

September 24, 2012

VIA ELECTRONIC MAIL

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

Re: Notice of Proposed Rulemaking, “Additional Requirements for Charitable Hospitals,” 26 Code of Federal Regulations Part 1, [REG-130266-11]

Dear Commissioner Shulman:

We appreciate the opportunity to respond to the [Notice of Proposed Rulemaking, “Additional Requirements for Charitable Hospitals”](#)¹ (the Notice). The Notice addresses key issues of transparency, fair billing, and collections, as outlined in the new requirements for tax-exempt hospitals found in Section 9007 of the Patient Protection and Affordable Care Act (ACA).² We respectfully submit the following comments to the Department of the Treasury and Internal Revenue Service (the Service).

We are health care advocates, legal service attorneys, labor, grassroots and faith-based community organizers working to improve access to quality care, strengthen relationships between hospitals and communities, and alleviate the heavy burdens caused by medical debt for low- and middle-income families. 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.

We write today to commend you and your staff for issuing proposed rules that thoughtfully address many of the problems that arise for low- and middle-income patients, insured and uninsured, as they deal with out-of-pocket expenses for hospital care. Our nation’s hospitals—particularly non-profit hospitals, which are exempted from most taxes and receive other financial benefits in exchange for promoting community health and access to care—stand in the gap for the millions of families who lack access to affordable, quality health care coverage. Today, millions of Americans are saddled with medical debt, which can have a chilling effect on patients’ willingness to seek preventive or follow-up care.³ Financial difficulties—including inadequate insurance coverage—can also directly

¹ Available at <http://www.irs.gov/pub/irs-drop/reg-130266-11.pdf>.

² 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).

³ Forgoing recommended follow-up care, not filling prescriptions, and delaying physician or specialist care when medical problems arise are all commonly reported behaviors among families carrying credit card debt; also, just under 75 percent of families that lost coverage due to unemployment reported using one of these strategies to keep costs down. M. Doty, S. Collins, R. Robertson, and T. Garber. “Realizing Health Reform’s Potential: When Unemployed Means Uninsured: The Toll of Job Loss on Health Coverage, and How the Affordable Care Act Will Help.” *The Commonwealth Fund*, August 2011.

impede access to care.⁴ Medical debt has also been linked to other phenomena currently impacting low- and middle-income Americans, such as foreclosure, poor credit ratings⁵ and bankruptcy.⁶

The hospital safety net will continue to play an important role for many people despite the benefits being rolled out by the ACA's coverage expansions. Even if the Medicaid expansion were implemented in every state, an estimated 20 million people would remain uninsured. Of those approximately 20 million, an estimated 37 percent will be eligible for Medicaid but not enrolled; 25 percent will be undocumented immigrants; 16 percent will be exempt from the personal responsibility provision to buy health insurance because it is unaffordable; 15 percent will not be eligible for subsidies and will choose to not buy health insurance; and 8 percent will be eligible for subsidized coverage in the Exchanges but not enroll.⁷ These numbers do not take into account the millions of Americans who will be *underinsured*, and unable to afford provider copays, deductibles, and other out-of-pocket expenses without assistance.

In many instances, non-profit hospitals treat all patients with dignity and respect, regardless of their ability to pay for care. Unfortunately, these practices are not uniform across all non-profit hospitals. A sample of major news stories from 2012 illustrate the problems:

- In **Minnesota**, a third-party collection agency hired by a non-profit hospital system allegedly “embedded” its staff within the hospital’s emergency room, asking patients with outstanding balances for payment upfront prior to receiving treatment.⁸
- In **North Carolina**, a public hospital routinely placed liens on low-income patients’ homes, including many who were likely within the qualifying income and asset test for the hospital’s own financial assistance policy.⁹
- In **New York**, there is evidence of systemic practices of non-profit hospitals suing patients with low incomes and few assets, including depleting a 48-year-old unemployed and uninsured woman’s \$17,000 in savings and taking her to court for the remaining \$88,000 in bills owed from treatment of a tumor.¹⁰

We applaud the proposed rules for outlining a federal floor that, subject to certain improvements, reasonably balances the need for stronger patient protections and greater transparency with

⁴ In one national survey, about one in ten Americans living with a serious illness, medical condition, injury or disability reported “being turned away by a doctor or hospital for financial or insurance reasons at some time during the past 12 months when they tried to receive care.” *NPR/Robert Wood Johnson Foundation/Harvard School of Public Health*, “Poll: Sick in America Summary.” Released May 2012.

