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May 20, 2010

The Honorable Douglas Shulman
Commissioner
Internal Revenue Service
1111 Constitution Ave., NW
Washington, DC 20224

Dear Commissioner Shulman:

We are consumer advocates working to improve access to care, strengthen relationships between hospitals and communities, and alleviate burdens caused by medical debt. Collectively, we counsel people struggling to find or afford medical care; survey hospitals to understand where financial assistance programs are working well and where they are faltering; and partner with hospitals to address health disparities in our neighborhoods. Wherever possible, we work with hospital leaders to find common ground and promote effective charity care and community benefit practices.

Section 9007 of the *Patient Protection and Affordable Care Act* (PPACA) added four new requirements for private tax-exempt hospitals related to financial assistance and community benefit.¹ It also gave the Internal Revenue Service (IRS) authority to issue guidance or enabling regulations as necessary to implement these reforms.

We write today to ask that the IRS move quickly to fully implement Section 9007. Our experience with these issues in the states shows that meaningful regulatory standards and oversight, proactive community education about hospital policies, and community involvement in hospitals' needs assessment processes are key to effectively implementing financial assistance and community benefit requirements.² In particular, we recommend issuing regulations or guidance that would:

- 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.***

¹ 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).

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

Hospitals retain tremendous discretion in developing financial assistance policies under Section 9007. We suggest issuing further guidance that, at a minimum:

- **Codifies best practices for ensuring that financial assistance policies are well-publicized and well-used.**³ These include notifying uninsured and underinsured patients—in the appropriate language—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.
- **Sets standards for fair application procedures**, including the kinds of documentation applicants will be asked to supply.
- **Specifies what assets and expenses hospitals can include** in an eligibility determination.
- Requires hospital policies to **peg eligibility criteria to an individual's family income**, rather than the size of the hospital bill.

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.⁴ This will help them to structure policies that correlate to their communities' unique needs.

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

Patients who qualify for financial assistance or are eligible for public programs such as Medicaid should be exempted from other collection actions. In no case should a hospital engage in or authorize garnishing wages, freezing bank accounts, or placing liens on patients' homes 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.

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

³ 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, 2010

⁴ Hospitals should include questions about patients' experience with the hospital's financial assistance and billing policies in their community needs assessments.

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 charges⁵ 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.

- 4) ***Clarify that hospitals, when conducting community needs assessments, must consult with members of the communities they serve, particularly vulnerable and disadvantaged populations.***

Effective community needs assessments leverage existing resources across organizations, actively involve the community, and prioritize the needs identified by disadvantaged community members.⁶ Because community benefit resources are limited, hospitals should be encouraged 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 directly with their communities—including representatives of underserved populations—during their community needs assessments, and should provide opportunities for public review and comment on the assessment before it is finalized.

* * *

Finally, because some states have already gone beyond what the new law requires, we think it important that the IRS issue guidance explicitly stating that 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 and not a ceiling.

We believe these recommendations include the basic steps necessary to create a fairer charity care and community benefit system under Section 9007. We would like to meet with you to discuss them in greater detail. In the meantime, please feel free to contact Jessica Curtis at 617.275.2859 or jcurtis@communitycatalyst.org for further information.

Yours sincerely,

Jessica L. Curtis
Project Director, Community Catalyst

⁵ 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.

⁶ 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).

On Behalf Of:

The Access Project
Boston, MA

Arkansas Community Organizations
Little Rock, Arkansas

Texas Legal Services Center
Austin, Texas

Community Service Society of New York
New York, New York

Kansas Health Consumer Coalition
Topeka, Kansas

Health Access California
Sacramento and Los Angeles, California

UHCAN Ohio
Columbus, Ohio

Georgia Watch
Atlanta, GA

Pennsylvania Health law Project
Philadelphia, PA

South Carolina Fair Share
Columbia, SC