September 24, 2012

Douglas Shulman, Commissioner, Internal Revenue Service
Internal Revenue Service
CC:PA:LPD:PR (Reg-130266-11), Room 5203
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044


Dear Commissioner Shulman:

Kentucky Equal Justice 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). We appreciate the opportunity to comment on these important rules.

KEJC is a state-wide, civil legal services organization that works closely with legal services programs across Kentucky. We represent the interests of low-income individuals in Kentucky, including their right to high-quality, affordable health care. We have a long history of assisting uninsured individuals navigate the complicated system of Disproportionate Share Hospital (DSH) coverage and have worked with our state agency to improve the related patient screening process. We also work with consumers to contest improper and inequitable medical debt.

Today, many Kentucky residents are losing the battle between physical health and financial security. While several factors contribute to medical debt, aggressive collection efforts used by hospitals and third-party contractors can create significant financial hardships for patients and prevent equitable access to care. Our comments reflect our experience on the ground and focus on the issues we believe are most critical to ensuring that patients are treated equitably and fairly in matters related to hospital financial assistance, billing, and collections in Kentucky.

We commend the IRS and Treasury for issuing proposed rules that will more fully implement the protections found in the ACA. The following comments suggest ways to further improve patient access to care and protect families from inequitable medical debt practices based on our experiences in Kentucky.

I. Establishing a Financial Assistance Policy

Under the ACA, non-profit hospitals must establish a written financial assistance policy that clearly outlines what kind of help is available, who is eligible, and how to apply. Non-profit hospitals also must 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 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 non-profit 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.

**Scope of the Financial Assistance Policy (§1.501(r)-4(b); pages 15, 63)**
We strongly support the proposed requirement that hospital financial assistance policies be applicable to all emergency and medical care provided by the hospital facility. We also encourage the IRS to issue specific guidance addressing the extent to which a non-profit hospital’s financial assistance policy should apply to 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.

**Widely Publicizing the Financial Assistance Policy (§1.501(r)-4(b)(5); pages 20-24, 67-72)**
In particular, we recommend that final rules retain the requirement that non-profit 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. Similarly, we strongly support the requirement that non-profit hospitals “inform and notify” community residents and hospital visitors about financial assistance, with special emphasis placed on communities most likely to need financial help. 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(b)(5)(i)(B), 1.501(r)-4(b)(5)(iii), and 1.501(r)-4(b)(5)(v); pages 22-23, 68-70)**
We believe the 10 percent threshold recommended in the Notice is too high to adequately reach community members with limited English proficiency (LEP). We respectfully request that the IRS:

- **Adopt a combined threshold of 500 LEP individuals or 5 percent for meeting the language access standard under “widely publicize.”** This mirrors existing Department of Labor (DOL) regulations, guidance from the Departments of Justice and Health and Human Services (HHS), and recently revised regulations from the Centers for Medicare and Medicaid Services (CMS) governing marketing by Medicare Part C and D plans.¹

¹ The proposed rule cites 26 CFR 54.9815—2719T(e) as an example of a similar federal regulation requiring notices or summaries to be issued in non-English languages. However, that regulation uses a 500-person numerical threshold in addition to a percentage of the “community served” threshold. 26 Code Fed. Regs. 54.9815—2719T(e). In addition, the Department of Health and Human Services (HHS) Office for Civil Rights recommends translation when a language group is 5 percent or 1,000 individuals. 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](http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.php).
• Adopt a county-level analysis to determine the “community served.”
• Require hospitals to provide **access to oral interpreters or bilingual staff** on request, regardless of whether thresholds for written translation are met.
• **Uniformly apply the language access thresholds to** all billing and financial assistance communications.

In Kentucky, we have found that LEP patients are the most likely to experience problems associated with access to hospital financial assistance. Even when hospitals have agreed to provide communications in a second language, usually Spanish, in our experience communications are not uniformly applied. For example, an interpreter may be available to assist with the initial paperwork, but not available to handle follow-up calls about the FAP process. We recommend strong safeguards in the regulations to ensure that this does not happen.