⁵ One survey found that medical bills and unemployment were among the leading contributors to credit card debt for low- and middle-income families, with 55 percent of survey respondents with poor credit citing medical debt as a contributing factor. A. Traub and C. Ruetschlin, “The Plastic Safety Net: Findings from the 2012 National Survey on Credit Card Debt of Low- and Middle-Income Households,” *Demos*, May 22, 2012.

⁶ See A. Carrns, “Medical Debt Cited More often in Bankruptcies,” *New York Times*, Aug. 8, 2011. See also D. Himmelstein, E. Warren, D. Thorne, & S. Woolhandler, “Illness and Injury as Contributors to Bankruptcy” *Health Affairs Web Exclusive*, Feb. 2, 2005; and Christopher Robertson, Richard Egelhof, & Michael Hoke, *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, Harvard Law School, Aug. 2007.

⁷ We note that these estimates were calculated before the Supreme Court ruling on the ACA, so additional people will remain uninsured if some states do not take up the Medicaid expansion. M. Buettgens and M. Hall “Who Will be Uninsured After Health Insurance Reform?” *Urban Institute*, March 2011. Available at <http://www.rwjf.org/files/research/71998.pdf>.

⁸ J. Silver-Greenberg, “[Debt Collector is Faulted for Tough Tactics in Hospitals](#),” *New York Times*, April 24, 2012.

⁹ A. Alexander and D. Raynor, “[Hospital Suits Force New Pain on Patients](#),” *Charlotte Observer*, April 23, 2012.

¹⁰ N. Bernstein, “[Hospitals Flout Charity Aid Law](#),” *New York Times*, Feb. 12, 2012.

providers' needs for efficiency and flexibility in their billing cycles and policy development. Our comments address key points that we believe will make implementation of these requirements meaningful for patients.

I. Establishing a Financial Assistance Policy

In general, we strongly support the approach taken within the Notice to define the steps non-profit hospitals must take to “widely publicize” information about financial assistance.

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 cover all emergency and medical care provided by the hospital facility. Because patients often see a range of providers or technicians while in the hospital setting, we encourage the Service to address 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)

We strongly support the adoption of the “widely publicize” standards in final rules. Access to timely information about financial assistance—the hospital's policy, eligibility criteria, and process for determining eligibility, among other things—is critical to preventing the financial and emotional toll taken on patients who cannot afford to pay for care. Greater transparency offers patients (and their advocates) the information they need to understand their responsibilities, seek help, and choose options they can afford, when available. In addition, access to financial assistance policies and other reportable information allows policymakers, patients and the public to evaluate institutional practices. Greater transparency will also help ensure eligibility is determined using a uniform application process and that all patients receive equal treatment, decreasing the risk that patients could be subjected to unlawful discrimination, even unintentionally.

Currently this information is not always readily accessible to patients, or to the advocates who work with them to solve billing and collections issues. In one national survey of 99 randomly chosen charitable hospitals conducted in 2009, researchers found that, upon request, fewer than half of hospitals surveyed (42) provided financial assistance application forms; only a quarter (26) gave information about eligibility criteria; and just over a third (34) offered information about financial assistance in languages other than English.¹¹ State and local advocates have also encountered repeated difficulty accessing information about hospital billing and financial assistance programs.

