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VIA ELECTRONIC MAIL

June 22, 2011

The Honorable Timothy Geithner
Secretary
United States Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Re: Internal Revenue Service Announcement 2011-37 ("Portion of Form 990 Schedule H Optional for Tax-Exempt Hospitals for Tax Year 2010")

Dear Secretary Geithner:

We appreciate the valuable work of the Internal Revenue Service ("the Service") in establishing fair, clear, transparent reporting guidelines for tax-exempt hospitals. However, we were disappointed to learn of its recent decision[1] to make reporting on compliance with consumer protections in the Affordable Care Act optional for tax-exempt hospitals for Tax Year 2010. These protections, found in Section 9007 of the Affordable Care Act and codified as Section 501(r) of the Internal Revenue Code, offer significant relief from medical debt and improve access to health care for low- and middle-income families.[2] Delaying the reporting requirement could unintentionally keep communities and individual consumers from gaining timely information about financial assistance programs and fair billing requirements. We are writing today to urge the Service to develop consumer-friendly guidance on these provisions this year, and we respectfully request the opportunity to meet with you to discuss future guidance and Schedule H reporting for tax-exempt hospitals.

Community Catalyst is a national non-profit consumer advocacy organization dedicated to ensuring quality, affordable access to health care for all. We work with partners in approximately 40 states on a variety of different issues relating to health care, focusing on vulnerable groups such as seniors, low-income children and families, immigrants, racial and ethnic minorities, and people living with chronic illness and special health care needs. Community benefit programs have long been a focus of our work. Recently, we have been working with advocates in 15 states on hospital billing and debt collection issues. Based on our observations of the issues facing these communities and our partners today, we believe that:

- The requirements for tax-exempt hospitals found in Section 501(r) are a critical, if underappreciated, building block for successful implementation of the Affordable Care Act.[3]
- Though tax-exempt hospitals could face additional reporting and may need to adjust their policies to comply with the Affordable Care Act's requirements, the brunt of the burden of inadequate financial assistance, billing and community benefit practices falls on consumers. When establishing reporting metrics and guidance, the Service should place equal weight on the impact its policies will have on vulnerable populations and communities served by tax-exempt hospitals.
- There is significant and immediate need for the Service to issue additional guidance on Section 501(r) that prioritizes the needs of vulnerable communities.

To ensure that reporting in future tax years—along with forthcoming guidance—adequately reflects the needs and concerns of vulnerable communities and hews to the intended aims of the Affordable Care Act, we respectfully submit the following and request an opportunity to share, in person, our ideas for structuring guidance and reporting that will allow communities to benefit fully from these reforms.

Section 501(r): A Critical Building Block of the ACA

Though not as well-known or heralded as other major coverage and delivery system provisions found in the Affordable Care Act, the consumer protections found in Section 501(r) of the Internal Revenue Code are incredibly important to achieving the law's immediate and long-term goals of expanding access to affordable care for all Americans. For example:

- **They serve as an intermediate—and immediate—protection against medical debt.** The major coverage provisions found in the Affordable Care Act do not become effective until 2014, leaving millions of Americans without access to regular care and susceptible to medical debt in the interim. A recent report by the Department of Health and Human Services (HHS) found that, "[o]n average, uninsured families can only afford to pay in full for about 12% of…(hospitalizations) they might experience. Even uninsured families with incomes above 400% of the Federal Poverty Level (FPL) can afford to pay in full for only 37% of their hospitalizations."[4] Because Section 501(r) requires hospitals to develop financial assistance policies and work with patients to determine whether they qualify, it can offer peace of mind to the millions of Americans stuck in precisely the position described by HHS who are uninsured or underinsured due to job loss, inadequate insurance coverage, chronic illness, and other circumstances beyond their control.
- **They resonate with families and communities hit hard by the economic downturn.** The public supports oversight of hospital programs similar to what is required by Section 501(r). A late 2008 poll showed that 90 percent of Americans believed that hospitals should be required to provide information about financial assistance and low-cost services to the community; and 88 percent believed that the prices hospitals charge patients—especially the uninsured—should be regulated to avoid huge markups for those who can least afford to pay.[5]
- **Hospital financial assistance policies can be designed to help transition patients who will become eligible for Medicaid, subsidies, and other coverage options in 2014.** In many states, low-income patients who currently qualify for hospital financial assistance programs will be newly eligible for Medicaid, subsidies, or other coverage when Affordable Care Act reforms take full effect in 2014. Because their financial assistance programs tend to target low-income patients, tax-exempt hospitals are well-positioned to expedite enrollment into new affordable coverage options.
- **They can help consumers understand their options when seeking local health care services.** Hospital financial assistance programs are the only viable link to health care for many people. But solid information about them has been difficult to come by in many communities, despite assurances from industry stakeholders to the contrary. Without this information, communities have no real gauge for understanding the value their hospitals bring, and individual patients lack timely access to information that would help them seek necessary care without incurring medical debt. Section 501(r) addresses this by requiring hospitals to report uniform information about their financial assistance programs.
- **They will remain critical after 2014** for patients in medically underserved areas, low-income insured patients having difficulty accessing primary or preventive care, and immigrants and others who will not be covered due to prohibitively high costs or inadequate outreach.

