § 1.501(r)-4(b)(3); and Third Party Verification and Flexibility - § 1.501(r)-6(4)(iv)***

Section 1.501(r)-4(b)(3) of the Notice requires nonprofit hospitals to describe the information and documentation the hospital may require an individual to submit as part of an application. It does not otherwise establish criteria hospitals may or may not use as part of the application process. Later in the Notice, comments are requested on how hospitals might appropriately use external information—including information provided by third parties—that would allow them to determine eligibility for financial assistance separately from a formal application process.

We believe these two issues are connected and address them together. We recommend the IRS:

- Add language to ensure that hospitals’ application and documentation requirements are not unduly burdensome for the patient;
- Add language to ensure that the lack of documentation is not a barrier to financial assistance (an affidavit signed by the applicant should be sufficient if no other documentation is reasonably available);
- Prohibit hospitals from requesting information that is not necessary for making an eligibility determination, including a Social Security number, citizenship or immigration status information;

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<sup>11</sup> See §1.501(r)-4(b)(2)(ii), pages 64-65.

- Allow hospitals to use patient-friendly methods to “presumptively” qualify patients for financial assistance other than through a formal application process (e.g., checking enrollment in means-tested public programs such as Medicaid, food stamps, or reduced or free school lunch programs); if such methods are used, require hospitals to adopt policies that ensure the privacy and security of the individual’s information, including ensuring that such information is used only for the purpose of determining eligibility for financial assistance .

**Emergency Medical Care Policy - §1.501(r)-4(c)**

We support the requirement that a hospital facility establish a written policy that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they are FAP-eligible.

We also appreciate and strongly support the prohibition on debt collection activities in the emergency department or other hospital venues where such activities could interfere with the treatment of emergency medical conditions. Too often, we have heard stories of patients with very limited means being pressured to pay for care at the time of service with credit cards, digging into retirement or savings accounts, or asking friends and family to cover the bill—all without any discussion about financial assistance, payment plans, and other consumer-friendly options the hospital may offer or know about. At the same time, our understanding is that providing patients with oral notice about financial assistance at the point of service is one of the most effective methods for informing them that this option exists. While we generally favor a provision that would significantly curtail collection attempts in emergency rooms and other, similar settings, we seek clarification that nothing in this section would prohibit a hospital from providing a patient with oral information about financial assistance.

**Implementing a Policy - § 1.501(r)-4(d)(3)**

We recommend that the IRS provide additional guidance as to when a hospital will have been deemed to “consistently carry out” its financial assistance policy.

## **II. Limiting Charges**

The ACA prohibits nonprofit hospitals from using “gross charges,” known colloquially as the rack rate or chargemaster rate. Gross charges are often a starting point in providers’ negotiations with other payers, such as private insurers, Medicare, and state Medicaid programs. They are usually set much higher than the costs a hospital incurs for providing care. One unintended consequence of this system is that uninsured and underinsured patients—who lack the clout and ability to negotiate better rates—can be held liable for paying significantly higher rates than insured patients, Medicare or commercial insurance plans.<sup>12</sup> To make pricing more equitable, the ACA prohibits gross charges and requires nonprofit hospitals to limit charges to

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<sup>12</sup> See, e.g., Gerard Anderson, “From ‘Soak the Rich’ to ‘Soak the Poor’: Recent Trends in Hospital Pricing,” *Health Affairs*, May 2007, 26:3780-789. Available at [http://content.healthaffairs.org/content/26/3/780.abstract/reply#healthaff\\_el\\_1878](http://content.healthaffairs.org/content/26/3/780.abstract/reply#healthaff_el_1878).

patients who qualify for financial assistance to the “amounts generally billed” to insured patients.