The twenty states that require hospitals to notify patients about financial assistance take a variety of approaches to prescribing what methods hospitals must use.¹² In our opinion, the Notice strikes the right balance between an easy-to-meet minimum standard—requiring hospitals to make free copies of the full financial assistance policy (FAP), application form, and a plain language summary available upon request and on the Web—with more flexible standards that allow hospitals to use approaches that “inform and notify” visitors, the broader community, and patients in a manner “reasonably calculated” to attract attention and reach vulnerable communities. We think this

¹¹ 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.

¹² See *Community Catalyst*, “Free Care Compendium, National Snapshot: Mandatory Notification States,” available at http://www.communitycatalyst.org/projects/hap/free_care/pages?id=0003.

approach appropriately marries flexibility with the need to have information available in a uniform way across facilities. We also recommend that the Service work with the Department of Health and Human Services (HHS) to post hospital policies on a national, searchable format, such as 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 Service:

- **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 (DOJ) and HHS, and recently revised regulations from the Centers for Medicare and Medicaid Services (CMS) governing marketing by Medicare Part C and D plans.¹³
- 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.

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.¹⁴

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

Hospital facilities should be required to consult with members of the community, including representatives of vulnerable or disadvantaged community members, 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. Community input on financial assistance could be

¹³ 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 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>.

¹⁴ See §1.501(r)-4(b)(2)(ii), pages 64-65.

incorporated as part of the overall framework for community health needs assessments, or any time hospitals review their financial assistance policies.

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 Service:

- Add language to ensure 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)
- Prohibit hospitals from requiring applicants to provide a Social Security Number
- Allow hospitals to use patient-friendly methods to “presumptively” qualify patients for financial assistance other than through a formal application process (e.g., checking enrollment in means-tested public programs such as Medicaid, Supplemental Nutrition Assistance Program, or reduced or free school lunch programs)

The feasibility of checking state databases varies by state, but hospitals should have flexibility to use these sources.

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

We recommend that the Service provide additional guidance as to when a hospital will have been deemed to have “consistently carried out” its financial assistance policy.

Emergency Medical Care Policy (§1.501(r)-4(c); pages 24-25, 72-74)

We appreciate and generally support the prohibition on debt collection activities in the emergency department or other hospital venues where such activities could interfere with the treatment of emergency medical conditions. Too often, we have heard stories of patients with very limited means being pressured to pay for care at the time of service with credit cards, digging into retirement or savings accounts, or asking friends and family to cover the bill—all without any discussion about financial assistance, payment plans, and other consumer-friendly options the hospital may offer or know about. At the same time, our understanding is that providing patients with oral notice about financial assistance at the point of service is one of the most effective methods for informing them that this option exists. While we generally favor a provision that would significantly curtail collection attempts in emergency rooms and other, similar settings, we seek clarification that nothing in this section would prohibit a hospital from providing a patient with oral information about financial assistance.

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.¹⁵ 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 are 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.¹⁶ This approach is inconsistent with the plain language of the statute. More practically, because the ACA and the proposed rules allow hospitals to establish their own eligibility criteria, we are concerned that this interpretation effectively crowds out low- and middle-income patients who may not qualify for the hospital’s financial assistance policy but are still unable to balance hospital bills with other living expenses.¹⁷ The equitable approach for these patients would be to require hospitals to tie charges to the patient’s ability to pay. Therefore, we recommend that hospitals limit amounts generally billed for patients under 500 percent of the Federal Poverty Level, regardless of whether they qualify for financial assistance. This is the approach taken by at least one state that regulates hospital charges.¹⁸

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

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 insurers and providers and are therefore transparent and publicly available, allowing patients and advocates to verify hospitals’ compliance with the law.¹⁹

¹⁵ See, e.g., G. Anderson, “From ‘Soak the Rich’ to ‘Soak the Poor’: Recent Trends in Hospital Pricing,” *Health Affairs*, May 2007, 26:3780-789. Available at:

http://content.healthaffairs.org/content/26/3/780.abstract/reply#healthaff_el_1878.