- **Solid community benefit practices—which include forthright public reporting on hospital practices and decision-making and meaningful community engagement,— encourage a stronger, smarter, more flexible use of health care resources that remove barriers to care at the local level.** The new requirements that hospitals engage community members and public health experts in researching, developing, and implementing a community health needs assessment and plan incentivizes hospitals to "swim upstream": that is, to collaborate with other providers, experts and community members to address the issues that lead to poor health and drive improper emergency room usage. These programs can ultimately help hospitals and communities to drive down burgeoning health costs for *all* payers and improve community health.

Communities as an Audience for Schedule H Reporting

The Service's decision to make reporting on Part V, Section B optional also seems out of step with the initial goals of its 2008 reforms to the Form 990, which included the introduction of Schedule H for tax-exempt hospitals. One of the guiding principles of those changes was to enhance transparency about hospital organizations' operations, providing the Service and others—including the communities served by tax-exempt hospitals—comparable information about the ways hospitals choose to conduct their business. From a community perspective, Part V, Section B builds on this goal by providing invaluable information about individual hospital practices—that is, information about the way local hospital facilities, as opposed to hospital systems, choose to serve their communities. The communities served by local hospitals within a system are likely to differ significantly with regard to economic status, unmet health needs and resources, cultural and linguistic preferences, and priorities. It follows that the need for financial assistance, billing and debt collection, and community benefit programs will also differ across communities. Hospitals—including those that are part of larger systems—should take these factors into consideration and use them to tailor policies that meet the unique needs of their local communities. The information found in Part V, Section B is unique in that it provides communities with unprecedented insight into their local hospitals' practice. This information, we note, is not repeated elsewhere in Schedule H, and certainly not to the level of detail found in Part V, Section B.

Our disappointment with the Service's decision to make this section optional for Tax Year 2010 stems in large part from the concern that many hospitals will opt out of reporting, leaving community members without access to information that the Affordable Care Act intended them to have. Research has shown that the information requested in Part V, Section B regarding financial assistance, billing and debt collection is simply not consistently available to hospitals' community members and to patients in need, despite the hospital industry's assertions to the contrary, and especially without active government oversight.[6] The Affordable Care Act intended to address such gaps by requiring every hospital facility to meet the basic standards outlined in Section 501(r) of the Internal Revenue Code . In our view, Part V, Section B of the 2010 Schedule H reasonably incorporates these changes:

- It asks hospitals to describe how they are complying with the law using a straightforward list of questions, most of which directly reference language found in the Affordable Care Act or the Joint Committee on Taxation's Technical Explanation of the law;
- In almost every instance, hospitals that follow procedures other than those specifically outlined in Part V, Section B can report their practices in Part VI;
- The questions asked within Part V, Section B of the Schedule routinely surface in community conversations with hospitals; many reflect "best practices" or voluntary standards supported by hospitals and other stakeholders;[7] and,

- With the exception of the requirement regarding community health needs assessments, these provisions have been in full effect since the passage of the Affordable Care Act on March 23, 2010.

Absent the data found in Part V, we are also concerned that the Service lacks a ready mechanism to monitor compliance with the Affordable Care Act requirements. This could weaken the protections that are available to low- and moderate-income families in many communities.

Moving forward, we strongly encourage the Service to retain Part V, with some improvements, and require all hospital facilities to report it. Including this data in Schedule H reporting will provide a valuable—and otherwise unavailable—baseline of qualitative and quantitative data about hospital performance. Hospitals have had ample time to come into compliance, even without additional guidance, and should be able to answer the questions found in Schedule H. For these reasons, we will be encouraging our partners around the country to ask their local hospitals to "take the option" and report in full on Part V, Section B for Tax Year 2010.