We are concerned with the 10% threshold. Although no language other than English would meet this when considering the entire Commonwealth of Kentucky, some areas of higher concentrations would meet the 5% threshold. For example, the Lexington/Fayette County area has at least a 5% Spanish-speaking population. For this reason, Kentucky uses this 5% threshold for Medicaid managed care companies as well, with the county as the specified region. Additionally, Kentucky, like many Southern states, has seen an increase in migrant communities over the last decade. By applying a lower threshold now, hospitals can better prepare for the increased need expected in coming years.

**Content of Financial Assistance Policies**

**Eligibility Criteria (§1.501(r)-4(2); pages 16, 62)**

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 non-profit 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.²

**Requiring Community Input on the Financial Assistance Policy, p. 17**

We believe that hospital facilities should be required to consult with members of the community, including representatives of vulnerable or disadvantaged communities, 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. In Kentucky, our

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experience is that hospitals with the best financial assistance policies are those with the strongest connection to their communities and those that have taken steps to reach out to vulnerable populations. 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. This would provide an efficient and effective way for hospitals to meet their obligations under the ACA and to create FAPs that are appropriate for their particular communities.

Method for Applying for Financial Assistance (§1.501(r)-4(b)(3); pages 18, 65-66); and Third Party Verification and Flexibility (§1.501(r)-6(4)(iv); pages 48, 89)

Section 1.501(r)-4(b)(3) of the Notice requires non-profit 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:

- Prohibit hospitals from requiring applicants to provide a Social Security Number
- 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)

In Kentucky, many of our immigrant clients have had difficulty accessing the hospital financial assistance for which they qualify. KEJC has worked with our state agencies to improve the process and encourages the IRS to adopt these changes. In particular, Kentucky has modified its DSH-001 form, the patients screening form used by hospitals participating in DSH, to explicitly state that a Social Security Number is not required. Federal privacy laws prohibit the use of a Social Security number except for certain federal programs. 42 U.S.C. §1320b-7(a)(1) and (b). The financial assistance programs required under the ACA do not fall into these exceptions. In addition, requiring a Social Security Number might discourage otherwise eligible Hispanics or members of other national groups from applying for assistance. Such a disparate impact could result in a violation of Title VI of the Civil Rights Act, 42 U.S.C. §2000-d et seq.

Hospitals should be encouraged to make the application/documentation process as simple as possible. With the consent of the applicant, we support allowing the hospital to access records of means-tested public benefits program to determine presumptive eligibility. One approach might be to have a system where the hospital could contact the state agency and ask for information on programs for which the individual is already qualified (instead of the hospital having direct access to public benefit records). Additionally, through our work with local hospitals, we have learned that accepting signed letters from neighbors and family members when other documentation is not readily available has decreased problems for many in the immigrant community. We also support allowing hospitals to determine ongoing eligibility for a certain period of time. For example, under our DSH program, an individual is determined eligible for up to 6 months at a time.

**Implementing a Policy (§1.501(r)-4(d)(3); pages 26, 75)**
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.

**Emergency Medical Care Policy (§1.501(r)-4(c); pages 24-25, 72-74)**
We appreciate that the Notice prohibits debt collection activities from occurring in the emergency department or other hospital venues where such activities could interfere with the treatment of emergency medical conditions, and we support the inclusion of this provision in the final rules.

**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. To make pricing more equitable, the ACA prohibits gross charges and requires non-profit hospitals to limit charges to patients who qualify for financial assistance to the “amounts generally billed” to insured patients.

**Gross Charges (§§1.501(r)-5(a) and (c); pages 27, 33-34, 75-76, and 79)**
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. We believe this approach to be inconsistent with the plain language of the statute. The intent of the ACA was to provide greater buying power for average Americans. This can be better achieved by prohibiting gross charges to all individuals paying for their own medical care directly. Additionally, we recommend that the IRS reconsider the decision to allow gross charges on bills for consumers whose FAP eligibility has not been determined. This can be very confusing for consumers and may lead them to pay a higher liability than they owe.

