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VIA ELECTRONIC MAIL

The Honorable Nancy Pelosi
Speaker, U.S. House of Representatives
H-232, U.S. Capitol
Washington, DC 20515

The Honorable Harry Reid
Majority Leader, U.S. Senate
SH-522, U.S. Capitol
Washington, DC 20510

Dear Speaker Pelosi and Majority Leader Reid:

As negotiations on final health care legislation wind down, we commend you for the tireless dedication you and your staff have shown toward improving our health care system, expanding access to affordable health coverage, and alleviating the heavy burden placed on our communities and hospitals by medical debt and uncompensated care. We thank you for your work to date.

We urge the incorporation of certain provisions from the House's *Affordable Health Care for America Act* (H.R. 3962) and the Senate's *Patient Protection and Affordability Act* (H.R. 3590) that would **establish a federal floor for consumer protection and accountability standards related to hospital safety net services**. Many of the individuals and families we represent are struggling to find care they can afford in the absence of adequate health coverage. When urgent health needs arise, local hospital's financial assistance, community benefit and safety net programs can make the difference between a family's ability to access care and remain financially secure without delaying treatment or falling deeply into medical debt. Even under health care reform, we anticipate that the hospital safety net will play a significant role in individuals' and families' ability to receive timely care. This is particularly true for the uninsured or underinsured in the pre-implementation period, as well as for people whose need for accessible, affordable care will not be wholly met by the current Congressional proposals.

Numerous consumers report encountering tremendous difficulty accessing safety net programs—problems confirmed by community monitors and the media.¹ We believe the following provisions work together to immediately strengthen consumer protections for people in need of hospital safety net services; improve hospital accountability standards; and enable more effective, strategic use of the federal funds provided to sustain those services.

¹ See, e.g., Schulte, F., and Drew, J., "[In Their Debt](#)," *Baltimore Sun* three-part series, December 21-23, 2008.

To that end, we **strongly urge** that you:

- **Adopt the Senate provision to establish consumer-friendly financial assistance and community benefit standards for private tax-exempt hospitals in its entirety (Section 9007).** Effective community benefits programs are a vital part of health care reform. Non-profit hospitals, in keeping with their missions and tax exemptions, are obligated to work with other stakeholders to identify and meet priority health care needs in their communities, particularly for underserved and vulnerable populations. Collaborative strategies addressing social determinants of health, prevention, early detection, and coordinated treatment of chronic diseases can both improve health and decrease health care costs over time, making coverage expansions economically sustainable.

In the absence of firm government oversight, non-profit hospitals' compliance with existing voluntary standards and guidelines varies dramatically, seriously impacting access to affordable care and curtailing effective health planning.² It can be difficult for community members and policymakers to obtain accurate, detailed information about local hospitals' community benefits practices in order to assess their involvement in addressing community needs. Although the new IRS Form 990, Schedule H will partially address this, it is fundamentally a reporting form that does not require hospitals to establish and publicize fair billing and financial assistance policies or to conduct community needs assessments.

The Senate provisions would help the public and policymakers gauge whether non-profit hospitals are pulling their fair share of the weight. The bill requires every private tax-exempt hospital to establish and publicize its fair financial assistance policy for people who are unable to pay for care. It also requires these hospitals to include community members in local and institutional health planning. These measures will help ensure that hospitals granted tax-exempt status serve their communities by providing free or reduced-cost care to the most needy, employing fair billing practices, and working with community members to target fundamental health needs that would otherwise go unaddressed.

- **Retain the House provision requiring states to adopt consumer-friendly transparency requirements for all hospitals, regardless of tax status (Section 1783).** The House bill calls for states to implement new transparency requirements for all hospitals as part of their state Medicaid plans effective October 1, 2010. Notably, all hospitals – not just private tax-exempt hospitals – would be required to inform patients and the public about their financial assistance policies, including eligibility criteria and application information. This is similar to requirements in California, Maine, and Rhode Island, where state guidelines for consumer-friendly hospital financial assistance policies apply to all hospitals. We also express our strong preference to have consumers included in the stakeholder group the HHS Secretary must consult before issuing implementing guidelines under this section.

² Past polling shows [tremendous public support](#) for this kind of government oversight for tax-exempt hospitals.

- **Retain House and Senate provisions that would fairly limit the fees tax-exempt hospitals can charge the uninsured and underinsured (House Section 1783; Senate Sections 2718, 2179A, 9007).** Self-pay patients are routinely charged up to four times the rates of other payers, including private insurers. Charges to these patients should be more clearly linked to the actual cost of providing care. We strongly support the provisions in the House and Senate bills that require hospitals to report what they charge for services to the Secretary of Health and Human Services. This information is a critical first step toward providing the public an accurate baseline from which to compare hospital pricing.