We also strongly encourage the Service to work with the Department of Health and Human Services (HHS) with regard to data collection. First, the quantitative data on charity care, bad debt, unreimbursed costs from government programs and community benefit expense that the Service must gather under the Affordable Care Act could be helpful in informing upcoming changes to Medicaid and Medicare Disproportionate Share Hospital funding.[8] Second, the quantitative information gathered in Schedule H—most notably in Part V, Section B—could be used to populate a searchable, national database such as http://finder.healthcare.gov/. This would allow individuals to access information about eligibility and applications for insurance coverage and local financial assistance programs in one easy process. Because the data gathered in Schedule H will be retroactive, we also encourage the Service and HHS to develop a mechanism for gathering information about hospital financial assistance policies in real time. California's Office of Statewide Health Planning and Development has already taken these steps, allowing consumers there to search for financial assistance based on the hospital's name and distance from a given street address.[9]

The Need for Clear, Consumer-Friendly Guidance

To the communities we serve, the Section 501(r) requirements stand for much more than justification of their local hospitals' tax-exempt status. For many, they represent the right to information about programs that can help them meet their families' health care needs without sacrificing their financial stability. They draw a fairer line for hospital charging than our current system, which places the uninsured and underinsured (who lack the clout to negotiate a fair price) at a disadvantage. They ensure that hospitals will work with patients to develop payment options families in crisis can afford, instead of subjecting them to the added stress of credit and collection woes when they are at their most vulnerable.

The data requested in the revised Schedule H serves another important function: it gives policymakers and the public a clearer picture of the value that tax-exempt hospitals bring to their communities. Local, state, and federal governments forego billions of dollars in tax revenues yearly with the understanding that tax-exempt hospitals are providing care to financially needy members in their communities. While we have worked with many dedicated hospital professionals who have used community benefit resources to innovatively and effectively improve access to care for vulnerable populations, many hospitals lag behind. Requiring an accounting for dollars foregone should help to bridge this gap in performance. We believe reporting solid data works to *hospitals'* benefit, as well, enabling them to show the value they bring to communities in a particularly difficult time for local, state, and federal budgets.

Because of the impact these programs have on local communities, as well as their direct connection to the goals of the Affordable Care Act, **we strongly encourage the Service to issue guidance on Section 501(r) this year that establishes meaningful standards that will actively consider what is necessary to protect consumers from medical debt and will require hospitals to engage their communities in community benefit planning, as intended by Congress in the Affordable Care Act.**

To that end, we have attached our July 2010 comment letter below.[10] This letter, signed by 66 other organizations across the country, outlines the most critical protections that, we believe, belong in 501(r) guidance. As we note in our letter, the Service can build on the steps several states have taken to address improper billing and collection practices or to codify key components for community benefit programs. In addition, our model laws on financial assistance and community benefit provide suggestions for ways to structure requirements that will empower and protect community members.[11] These model laws are based on an amalgamation of the best practices observed in the field, compounded by the needs articulated by community members and other advocates after observing the effect of these laws—or the absence of them—on communities.

As you consider guidance and reporting for Tax Years 2011 and beyond, we welcome the opportunity to discuss our recommendations in greater detail with you and your staff. Thank you for your many efforts in this arena to date.

Yours very truly,

Robert Restuccia
Executive Director

Jessica L. Curtis, J.D.
Project Director

cc: Doug Schulman, Commissioner, Internal Revenue Service
Kathleen Sebelius, Secretary, United States Department of Health and Human Services

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[1] "Portion of Form 990 Schedule H Optional for Tax-Exempt Hospitals for Tax Year 2010," Internal Revenue Service Announcement 2011-37. Accessed June 22, 2011 at http://www.irs.gov/pub/irs-drop/a-11-37.pdf.

[2] See Section 9007 of the *Patient Protection and Affordable Care Act* (Pub.L. 111-148 and 111-152).

[3] Under the Affordable Care Act, tax-exempt hospitals must:

- Develop written, robust financial assistance policies
- Fairly limit what they charge for services
- Avoid taking extraordinary debt collection actions without first making reasonable efforts to qualify patients for financial assistance
- Develop and implement plans to address community health needs, in consultation with community members and public health experts.

[4] "The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to pay Potential Hospital Bills." May 2011. Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Accessed June 20, 2011 at http://aspe.hhs.gov/health/reports/2011/ValueofInsurance/rb.shtml#_ftnref1.

[5] "Americans Believe Non-profit Hospitals Should Provide Charity Care and Support Regulation and Penalties if They Fall Short," Community Catalyst, December 2008. Available at http://www.communitycatalyst.org/doc_store/publications/HAP_Polling_Fact_Sheet.pdf.

[6] See, *e.g.,* 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. In this 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.

[7] See, *e.g.,* the Patient-Friendly Billing Project's Recommended Practice, Healthcare Financial Management Association, available at http://www.hfma.org/HFMA-Initiatives/Patient-Friendly-Billing/Early,-Transparent-Financial-Communications/; *A Guide for Planning and Reporting Community Benefit,* the Catholic Health Association, 2008 edition.

[8] Section 501(r) may also prove critical to safety-net hospitals that serve disproportionately high numbers of low-income and vulnerable populations, or to hospitals that provide crucial (but money-losing) services. Many hospitals receive partial reimbursement for these services through Medicare and Medicaid Disproportionate Share Hospital (DSH) dollars. However, the Affordable Care Act requires the Secretary of the Department of Health and Human Services to restructure funding for these programs quite significantly. The information Section 501(r) requires the Service to gather about charity care and community benefit, in particular, could help to ensure that the bulk of remaining resources are directed to hospitals truly serving needy communities. See Sections 3133 and 2551 of the *Patient Protection and Affordable Care Act* (Pub.L. 111-148 and 111-152).