**Limitations on Charges: Amounts Generally Billed (§1.501(r)-5(b); pages 27-33, 75-79)**
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

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insurers and providers and are therefore transparent and publicly available, allowing patients and advocates to verify hospitals’ compliance with the law.5

III. Hospital Billing and Collections

Under the Affordable Care Act, non-profit 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); pages 36, 80)

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, and only 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
- Limit attorneys’ fees that can be added to the cost of services rendered
- Prohibit extra-judicial garnishments, attachments and seizures

In Kentucky, we have at least one state university-connected hospital that forwards unpaid hospital bills to the state revenue agency for collection as a debt owed to the state. The revenue agency proceeds to collect hospital bills without filing any legal action, by administratively garnishing wages or bank accounts, filing of liens on property, and seizing tax refunds. We think this practice is legally questionable under Kentucky law. More generally, we are concerned that such actions may be interpreted by a hospital as falling outside the rule’s definition of ECAs as an extra-legal or extra-judicial process. We suggest that the definition be clarified to cover such situations.

The notice also requested comment on the sufficiency of the safe harbor provisions to protect hospitals from overcharging consumers who might be eligible for the FAP. We encourage the IRS to change these provisions because in their current form they do not do enough to ensure that ECAs do not harm patients. In our view, hospitals should be prohibited from charging above AGB rates until after the notification and application periods have passed, to allow sufficient time for an individual to apply and be qualified for the FAP. It is much more difficult.

5 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.
for an individual to get the rates reduced after qualifying for the FAP than it would be for the hospital to increase the charges when it is clear an individual does not qualify for the FAP.

Under the proposed rule, if an individual does not submit an application until after the notification period ends, the hospital may already be engaged in ECAs that will be difficult to reverse. This creates many potential problems. First, in many cases hospitals sell the debt or at least pass it on to collection agencies, after which the consumers have little recourse without costly legal action. Second, many patients choose to pay the bills they receive, out of a desire to be good citizens, when they should have received financial assistance. In some cases, paying these improper hospital bills requires taking out high interest loans causing consumers to pay even more.

While these ECAs (with the exception of sale of the debt) are supposed to be reversed by the hospital once an individual is qualified as eligible for FAP, this process will be confusing to the individual and bureaucratically complicated. Our experience in dealing with hospital collections offices is that it is extremely difficult (even for attorneys) to get clear records and answers as to what bills are legitimately charged, what is really owed, and what actions the hospital has taken to collect the debt. This whole process will be exacerbated by the current rule’s allowance that individuals not yet designated as FAP-eligible be charged above AGB rates. We strongly encourage the IRS to amend that provision.

**Reasonable Efforts (§1.501(r)-6(c); pages 39, 81)**
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); pages 42-45, 81-82)**
We support the inclusion of requirements to notify individual patients—in addition to the community at large, as discussed above—about financial assistance. However, notification procedures will not reach some of the most vulnerable unless those consumers can understand them. We again encourage the IRS to lower the 10% threshold to 5% or 500 persons when translation is required. Additionally, if the hospital knows that the consumer has limited English proficiency the written notice should be provided in a language the consumer can understand, or the hospital must take additional steps before notice is considered sufficient. In addition, to reach those who may not be well educated, the IRS should require that the plain language description of the FAP be at a sixth grade reading level or less.

**Incomplete Financial Assistance Policy Applications (§1.501(r)-6(c)(3); pages 45, 84)**
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); pages 46, 86)**

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.

However, as noted above, refunding excess payments may not be sufficient to make the consumer “whole.” For consumers who have taken out loans, they may now owe interest. They may also have not paid other obligations because of fear of their medical debt. For this reason, there should be additional safeguards before a hospital can begin the ECA process.

**Additional Procedural Protections for Patients (page 39)**

We strongly urge Treasury and the IRS to permit patients to raise their eligibility for financial assistance at any time—not just within the 240-day application period—as an affirmative defense if they are subject to an extraordinary collection action. We also recommend that the final rules expressly state that nothing in this section precludes an individual who is the subject of an extraordinary collection action by a hospital or a debt collector after the application period from submitting, at that point, an application for financial assistance. If the individual is found to be eligible for financial assistance, the hospital need not provide the individual with assistance but must suspend any extraordinary collection actions once the determination is made.

**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. We appreciate your consideration of the above comments and would be happy to discuss them further with you. Please feel free to contact us at (859) 233-0323 if you have any questions.

Sincerely,

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Anne Marie Regan, Senior Attorney