Earlier versions of the Senate bill’s Section 9007 limited charges to patients covered by the hospital’s financial assistance policy to the lowest amount charged any payer. We were very disappointed to see this language removed from the final Senate bill, since limiting charges to the “amounts generally billed” offers little relief to self-pay patients. We recommend that any amount owed by an uninsured or underinsured individual be calculated at the lower of either the lowest rate that would be paid by Medicare or Medicaid, or the actual unreimbursed cost to the Hospital for such service, as determined by the cost-to-charge ratio calculated in a hospital’s most recently settled Medicare Cost Report.³

- **Retain House and Senate provisions that would move toward fair, transparent hospital billing and debt collection practices (House Section 1783; Senate Sections 2718, 2179A, 9007).** Section 9007 of the Senate bill prohibits non-profit hospitals from engaging in “extraordinary” collection actions before making a reasonable effort to determine whether an individual qualifies for financial assistance. We believe that this provision should be preserved in final legislation and, in fact, strengthened. All hospitals – not just tax-exempt hospitals – should be required to observe fair, transparent billing standards that provide adequate protections to consumers facing medical bills.

Safeguarding consumers against unfair billing practices in the final legislation is a no-cost way of providing immediate relief to the millions of people who will remain uninsured or underinsured prior to full implementation of reform.⁴ Certain hospital billing practices create unnecessary barriers to health care and play a significant role in unfairly saddling low- and middle-income families with medical debt, ruining their credit and driving many toward bankruptcy.⁵ These include:

- Requiring self-pay patients to pay upfront fees or forgo necessary medical services, such as chemotherapy and treatments for chronic illness
- Charging fees to apply for financial assistance

³ Alternatively, these individuals could be charged the same rates as the hospital’s most preferred private payer.

⁴ State policymakers and attorneys general in California, New York, New Jersey, Illinois, Maryland, and Minnesota have increasingly scrutinized hospital charging practices, passing laws or entering into formal agreements that limit what hospitals can charge the uninsured, generally to a fixed percentage of cost. See [Free Care Compendium](#), Community Catalyst.

⁵ See, e.g., Martinez, B. “[Cash Before Chemo: Hospitals Get Tough](#),” *Wall Street Journal Online*, April 28, 2008.

- Charging undisclosed extraneous fees, such as special facility fees for urgent care or physician services provided in a hospital facility
- Garnishing wages or placing liens on homes as collateral for medical debt
- Failing to screen patients for financial assistance or public programs prior to referring accounts to collections agencies
- Using patients' credit scores to determine how patients will be billed, rather than uniformly applying financial assistance and collection policies⁶

We believe it is reasonable to require tax-exempt hospitals to establish written, board-approved⁷ billing and credit collection policies, akin to their financial assistance policies, and make this information available in all languages for which the hospital provides interpreter services.⁸ To ensure consumers are adequately protected, the HHS and IRS Secretaries should be required to consult with consumer representatives prior to issuing regulations or guidelines related to this section.

- **Adopt the Senate provision requiring the Secretary of HHS to study trends in hospital spending on safety net services (Section 9007), and retain the House provision requiring the Secretary to study and recommend ways to improve transparency and accountability of Disproportionate Share Hospital (DSH) funds (Sections 1112 and 1704).** While we expect that coverage expansions in national health reform will reduce uncompensated care, near-universal coverage in Massachusetts has shown that expansion will significantly lessen but not negate the need for free care and other safety net services. Adequate funding for safety net services will remain necessary after national health care reform, both for people who will remain uninsured and for low-to moderate-income patients with insurance who face burdensome out-of-pocket costs. Studying national health reform's impact on hospitals' safety net services and the use of DSH funding may provide vital information to ensure that funding for essential care for vulnerable populations is properly targeted in the future. Also, requiring consumer input on the future of the DSH program will be key to achieving effective, appropriate use of these taxpayer funds.

In conclusion, establishing new federal standards that clarify the special role played by hospitals in the health care safety net is an undervalued benefit of meaningful health care reform. The provisions above offer tangible, immediate relief to people who are currently uninsured and underinsured. They take steps to ensure that hospital safety net programs are transparent and fair. Including such provisions will enable vulnerable populations to access care for years to come. We strongly urge their inclusion and welcome the opportunity to further discuss these hospital safety net provisions with you.

⁶ See Rubenstein, S. "[Why Hospitals Want Your Credit Report.](#)" *The Wall Street Journal Online*, March 18, 2008.

⁷ See "[Consumer Perspective on Senate Finance Committee Proposals for Modifying the Requirements for Tax-Exempt Hospitals.](#)"

⁸ See "Recommended Hospital Debt Collection Practices," Appendix II, *The Attorney General's Community Benefits Guideline for Non Profit Hospitals*, pp. 28-30, for a full list of recommended consumer-friendly hospital billing and collection practices.

Yours very truly,



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Executive Director
Community Catalyst



Jessica L. Curtis
Project Director
Community Catalyst

cc: Senator Max Baucus, Chairman, Senate Finance Committee

ALSO SUBMITTED ON BEHALF OF:

SEIU

The Access Project (Massachusetts)

Alabama
Alabama Arise

Arkansas
Rev. Stephen Copley, Chair
Arkansas Interfaith Alliance

California
Congress of California Seniors
Health Access

Illinois
Champaign County Health Care Consumers

Indiana
Citizens Action Coalition of Indiana

Florida
Florida CHAIN
Florida Child Health Care Coalition
Florida Legal Services, Inc.
Human Services Coalition

Kansas
Kansas Health Consumer Coalition

Louisiana
Louisiana Consumer Healthcare Coalition

Maryland
Maryland Citizens' Health Initiative

Massachusetts
Health Care For All
Health Law Advocates

New Jersey
Health Professionals and Allied
Professionals
New Jersey Citizen Action

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