[9] See the California Office of Statewide Health Planning and Development, California Hospital Free and Discount Payment Programs. Accessed June 22, 2011 at http://syfphr.oshpd.ca.gov/search.aspx. For a description of California's regulatory scheme and a guide for consumers interested in applying for discounts, see "If You Have a Bill: Hospital Fair Pricing Discounts and Free Care," Health Access et al. Available at http://www.hospitalbillhelp.org/have_bill/no_insurance?id=0002.

[10] Letter to Sarah Hall Ingram, Commissioner, Internal Revenue Service Tax-Exempt and Government Entities Division, July 21, 2010. Available at http://www.communitycatalyst.org/doc_store/publications/IRS_Sign-on_Letter_RE_Nonprofit_Hospitals_with_sign_ons.pdf.

[11] See Community Catalyst, *Build Your Own Patient Financial Assistance Act,* available at http://freecareactbuilder.communitycatalyst.org/; the *Health Care Institution Responsibility Model Act,* available at http://www.communitycatalyst.org/doc_store/publications/the_health_care_instititution_responsibility_model_act_1999.pdf; and the *Commentary to the Health Care Institution Responsibility Model Act,* available at http://www.communitycatalyst.org/doc_store/publications/commentary_to_the_health_care_institution_responsibility_model_act_1999.pdf.

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July 21, 2010

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.[12] 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**.[13] 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 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**.[14] 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 – have enacted strong notification laws that could serve as models.[15] 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. This will help ensure that individuals struggling to find affordable care can quickly access the policies of hospitals in their area.[16]
   - **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.[17] 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.

In addition, the IRS should issue regulations that prohibit certain debt collection activities outright.[18] 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 capiases, 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[19] 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 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.[20] 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 recommendations 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,

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
National Immigration Law Center
National Latina Institute for Reproductive Health
Northeast Action
Sargent Shriver National Center on Poverty Law
SEIU
Trust For America's Health
Young Invincibles

Alabama
Alabama Arise

Arkansas
Arkansas Community Organizations

Colorado
Colorado Consumer Health Initiative
Colorado Council of Churches

Florida
Florida CHAIN
Human Services Coalition Miami-Dade

Georgia
Georgia Free Clinic Network
Georgia Watch
Georgia Women for a Change, Inc.
Georgians for a Healthy Future
HealthStat
Healthy Mothers, Healthy Babies Coalition of Georgia, Inc.
Voices for Georgia's Children
WonderRoot

Illinois
Campaign for Better Health Care

Indiana
Citizens Action Coalition of Indiana

Kansas
Kansas Health Consumer Coalition

Kentucky
Kentucky Equal Justice Center

Louisiana
Louisiana Consumer Healthcare Coalition

Massachusetts
Health Care for All
Health Care for Artists
Health Law Advocates

Maine
Consumers for Affordable Health Care
Maine Center for Economic Policy

Maryland
Maryland Citizens' Health Initiative

Mississippi
Mississippi Center for Justice
Mississippi Coalition for Citizens with Disabilities

Missouri
Missouri Health Advocacy Alliance

Nebraska
Nebraska Appleseed Center for Law in the Public Interest

New Jersey
Family Voices NJ
New Jersey Citizen Action

New York
New York Immigration Coalition

New Mexico
Health Action New Mexico

North Carolina
North Carolina Justice Center

Nevada
Jon L. Sasser, Chair, Nevada Lawyer for Progressive Policy

South Carolina
South Carolina Appleseed Legal Justice Center
South Carolina Fair Share

Tennessee
Tennessee Health Care Campaign

Texas
Center for Public Policy Priorities
Texas Legal Services Center

Ohio
Cerebral Palsy Association of Ohio
Ohio Poverty Law Center
Progress Ohio
UHCAN Ohio

Oregon
Oregon Health Action Campaign

Pennsylvania
Community Legal Services
Consumer Health Coalition
Philadelphia Health Law Project

Utah
Utah Health Policy Project

Virginia
Virginia Organizing Project

Vermont
Vermont Campaign for Health Care Security
Vermont State Health Care Ombudsman

Washington
Northwest Health Law Advocates
Washington Community Action Network

[12] 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).
[13] Community Catalyst's *Patient Financial Assistance Model Act and Commentary* includes additional recommendations for structuring effective hospital charity care policies.
[14] 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.
[15] 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.*
[16] 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.
[17] Hospitals should include questions about patients' experience with the hospital's financial assistance and billing policies in their community needs assessments.
[18] 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.
[19] 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.
[20] 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).