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**VIA ELECTRONIC MAIL**

Sarah Hall Ingram, Commissioner, Tax Exempt and Government Entities Division  
Lois G. Lerner, Director, Exempt Organizations  
Internal Revenue Service  
CC:PA:LPD:PR (Notice 2010-39)  
Room 5203  
P.O. Box 7604  
Ben Franklin Station  
Washington, DC 20044

**Re: Notice 2010-39 (New Requirements for Tax-Exempt Hospitals)**

Dear Commissioner Ingram and Director Lerner:

We are responding to your request for comments on the necessity of additional guidance to fully implement the new requirements for tax-exempt hospitals found in Section 9007 of the Patient Protection and Affordable Care Act (ACA), which was enacted on March 23, 2010.<sup>1</sup> We write in strong support of issuing further regulations that will build on the framework of greater transparency, consumer protection, and community engagement found within Section 9007.

We are health care advocates working to improve access to quality care, strengthen relationships between hospitals and communities, and alleviate burdens caused by medical debt. We give consumers a voice in health care policy debates and decisions, and work to ensure that the health care system works for everyone, particularly the most vulnerable people in our communities.

Our experience with these issues in our states has been that **meaningful regulatory standards and oversight are necessary to effectively implement financial assistance and community benefit requirements.**<sup>2</sup> While the new requirements for tax-exempt hospitals found in the ACA are certainly welcomed, we are concerned that they are still too vague to

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<sup>1</sup> The new requirements were added by Section 9007 of the *Patient Protection and Affordable Care Act*, Pub. L. 111-148 (2010), as amended by the *Health Care and Education Reconciliation Act*, Pub. L. 111-152 (2010).

<sup>2</sup> Community Catalyst's [Patient Financial Assistance Model Act and Commentary](#) includes additional recommendations for structuring effective hospital charity care policies.

effectively address some of the more troubling practices we have witnessed in our communities. These practices include overcharging self-pay patients; failing to notify patients that they may be eligible for charity care or government programs; failing to make the hospital's charity care policy available to the public; engaging in highly aggressive debt collection activity, or selling debts to third parties who do so; and failing to regularly assess community health needs and engage the community in making those assessments.

Of course, these are the very practices that Section 9007 seeks to address. Below we have outlined areas where we believe further regulation is necessary to achieve the law's aims of creating a fairer, more transparent system around hospital financial assistance and community benefit programs.

We recommend that the IRS issue further regulations that will:

1. *Set standards for financial assistance policies that guarantee effective notification practices, fair and transparent application procedures, and eligibility criteria that reflect the needs of the hospital's community.*

Though we welcome Section 9007's new requirement that hospitals have and publicize financial assistance policies, we note that hospitals retain tremendous discretion in establishing eligibility thresholds and notification processes, for example. It is unclear to what extent, if any, hospitals will be required to consult with their communities when designing or updating these policies. We are very concerned that failure to set firm standards through additional guidance will allow undesirable and harmful practices to continue. And, because only those patients who qualify for the hospital's financial assistance policy will reap the full benefits of the new limitations on debt collection and billing, it is imperative that hospital policies explicitly benefit the uninsured, underinsured, and medically indigent members of the communities they serve to the greatest extent possible. To that end, we suggest issuing further guidance that, at a minimum:

- **Codifies best practices for ensuring that financial assistance policies are well-publicized and well-used.**<sup>3</sup> These include notifying uninsured and underinsured patients – in the appropriate language(s) – that financial assistance is available, in person and on any billing statement. Hospitals should also post their policies through signs, websites, newspapers and social services agencies in languages that are appropriate to the community served, and should routinely train staff members and personnel about financial assistance, billing and debt collection policies. Several states – most notably California, Maine, New York and Rhode Island –

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<sup>3</sup> In a random national survey of 99 nonprofit hospitals conducted in 2009, researchers found that fewer than half of hospitals surveyed (42) provided charity care application forms; only a quarter (26) gave information about eligibility criteria; and just over a third (34) offered information about charity care in languages other than English. C. Pryor et al. *Best-Kept Secrets: Are Non-Profit Hospitals Informing Patients About Charity Care Programs?*, The Access Project and Community Catalyst, May 2010.