**Gross Charges - §§ 1.501(r)-5(a) and (c)**

We were disappointed that the Notice adopts the interpretation put forward by the Joint Committee on Taxation that the limitation on charges applies only to individuals who are eligible for financial assistance.<sup>13</sup> We believe this approach to be inconsistent with the plain language of the statute. More practically, because the ACA and the proposed rules allow hospitals to establish their own eligibility criteria, we are concerned that this interpretation effectively crowds out low- and middle-income patients who may not qualify for the hospital’s financial assistance policy but are still unable to balance hospital bills with other living expenses.<sup>14</sup> The equitable approach, is already used by other safety-net providers such as public hospitals and community clinics that serve the uninsured, would be to require hospitals to tie charges to the patient’s ability to pay. Therefore, we recommend that hospitals limit amounts generally billed for patients under 500 percent of the Federal Poverty Level, regardless of whether they qualify for financial assistance. This is the approach taken by at least one state that regulates hospital charges.<sup>15</sup>

**Limitations on Charges: Amounts Generally Billed - § 1.501(r)-5(b)**

We believe it is imperative that the methods used to calculate the Amounts Generally Billed provide consumers and the general public with maximum degrees of transparency and fairness in the overall price—two elements that have historically been missing for many patients. Therefore, we strongly recommend that the Amounts Generally Billed calculation be based on Medicare fee-for-service payment rates alone, and not include private payer or Medicare Advantage rates. Medicare fee-for-service payments are not based on proprietary contracts between different insurers and providers and are therefore transparent and publicly available, allowing patients and advocates to verify hospitals’ compliance with the law.<sup>16</sup>

### **III. Hospital Billing and Collections**

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<sup>13</sup> Staff Report, Joint Committee on Taxation, *Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010,” as amended, in combination with the “Patient Protection and Affordable Care Act.”* JCX-18-10 (March 21, 2010), page 82.

<sup>14</sup> A recent report by the Department of Health and Human Services (HHS) found that hospital charges are simply too expensive for many uninsured families, with most families able to afford only 12 percent of the cost of a hospital stay. Even uninsured families with relatively higher incomes (more than 400 percent of the Federal Poverty Level) could afford only 37 percent of what was charged for the stay. *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.

<sup>15</sup> New Jersey limits charges to 115 percent of Medicare payments for uninsured patients with gross family income below 500 percent of the Federal Poverty Level. N.J. Stat. § 26:2H-12.52. This plan uses Medicare payments (which are transparent and widely used) are the baseline for calculating the charges to uninsured patients.

<sup>16</sup> Furthermore, the Medicare Payment Advisory Commission, the independent Congressional agency that helps set Medicare rates, has repeatedly found that rates are sufficient for efficient providers. See Chapter 3: Hospital Inpatient and Outpatient Services, in “Report to the Congress: Medicare Payment Policy.” MedPAC, March 2011. Available at [http://www.medpac.gov/chapters/Mar11\\_Ch03.pdf](http://www.medpac.gov/chapters/Mar11_Ch03.pdf).

Under the Affordable Care Act, nonprofit hospitals are required to make “reasonable efforts” to determine whether a patient qualifies for financial assistance under its policy before engaging in “extraordinary collection actions.” The Notice defines these key terms and sets a defined timeline and process that hospitals—and their third party agents—must follow in order to meet this requirement.

### **Extraordinary Collection Actions (§ 1.501(r)-6(b))**

We support the non-exhaustive list of Extraordinary Collection Actions (ECAs) as defined in the Notice and strongly recommend their inclusion in the final rules. The impact of these more extreme collection actions, which include reporting “bad” medical debts to credit bureaus, can follow patients for years after a debt is resolved. Therefore, they should be used rarely, after all other options have been exhausted. To ensure patients are well-protected from medical debt, we recommend the following be incorporated into final rules:

- Add charging interest on patient bills to the list of ECAs;
- Retain the provisions that hold hospitals accountable for the billing and collection actions of third-party contractors and debt buyers;
- Exempt patients who are eligible for hospital financial assistance, means-tested public programs or subsidies from further collection action;
- Completely prohibit the selling of debt.