¹⁶ *Staff Report, Joint Committee on Taxation*, “Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010,” as amended, in combination with the “Patient Protection and Affordable Care Act.” JCX-18-10 (March 21, 2010), page 82.

¹⁷ A recent report by the Department of Health and Human Services (HHS) found that hospital charges are simply too expensive for many uninsured families, with most families able to afford only 12 percent of the cost of a hospital stay. Even uninsured families with relatively higher incomes (more than 400 percent of the Federal Poverty Level) could afford only 37 percent of what was charged for the stay. *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills*, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, May 2011.

¹⁸ New Jersey limits charges to 115 percent of Medicare payments for uninsured patients with gross family income below 500 percent of the Federal Poverty Level. N.J. Stat. § 26:2H-12.52. This plan uses Medicare payments (which are transparent and widely used) are the baseline for calculating the charges to uninsured patients.

¹⁹ Furthermore, the Medicare Payment Advisory Commission, the independent agency that advises Congress on 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.

III. Hospital Billing and Collections

Under the ACA, 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 sparingly, 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;
- Completely prohibit the selling of debt, as discussed below (see “Additional Procedural Protections.”)

Reasonable Efforts (§1.501(r)-6(c); pages 39, 81)

We appreciate and support the inclusion of timelines for hospitals to delay engaging 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. However, we recommend several changes to the proposed rules.

Lengthen the Time of the Application Period

We urge the Treasury and the Service to provide for an application period greater than 240 days after the first bill in order to adequately protect low- and middle-income patients. In some cases, patients will not respond to a healthcare provider’s billing statement, especially if they have insurance, within the time frames outlined in the proposed rules. Insured patients, in particular, may assume their insurer will be paying the bill, and may not realize they are liable for the bill until they start receiving debt collection notices or phone calls. In these cases, 240 days may be inadequate for a consumer to seek to apply for financial assistance.²⁰

Below, we request that consumers be permitted to raise the fact that they are FAP-eligible as a defense to an ECA at any time. At a minimum, we urge Treasury to provide that a consumer may apply at any time during the applicable state statute of limitations for the debt, or at a minimum within 24 months, for the purpose of invoking the protections against ECAs. While the hospital’s

²⁰ See J. Steinhauer, “Will Doctors Make Your Credit Sick?,” *New York Times*, Feb. 4, 2001 (quoting American Collectors Association that traditionally sent bills to collections 150 to 210 days after missed payment, but some were doing so more quickly). By contrast, California law effectively inhibits referrals to collection agencies for 150 days after the first bill. Cal. Health & Safety Code § 127425(d). In some cases, the patient’s first “notice” is when wages are garnished. See, e.g., “No Mercy for Consumers,” *Boston Globe*, July 30, 2006. With smaller debts, some collectors “park” the debt on a consumer’s credit report without even sending out a notice.

obligation to notify patients of the FAP process would end at 120 days, the patient could apply for assistance any time within the 24 months.

Notification (§1.501(r)-6(c)(2); pages 42-45, 81-82)

We generally support the inclusion of requirements to notify individual patients—in addition to the community at large, as discussed above—about financial assistance. We are continuing to discuss the implications of the specific requirements in the Notice with partners and other stakeholders, and plan to submit additional comments in the near future.

We recommend Treasury and the Service also provide that the time period starts when the hospital actually provides the patient with the notice of financial assistance policy in a billing statement. If the hospital does not provide the required notices under §1.501(r)-6(c)(2), then neither the 120-day notification period nor the 240-day application will begin running. This is simply a variation of the “discovery” rule in civil litigation, in which a statute of limitations begins to run from the time when a person discovers, or should have discovered, a violation, not when the violation occurs.²¹ Some consumer protection laws have this protection explicitly contained within their statute of limitations.²²

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

We strongly support the proposed protection 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.

Additional Procedural Protections for Patients (pages 38-39)

The Service has requested comments on additional procedural protections for patients related to debt collection. We recommend the following additional steps be taken.