have enacted strong notification laws that could serve as models.<sup>4</sup> One concrete way to make notice requirements meaningful would be to require that these policies be linked on the newly launched federal Web Portal at [www.healthcare.gov](http://www.healthcare.gov). This will help ensure that individuals struggling to find affordable care can quickly access the policies of hospitals in their area.<sup>5</sup>

- **Sets standards for fair application procedures**, including the kinds of documentation required.
- **Specifies what assets and expenses hospitals can include** in determining eligibility.
- Requires hospital policies to **peg eligibility criteria to an individual's family income**, rather than the size of the hospital bill.
- Establish a **national benchmark to serve as the "floor" for eligibility for full or partial financial assistance**. Several states – including California, Maine and Rhode Island – have used family income to set statewide floors for all hospitals on qualification for hospital financial assistance. These states could serve as models for a national minimum standard.
- Requires hospitals to also **assist patients in qualifying for public programs and, eventually, for Exchange subsidies**.

Hospitals should consult with community partners and consumer advocates, particularly those who work on behalf of the most vulnerable or disadvantaged members of the hospital's service area, as they develop or revisit their financial assistance policies.<sup>6</sup> This will help them to structure policies that correlate to their communities' unique needs.

## 2. *Protect consumers from harmful debt collection practices.*

You have asked specifically for comments on how the IRS should define what constitutes a "reasonable effort" to determine eligibility for financial assistance, in the context of a hospital's debt collection practices. We believe that having strong, uniform, fair financial assistance policies and upfront notification procedures – as described above – is both wholly "reasonable" within the meaning of the law and necessary to achieve its aims of protecting consumers from avoidable medical debt.

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<sup>4</sup> For a comprehensive summary of current laws and regulations related to free care in all fifty states and the District of Columbia, see Community Catalyst's [Free Care Compendium](#).

<sup>5</sup> The version of the Web Portal released on July 1, 2010, includes a perfect placeholder for this information under the option "Finding Health Care You Can Afford." Choosing this option redirects consumers to the Human Resources and Services Administration (HRSA) website, with links to community health centers and facilities with lingering Hill-Burton obligations to provide free or reduced-cost care. But few hospitals have existing Hill-Burton obligations. Linking to hospitals' financial assistance policies here will give consumers better information on affordable care options.

<sup>6</sup> Hospitals should include questions about patients' experience with the hospital's financial assistance and billing policies in their community needs assessments.

In addition, the IRS should issue regulations that prohibit certain debt collection activities outright.<sup>7</sup> For example, patients who qualify for financial assistance or are eligible for public programs such as Medicaid should be exempted from debt collection activity. In general, hospital debts should not be referred to collections or reported to credit bureaus until the patient is screened for financial assistance or public programs. In no case should a hospital engage in or authorize collection lawsuits, garnishing wages, freezing bank accounts, body attachments or capias, or placing liens on patients' homes or cars without the express approval of its governing board. Practices such as selling patient debts to third parties or charging interest on outstanding patient debts should be prohibited outright. Each of these practices creates tremendous hardship for families, with long-lasting effects that spill over into the financial well-being of whole communities.

3. *Clarify the scope of the provisions limiting what hospitals can charge their patients for care.*

The longstanding practice of overbilling self-pay patients disproportionately burdens uninsured and underinsured patients – those least able to pay out of pocket and least able to negotiate rates they can afford. While Section 9007 includes limits on what hospitals can charge, they are fairly weak: hospitals cannot use “gross charges” and must limit charges to patients who qualify for financial assistance to the “amounts generally billed” to insured patients.