### ***Prohibit the Selling of Patient Debt***

We urge the Treasury and the Service to ban nonprofit hospitals’ selling of patient debt. Debt buyers typically purchase consumer debts for pennies on the dollar with serious gaps in the data and documentation related to the account.<sup>17</sup> Despite buying debt at deeply discounted rates, buyers aggressively seek to collect the full amount plus interest, penalty fees, and attorneys’ fees. Debt buyers are also more persistent in seeking payments for very old debts.<sup>18</sup> As a result, they frequently pursue flawed claims that may be compounded by billing errors in original medical bills that are no longer available.<sup>19</sup> Debt buyers press financially stressed families to pay bills even when they are not legally liable.<sup>20</sup> Indeed, it was partly abuses of debt buyers that

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<sup>17</sup> Debt buyers purchase accounts in bulk, typically obtaining only an electronic spreadsheet with minimal information about the debt. Often, they do not purchase the underlying documentation of the debt, such as the actual bill, monthly statements, payment records, or customer service records that would reflect customer disputes.

<sup>18</sup> Reports by consumer groups document these serious abuses by debt buyers. See C. Wilner and N. Sheftel-Gomes, *Neighborhood Econ. Dev. Advocacy Project and Urban Justice Center*, “Debt Deception: How Debt Buyers Abuse The System To Prey On Lower-Income New Yorkers.” 6 (May 2010), available at [http://www.nedap.org/pressroom/documents/DEBT\\_DECEPTION\\_FINAL\\_WEB.pdf](http://www.nedap.org/pressroom/documents/DEBT_DECEPTION_FINAL_WEB.pdf) [hereinafter “NEDAP, Debt Deception”]; R. Hobbs and R. Jurgens, *National Consumer Law Center*, “The Debt Machine” (July 2010), available at [http://www.nclc.org/images/pdf/debt\\_collection/debt-machine.pdf](http://www.nclc.org/images/pdf/debt_collection/debt-machine.pdf).

<sup>19</sup> The FTC has concluded that “the information received by debt collectors is often inadequate and results in attempts to collect from the wrong consumer or to collect the wrong amount.” *Federal Trade Commission*, “Collecting Consumer Debts: The Challenges of Change, A Workshop Report,” at 24 (Feb. 2009).

<sup>20</sup> Some of the claims go into collection when they have already been settled or paid in full, others were someone else’s debt, and some were created by an identity thief. Still others are beyond the statute of limitations, were discharged by the consumer in bankruptcy, or were disputed with the original creditor years before by the consumer for fraud, nonperformance, or another problem. One report by several New York City nonprofit and legal services organizations found that 35 percent of debt buyer lawsuits were meritless. NEDAP, *Debt Deception* at 2.

prompted the Federal Trade Commission to declare in a recent report that “the system for resolving disputes about consumer debts is broken.”<sup>21</sup> Nonprofit hospitals should not be permitted to sell debts to the very entities that were at least partly responsible for breaking this system.<sup>22</sup>

**Reasonable Efforts - § 1.501(r)-6(c)**

We appreciate and support the inclusion of timelines for hospitals to engage in ECAs and the process they have to follow to notify, qualify, and discuss the outcome of eligibility determinations with patients who apply for financial assistance. These are necessary to give patients a base level of protection from being sent to collections too quickly after a hospital visit.

***Notification - § 1.501(r)-6(c)(2)***

We support the inclusion of requirements to notify individual patients—in addition to the community at large, as discussed above—about financial assistance.

***Incomplete Financial Assistance Policy Applications - § 1.501(r)-6(c)(3)***

We strongly support the protection in place for patients who submit incomplete financial assistance applications. Patients who have made a good-faith effort to resolve their bills should be supported by the hospital throughout the application period. To encourage timely completion of incomplete applications, we recommend hospitals use applications that are simple, easy to read, and ask only for the information necessary to determine eligibility. One way to make the process less burdensome would be to expressly allow hospitals to rely on a determination of eligibility for financial assistance for up to one year after the completed application is filed, with the stipulation that patients be allowed to resubmit an application any time their financial situation has changed.