²¹ For example, many states have adopted the discovery rule for claims brought under their consumer protection laws. See *National Consumer Law Center*, “Unfair and Deceptive Acts and Practices,” § 12.3.2.1 (7th ed. 2008 and Supp.).

²² See, e.g., Fair Credit Reporting Act, 15 U.S.C. §1681p.

Prohibit the Selling of Patient Debt

We urge the Treasury and the Service to ban non-profit hospitals' selling of patient debt. Debt buyers typically purchase consumer debts for pennies on the dollar with serious gaps in the data and documentation related to the account.²³ Despite buying debt at deeply discounted rates, buyers aggressively seek to collect the full amount plus interest, penalty fees, and attorneys' fees. Debt buyers are also more persistent in seeking payments for very old debts.²⁴ As a result, they frequently pursue flawed claims that may be compounded by billing errors in original medical bills that are no longer available.²⁵ Debt buyers press financially stressed families to pay bills even when they are not legally liable.²⁶ Indeed, it was partly abuses of debt buyers that prompted the Federal Trade Commission to declare in a recent report that "the system for resolving disputes about consumer debts is broken."²⁷ Non-profit hospitals should not be permitted to sell debts to the very entities that were at least partly responsible for breaking this system.²⁸

Expressly Allow Patients to Raise FAP-Eligibility as a Defense

One of our greatest concerns with the proposed regulations is that the protections for ECAs only apply for a limited period of time. Low- and moderate-income patients should be protected from ECAs such as collection lawsuits or garnishment when lawsuits are filed a year or two or even many years after the date of service, which is common with debt collection.²⁹

Unfortunately, a sizable segment of patients will not read or respond to billing and collection notices, let alone take the complicated steps necessary to apply for financial assistance. Analogous issues currently arise in debt collection cases, where numerous studies indicate that consumers fail to respond to notices or complaints in collection actions for a variety of reasons.³⁰ These can range from

²³ Debt buyers purchase accounts in bulk, typically obtaining only an electronic spreadsheet with minimal information about the debt. Often, they do not purchase the underlying documentation of the debt, such as the actual bill, monthly statements, payment records, or customer service records that would reflect customer disputes.

²⁴ Reports by consumer groups document these serious abuses by debt buyers. See C. Wilner and N. Sheftel-Gomes, *Neighborhood Econ. Dev. Advocacy Project and Urban Justice Center*, "Debt Deception: How Debt Buyers Abuse The System To Prey On Lower-Income New Yorkers." 6 (May 2010), available at http://www.nedap.org/pressroom/documents/DEBT_DECEPTION_FINAL_WEB.pdf [hereinafter "NEDAP, Debt Deception"]; R. Hobbs and R. Jurgens, *National Consumer Law Center*, "The Debt Machine" (July 2010), available at http://www.nclc.org/images/pdf/debt_collection/debt-machine.pdf.

²⁵ The FTC has concluded that "the information received by debt collectors is often inadequate and results in attempts to collect from the wrong consumer or to collect the wrong amount." *Federal Trade Commission*, "Collecting Consumer Debts: The Challenges of Change, A Workshop Report," at 24 (Feb. 2009).

²⁶ Some of the claims go into collection when they have already been settled or paid in full, others were someone else's debt, and some were created by an identity thief. Still others are beyond the statute of limitations, were discharged by the consumer in bankruptcy, or were disputed with the original creditor years before by the consumer for fraud, nonperformance, or another problem. One report by several New York City nonprofit and legal services organizations found that 35 percent of debt buyer lawsuits were meritless. NEDAP, *Debt Deception* at 2.

²⁷ *Federal Trade Commission*, "Repairing a Broken System: Protecting Consumers in Debt Collection and Arbitration" (July 2010) at 5, available at <http://www.ftc.gov/os/2010/07/debtcollectionreport.pdf> [hereinafter "FTC, Repairing a Broken System"] at 7 at I (Executive Summary).