These terms were not defined in the law. Their commonly accepted definitions, however, pose several problems from a consumer perspective. First, there is no transparent method for determining gross charges<sup>8</sup> or the amounts hospitals generally bill to insured individuals. Second, the “amount billed” to insured patients is not equivalent to the lower amount they typically pay. In effect, the provision is vague enough to still permit hospitals to overbill the uninsured, even when they qualify for financial assistance.

We recommend that the IRS issue regulations that clarify these key terms so 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.

4. *Clarify the steps hospitals must take in consulting with public health experts and other members of the communities they serve, particularly vulnerable and disadvantaged populations.*

Community health needs assessments are a critical first step in planning and evaluating hospital community benefit programs that address longstanding health issues and

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<sup>7</sup> California, Connecticut, Massachusetts, Washington and New Jersey are among the states that have already taken steps to prohibit hospitals from engaging in some of the practices we discuss.

<sup>8</sup> We note, however, that Section 2718(e) of the PPACA, as amended, requires all hospitals to annually publish their standard charges for items and services.

systemic reasons for poor health status. We commend the IRS for requesting comments on what constitutes an effective community health needs assessment, and we strongly encourage you to issue further guidance to achieve the full aims of this requirement.

Our long-held perspective is that effective community needs assessments leverage existing resources across organizations, actively involve the community, and prioritize the needs identified by disadvantaged community members.<sup>9</sup> Because community benefit resources are limited, hospitals should be required to collaborate with other health care institutions and community organizations, in addition to public health experts, to identify and target needs whenever possible. Hospitals should:

- Consult with local public health departments and incorporate quantitative and qualitative public health data and priorities in their assessments. These and other available data sources, such as medical data from patients entering through the hospital's emergency room, provide a valuable window into the community's current challenges and priorities.
- Collaborate directly with their communities – including representatives of underserved populations – during their community health needs assessments and throughout implementation. Hospitals should be required through regulation to provide opportunities for public review and comment on the assessment and implementation strategies before they are finalized.

The ACA requires hospitals to file reports with the IRS that describe how they are meeting the needs they uncover through the assessment process. At a minimum, we recommend that these reports also include a description of the process hospitals use to elicit participation from community organizations, public health experts and other government officials; a statement identifying the community needs addressed through the implementation strategy and the intended impact of the hospitals' interventions (e.g., measurable goals and objectives); and the mechanisms they are using to evaluate the effectiveness of their implementation strategies.

5. *Clarify that these requirements serve as a federal floor.*

Finally, because some states have already gone beyond what the new law requires, we think it important that the IRS explicitly state these requirements do not preempt stronger state laws. This will help to avoid confusion and clearly mark that the federal requirements are intended to serve as a floor for non-profit hospitals, not a ceiling.

We believe that the recommendations we have made include the basic steps necessary to create a fairer charity care and community benefit system. We appreciate your attention to this important issue and welcome the opportunity to meet with you to discuss our

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<sup>9</sup> See, e.g., Section 103 of Community Catalyst's [Health Care Institution Responsibility Model Act and Commentary](#); the Massachusetts Attorney General's [Community Benefit Guidelines for Non-Profit Acute Care Hospitals](#); and the Catholic Health Association's *A Guide for Planning and Reporting Community Benefit* (2008).

recommendations in greater detail. In the meantime, please feel free to contact Jessica Curtis at 617.275.2859 or [jcurtis@communitycatalyst.org](mailto:jcurtis@communitycatalyst.org) for further information.

Yours sincerely,



Robert Restuccia  
Executive Director  
Community Catalyst



Jessica L. Curtis  
Project Director  
Community Catalyst

**cc:** Senator Max Baucus, Chair, Senate Finance Committee  
Senator Charles Grassley, Ranking Minority Member, Senate Finance Committee  
Senator Jeff Bingaman  
Jay Angoff, Director, Office of Consumer Information and Insurance Oversight  
Karen Pollitz, Deputy Director for Consumer Support, Office of Consumer Information and Insurance Oversight

**ALSO SUBMITTED ON BEHALF OF:**

The Access Project  
Families USA  
MergerWatch  
National Consumer Law Center  
National Health Law Program  
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