***Complete Financial Assistance Policy Applications - § 1.501(r)-6(c)(4)***

We strongly support the requirement that hospitals refund excess payments and take all reasonably available measures to reverse ECAs if a patient has been found to be eligible for financial assistance. This serves multiple purposes. First, it puts some of the responsibility for undoing ECAs back on the hospital, which is more likely to have the information and know-how about how to reverse the effects of an ECA than individual patients. Second, it promotes fairness by ensuring that patients who have attempted to settle a bill in good faith prior to a determination of eligibility for financial assistance are reimbursed. Third, it encourages hospitals that choose to use certain ECAs to thoroughly vet patients for financial assistance, in keeping with the intent of the statute.

**Additional Procedural Protections for Patients**

***Expressly Allow Patients to Raise FAP-Eligibility as a Defense***

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<sup>21</sup> *Federal Trade Commission*, “Repairing a Broken System: Protecting Consumers in Debt Collection and Arbitration” (July 2010) at 5, available at <http://www.ftc.gov/os/2010/07/debtcollectionreport.pdf> [hereinafter “FTC, Repairing a Broken System”] at 7 at I (Executive Summary).

<sup>22</sup> Debt buyers are notorious for their employment of questionable and even illegal techniques. See, e.g., Press Release, *Federal Trade Commission*, “Under FTC Settlement, Debt Buyer Agrees to Pay \$2.5 Million for Alleged Consumer Deception,” January 30, 2012, available at <http://www.ftc.gov/opa/2012/01/asset.shtm>.

One of our greatest concerns with the proposed regulations is that the protections for ECAs only apply for a limited period of time. Low- and moderate-income patients should be protected from ECAs such as collection lawsuits or garnishment when lawsuits are filed a year or two or even many years after the date of service, which is common with debt collection.<sup>23</sup>

Unfortunately, a sizable segment of patients will not read or respond to billing and collection notices, let alone take the complicated steps necessary to apply for financial assistance due to numerous factors. Analogous issues currently arise in debt collection cases, where numerous studies indicate that consumers fail to respond to notices or complaints in collection actions for a variety of reasons.<sup>24</sup> These can range from literacy issues<sup>25</sup> to confusion, fear, or denial about the process. Patients often end up doing nothing as a default because they are overwhelmed or do not know how to proceed or how they are going to pay a sizable bill.<sup>26</sup> They also may not receive the information because of outdated addresses due to moving or neglect by the collector in obtaining the proper address.<sup>27</sup> The issue of “sewer service,” *i.e.*, where the person tasked with serving a legal summons fails to do so, but claims to have done so – is a serious problem in debt collection as well.<sup>28</sup> Furthermore, there may be instances in which a consumer may not have been eligible for the FAP within 240 days of the date of service, but will be when he or she is subject to the ECA (for example, a consumer may be making payments pursuant to a payment plan, but then lose her job and fall

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<sup>23</sup> Note that consumer debt is resold one or more times as it moves through the debt collection system. Thus, it may not be the hospital or its collector that files a collection lawsuit on a debt, but the second or third debt buyer in the chain. *See* FTC, *Repairing a Broken System*.

<sup>24</sup> The incidence of default actions ranges from 70 to over 90 percent. *See* NEDAP Debt Collection (finding that 94.3 percent of New York City collection lawsuits in the sample resulted in a default judgment or settlement); B. Healy, “Dignity Faces a Steamroller: Small-Claims Proceedings Ignore Rights, Tilt to Collectors,” *The Boston Globe*, July 31, 2006 (finding an 80 percent default rate in a study of collection actions in Massachusetts); *McCullough v. Johnson, Rodenburg & Lauinger, L.L.C.*, F.3d, 2011 WL 746892 (9th Cir. Mar. 4th 2011) (citing a Montana collection attorney’s estimate that 90 percent of collection lawsuits resulted in default); *see also* FTC, *Repairing a Broken System*, at 7.