²⁸ Debt buyers are notorious for their employment of questionable and even illegal techniques. See, e.g., Press Release, *Federal Trade Commission*, "Under FTC Settlement, Debt Buyer Agrees to Pay \$2.5 Million for Alleged Consumer Deception," January 30, 2012, available at <http://www.ftc.gov/opa/2012/01/asset.shtm>.

²⁹ Note that consumer debt is resold one or more times as it moves through the debt collection system. Thus, it may not be the hospital or its collector that files a collection lawsuit on a debt, but the second or third debt buyer in the chain. See FTC, *Repairing a Broken System*.

³⁰ The incidence of default actions ranges from 70 to over 90 percent. See NEDAP *Debt Collection* (finding that 94.3 percent of New York City collection lawsuits in the sample resulted in a default judgment or settlement); B.

literacy issues³¹ to confusion, fear, or denial about the process. For various reasons, many patients may choose the “default option” (in this case, doing nothing).³² Patients may simply not receive the information because of outdated addresses due to moving or neglect by the collector in obtaining the proper address.³³ The issue of “sewer service,” *i.e.*, where the person tasked with serving a legal summons fails to do so, but claims to have done so – is a serious problem in debt collection as well.³⁴ Furthermore, there may be instances in which a consumer may not have been FAP-eligible within 240 days of the date of service, but will be when he or she is subject to the ECA (for example, a consumer may be making payments pursuant to a payment plan, but then lose her job and fall behind). These consumers should be able to raise the fact they are and remain eligible for financial assistance in response to these ECAs.

We strongly urge Treasury and the Service to permit patients to raise FAP eligibility at any time—not just within the 240-day timeframe—as an affirmative defense if the consumer is subject to an ECA. In such circumstances, the hospital would not be considered in violation of the regulations for engaging in ECAs after the notification period but before the time that the patient raised it as an affirmative defense. However, the hospital would be precluded from pursuing ECAs once it received notice that the patient may qualify for financial assistance. We suggest the following language:

“If an individual is the subject of an extraordinary collection action by a hospital or a debt collector on behalf of the debt collector after the application period, the individual may at that point submit a FAP application. The hospital need not provide the individual with assistance, but must suspend any ECAs at that time. Any prior ECAs will not be considered in violation of section 501(r)(6) if they occurred after the notification period.”

Healy, “Dignity Faces a Steamroller: Small-Claims Proceedings Ignore Rights, Tilt to Collectors,” *The Boston Globe*, July 31, 2006 (finding an 80 percent default rate in a study of collection actions in Massachusetts); *McCullough v. Johnson, Rodenburg & Lauinger, L.L.C.*, F.3d , 2011 WL 746892 (9th Cir. Mar. 4th 2011) (citing a Montana collection attorney’s estimate that 90 percent of collection lawsuits resulted in default); *see also* FTC, *Repairing a Broken System*, at 7.

³¹ According to the 2003 National Assessment of Adult Literacy, 1 in 20 adults in the U.S. is non-literate in English and 14 percent of adults have below basic prose literacy skills. M. Kutner, et al., Nat’l Ctr. For Educ. Statistics, “Literacy In Everyday Life: Results From The 2003 National Assessment Of Adult Literacy” 13 (2007), available at <http://nces.ed.gov/Pubs2007/2007480.pdf>.

³² A number of studies in a wide range of contexts have shown that people do not tend to change the default arrangement. *See, e.g.*, B. Madrian and D. Shea, *The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior*, 116 Q J Econ 1149, 1149-50 (2001); J. Beshears et. al., *The Importance of Default Options for Retirement Savings Outcomes: Evidence from the United States* (Mar. 2007). C. Sunstein and R. Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 U. Chi. L. Rev. 1159, 1172-73 (Fall 2003) (Johnson, E.J. et. al., *Framing, Probability, and Insurance Decisions*, *Journal of Risk and Uncertainty*, 7, 35-51 (1993).

³³ A Charlotte Observer series on medical debt describes a typical example in which a hospital claims that it sent a patient five statements and left three messages at her home before filing suit, but the patient stayed with her brother for a long period after she was hospitalized for pancreatitis and does not remember receiving the letters. A. Alexander and D. Raynor, “Hospital Suits Force New Pain on Patients,” *Charlotte Observer*, Apr. 23, 2012, available at <http://www.charlotteobserver.com/2012/04/23/3193509/hospital-suits-force-new-pain.html#storylink=cpy>.

³⁴ *See* “New York Sues Process Server for High-Volume Debt Collectors: Company Allegedly Failed to Serve Legal Notices on Consumers; Law Firm Also Faces Suit,” *Consumer Affairs*, Apr. 14, 2009, available at http://www.consumeraffairs.com/news04/2009/04/ny_process_servers.html; *Matter of Pfau v. Forster & Garbus* (N.Y. Sup. Ct. 2009). *See also* B. Healy, “Dignity Faces a Steamroller,” *Boston Globe*, July 31, 2006, at A1 (reporters tested the small claims courts’ service by first class mail by sending out 100 misaddressed letters and found only 52 were returned).

There is significant precedent in the law for the idea of being able to raise an issue defensively after a deadline has past. Most states follow the doctrine of “recoupment,” which permits a consumer to raise a counterclaim arising out of the same transaction to offset a creditor or debt collector’s claim even after the statute of limitations has run.³⁵ A failure by Treasury to permit consumers to raise FAP eligibility after the 240-day period ends will leave many patients unprotected, even though they may be within the FAP eligibility guidelines of the hospital.

Acknowledgment of Patient Defenses under State or Common Law

Finally, if Treasury and the Service are not willing to permit patients to raise the fact that they are FAP-eligible as a defense to ECAs under its regulations, they should at least ensure that rules do not negatively impact patients’ ability to raise defenses under state or common law. For instance, consumers have alleged that hospitals violate state consumer protection laws by charging them grossly inflated chargemaster rates while charging sharply lower market rates to third-party payers.³⁶ Other consumers have argued, when hospitals sue them, that gross chargemaster rates are not “reasonable charges” under certain legal theories (*e.g.*, *quantum meruit*).³⁷ We are concerned that §1.501(r)-5, particularly the safe harbor of subsection (d), would undermine such arguments because hospitals would assert that the safe harbor permits them to charge full gross chargemaster rates so long as the patient has not been determined to be FAP-eligible. Thus, we urge Treasury to state in §1.501(r)-5 that “Nothing in this section shall affect whether the hospital is permitted to charge gross charges or more than AGB under state law.”

Conclusion

We commend the Service and Treasury for seeking to strike an appropriate balance between the need to increase transparency and make billing and collections more equitable for patients with hospitals’ needs to maintain efficient, fair billing and collections cycles. On the whole, we believe that these proposed rules represent significant gains for vulnerable communities by extending consumer protections, promoting access to care, and increasing transparency between hospitals and the communities they serve. By establishing a federal floor, the rules provide patients and hospitals across the country with a grounded set of expectations—a benchmark of common-sense protections and behaviors the public has come to expect from charitable institutions. We believe the proposed rules codify the existing practices of many leader hospitals that have already made significant

³⁵ For example, the vast majority of court decisions considering the issue have permitted Truth in Lending Act claims to be raised in recoupment. See *National Consumer Law Center*, “Truth in Lending” §12.2.5 (7th ed. 2010).