<sup>25</sup> According to the 2003 National Assessment of Adult Literacy, 1 in 20 adults in the U.S. is non-literate in English and 14 percent of adults have below basic prose literacy skills. M. Kutner, et al., Nat’l Ctr. For Educ. Statistics, “Literacy In Everyday Life: Results From The 2003 National Assessment Of Adult Literacy” 13 (2007), available at <http://nces.ed.gov/Pubs2007/2007480.pdf>.

<sup>26</sup> A number of studies in a wide range of contexts have shown that people do not tend to change the default arrangement. *See, e.g.*, B. Madrian and D. Shea, *The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior*, 116 Q J Econ 1149, 1149-50 (2001); J. Beshears et. al., *The Importance of Default Options for Retirement Savings Outcomes: Evidence from the United States* (Mar. 2007). C. Sunstein and R. Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 U. Chi. L. Rev. 1159, 1172-73 (Fall 2003) (Johnson, E.J. et. al., *Framing, Probability, and Insurance Decisions*, *Journal of Risk and Uncertainty*, 7, 35-51 (1993)).

<sup>27</sup> A Charlotte Observer series on medical debt describes a typical example in which a hospital claims that it sent a patient five statements and left three messages at her home before filing suit, but the patient stayed with her brother for a long period after she was hospitalized for pancreatitis and does not remember receiving the letters. A. Alexander and D. Raynor, “Hospital Suits Force New Pain on Patients,” *Charlotte Observer*, Apr. 23, 2012, available at <http://www.charlotteobserver.com/2012/04/23/3193509/hospital-suits-force-new-pain.html#storylink=cpy>.

<sup>28</sup> *See* “New York Sues Process Server for High-Volume Debt Collectors: Company Allegedly Failed to Serve Legal Notices on Consumers; Law Firm Also Faces Suit,” *Consumer Affairs*, Apr. 14, 2009, available at [http://www.consumeraffairs.com/news04/2009/04/ny\\_process\\_servers.html](http://www.consumeraffairs.com/news04/2009/04/ny_process_servers.html); *Matter of Pfau v. Forster & Garbus* (N.Y. Sup. Ct. 2009). *See also* B. Healy, “Dignity Faces a Steamroller,” *Boston Globe*, July 31, 2006, at A1 (reporters tested the small claims courts’ service by first class mail by sending out 100 misaddressed letters and found only 52 were returned).

behind). These consumers should be able to raise the fact they are and remain eligible for financial assistance in response to these ECAs.

We strongly urge Treasury and the IRS to permit patients to raise FAP eligibility at any time—not just within the 240-day timeframe—as an affirmative defense if the consumer is subject to an ECA. In such circumstances, the hospital would not be considered in violation of the regulations for engaging in ECAs after the notification period but before the time that the patient raised it as an affirmative defense. However, the hospital would be precluded from pursuing ECAs once it received notice that the patient may qualify for financial assistance.

There is significant precedent in the law for the idea of being able to raise an issue defensively after a deadline has past. Most states follow the doctrine of “recoupment,” which permits a consumer to raise a counterclaim arising out of the same transaction to offset a creditor or debt collector’s claim even after the statute of limitations has run.<sup>29</sup> A failure by Treasury to permit consumers to raise FAP eligibility after the 240-day period ends will leave many patients unprotected, even though they may be within the FAP eligibility guidelines of the hospital.