³⁶ See, *e.g.*, *Hale v. Sharp Healthcare*, 108 Cal. Rptr.3d 669 (Cal. Ct. App. 2010) (patient stated claim for violation of California Unfair Competition Law and California Legal Remedies Act for charging gross rates); *In re Sutter Health Uninsured Pricing Cases*, 2005 WL 1842582 (Cal. Super. Ct. July 16, 2005) (denying dismissal of state consumer protection and unconscionability claims for charging gross rates); *Hill v. Sisters of St. Francis Health Services*, 2006 WL 3783415 (N.D. Ill. Dec. 20, 2006) (denying dismissal of state consumer protection and unconscionability claims for charging gross rates pricing); *Servedio v. Our Lady of the Resurrection Med. Ctr.*, Clearinghouse No. 55, 626 (Ill. Cir. Ct. Cook County Jan. 6, 2005); *Turner v. Legacy Health Sys.*, 2006 WL 657176 (Or. Cir. Ct. Oct. 4, 2005) (granting class certification in case challenging gross rates and hospital pricing under Oregon consumer protection law). See also “Press Release: Court Rules That Advocate Health Care Network May Be Liable for Price Gouging, Hospital Accountability Project,” *SEIU*, Jan. 27, 2006; M.J. Feldstein, “BJC Overpayment Case is Class-Action,” *St. Louis Post-Dispatch*, Mar. 7, 2007 (class action certification granted in case against St. Louis area hospital)

³⁷ For a discussion of these cases, see *National Consumer Law Center*, Collection Actions § 9.5.5 (2d ed. 2011 and Supp.)

commitments to ensuring patient access to care, and we are pleased that the Service has chosen to raise the bar for other hospitals that may be lagging behind in these areas.

As you are undoubtedly aware, one key issue not addressed in these proposed rules is that of noncompliance, or the consequences hospitals will face for failing to satisfy these requirements. In our experience, enforcement and monitoring are crucial to making protections and standards meaningful for patients. At the same time, we recognize and share concerns that an overly inflexible enforcement scheme could lead to bad results for hospitals and patients. We plan to submit additional recommendations about compliance measures pending further discussions with partners and other stakeholders.

We appreciate your consideration of the above comments and cordially request an opportunity to meet to discuss them further with you and your staff. In the meantime, please contact Jessica Curtis at 617.275.2859 or jcurtis@communitycatalyst.org if you have any questions about these comments.

Sincerely,



Robert Restuccia
Executive Director
Community Catalyst



Jessica L. Curtis
Hospital Accountability Project Director
Community Catalyst

cc: The Honorable Timothy Geithner, Secretary, Department of the Treasury
The Honorable Kathleen Sebelius, Secretary, Department of Health and Human Services

On behalf of:

National

Asian American Pacific American Legal
Center, member of the Asian American
Center for Advancing Justice
Families USA
Health Care for America Now (HCAN)
National Consumer Law Center (on behalf of
its low-income clients)
PICO National Network

Alabama

Alabama Arise

California

California Pan-Ethnic Health Network
Health Access California

Colorado

Colorado Center on Law and Policy
Colorado Consumer Health Initiative

Florida

Annie Appleseed Project
Florida CHAIN

Illinois

Illinois Coalition for Immigrant and Refugee
Rights
Doctors Council SEIU
Illinois Maternal and Child Health Coalition

Kansas

Kansas Health Consumer Coalition

Kentucky

Kentucky Equal Justice Center
Kentucky Voices for Health

Louisiana

Louisiana Consumer Healthcare Coalition

Maine

Consumers for Affordable Health Care

Massachusetts

Health Care for All

Health Care for Artists

Massachusetts Law Reform Institute

Michigan

Michigan Consumers for Healthcare

Minnesota

TakeAction Minnesota

New Jersey

Health Professionals and Allied Employees

New Jersey Citizen Action

New Mexico

New Mexico Center on Law and Poverty

Vision for Dignity, Access, & Accountability
in Healthcare (VIDA)

New York

Commission on the Public's Health System

Ohio

Contact Center

People's Empowerment Coalition of Ohio

UHCAN Ohio

Oregon

Oregon Center for Public Policy

Pennsylvania

Pennsylvania Health Law Project

Tennessee

Tennessee Justice Center

Texas

Texas Legal Service Center

Utah

Utah Health Policy Project

Virginia

Virginia Consumer Voices for Healthcare

Virginia Organizing

Virginia Poverty Law Center