#### ***Acknowledgment of Patient Defenses under State or Common Law***

Finally, if Treasury and the IRS are not willing to permit patients to raise the fact that they are FAP-eligible as a defense to ECAs under its regulations, they should at least ensure that rules do not negatively impact patients’ ability to raise defenses under state or common law. For instance, consumers have alleged that hospitals violate state consumer protection laws by charging them grossly inflated chargemaster rates while charging sharply lower market rates to third-party payors.<sup>30</sup> Other consumers have argued, when hospitals sue them, that gross chargemaster rates are not “reasonable charges” under certain legal theories (*e.g.*, *quantum meruit*).<sup>31</sup> We are concerned that §1.501(r)-5, particularly the safe harbor of subsection (d), would undermine such arguments because hospitals would assert that the safe harbor permits them to charge full gross chargemaster rates so long as the patient has not been determined to be FAP-eligible. Thus, we urge Treasury to state in §1.501(r)-5

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<sup>29</sup> For example, the vast majority of court decisions considering the issue have permitted Truth in Lending Act claims to be raised in recoupment. See *National Consumer Law Center*, “Truth in Lending” §12.2.5 (7th ed. 2010).

<sup>30</sup> See, *e.g.*, *Hale v. Sharp Healthcare*, 108 Cal. Rptr.3d 669 (Cal. Ct. App. 2010) (patient stated claim for violation of California Unfair Competition Law and California Legal Remedies Act for charging gross rates); *In re Sutter Health Uninsured Pricing Cases*, 2005 WL 1842582 (Cal. Super. Ct. July 16, 2005) (denying dismissal of state consumer protection and unconscionability claims for charging gross rates); *Hill v. Sisters of St. Francis Health Services*, 2006 WL 3783415 (N.D. Ill. Dec. 20, 2006) (denying dismissal of state consumer protection and unconscionability claims for charging gross rates pricing); *Servedio v. Our Lady of the Resurrection Med. Ctr.*, Clearinghouse No. 55, 626 (Ill. Cir. Ct. Cook County Jan. 6, 2005); *Turner v. Legacy Health Sys.*, 2006 WL 657176 (Or. Cir. Ct. Oct. 4, 2005) (granting class certification in case challenging gross rates and hospital pricing under Oregon consumer protection law). See also “Press Release: Court Rules That Advocate Health Care Network May Be Liable for Price Gouging, Hospital Accountability Project,” *SEIU*, Jan. 27, 2006; M.J. Feldstein, “BJC Overpayment Case is Class-Action,” *St. Louis Post-Dispatch*, Mar. 7, 2007 (class action certification granted in case against St. Louis area hospital)

<sup>31</sup> For a discussion of these cases, see *National Consumer Law Center*, *Collection Actions* § 9.\_\_\_\_ (2d ed. 2011 and Supp.)

that “Nothing in this section shall affect whether the hospital is permitted to charge gross charges or more than AGB under state law.”

### **Conclusion**

On the whole, we find that the Notice strikes a good balance between the need to increase transparency and strengthen patient protections against particularly harmful collections activity with hospitals’ needs to maintain efficient, fair billing and collections cycles. On the whole, we believe that these proposed rules represent significant gains for vulnerable communities by extending consumer protections, promoting access to care, and increasing transparency between hospitals and the communities they serve. By establishing a federal floor, the rules provide patients and hospitals across the country with a grounded set of expectations—a benchmark of common-sense protections and behaviors the public has come to expect from charitable institutions. We believe the proposed rules codify the existing practices of many leader hospitals that have already made significant commitments to ensuring patient access to care, and we are pleased that the Service has chosen to raise the bar for other hospitals that may be lagging behind in these areas.

As you are undoubtedly aware, one key issue not addressed in these proposed rules is that of noncompliance, or the consequences hospitals will face for failing to satisfy these requirements. In our experience, enforcement and monitoring are crucial to making protections and standards meaningful for patients. We look forward to future guidance on this issue.

We appreciate your consideration of the above comments and would be happy to discuss them further with you. Please feel free to contact me at [rejeske@nilc.org](mailto:rejeske@nilc.org) or 202-683-1994 if you have any questions.

Sincerely,

/s/

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