GeorgiaWatch

Protecting Consumers, Promoting Transparency, Empowering Citizens

September 21, 2012

VIA ELECTRONIC SUBMISSION

CC:PA:LPD:PR (REG-13026-11)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

RE: 26 CFR Part 1 (REG-13026-11); RIN 1545-BK57; Additional Requirements for Charitable Hospitals; Notice of Proposed Rulemaking issued June 26, 2012

Dear Sir/Madam:

Founded in 2002, Georgia Watch serves as a powerful statewide advocate for Georgians and a trusted resource for the public, the media, legislators, and regulators. Georgia Watch is the state's leading consumer group advocating on behalf of Georgians in the following areas: health care, energy, and personal finance. Through our Health Access Program (HAP) we implement the Georgia Watch mission in the field of health care. Specifically, HAP seeks to ensure and expand access to safe and affordable health care for all Georgians through consumer empowerment, policy development, and advocacy. Since its inception in 2007, HAP has focused primarily on consumers' interactions with hospitals. We have issued numerous reports and policy briefs on hospital billing practices and vulnerable patients. In 2010, we issued the Metropolitan Atlanta Hospital Accountability Project Report, detailing the results of our evaluations of acute-care facilities and surveys of 900 consumers in 21 counties in metropolitan Atlanta. This report provided detailed information on non-profit hospitals' finances, community benefits, and financial assistance plans.

We greatly appreciate the opportunity to submit the following comments on the proposed regulations for hospitals set forth in the Notice of Proposed Rulemaking (NPRM) for IRS Code §501(r), governing the financial assistance policies of non-profit hospitals. Our comments below are informed not only by our concern for Georgia's health care consumers, but also by our extensive experience evaluating non-profit hospitals and advocating for their patients. We commend the IRS for its extensive efforts to receive and consider comments from the public on these important regulations that are to be issued in accordance with the Patient Protection and Affordable Care Act (ACA).

26 CFR § 1.501(r)-1(b)(16): Definition of Hospital Organizations

We commend the IRS for making government hospitals subject to the same regulations issued pursuant to IRS Code §501(r) as all non-profit hospitals that apply for and receive §501(c)(3) status. Carving out any exceptions or creating alternative methods of compliance would be unfair to consumers and cause confusion for hospitals.

From the perspective of the indigent consumer, all hospitals are equal. Therefore, the ability of a consumer to apply for and receive financial assistance should not depend on a non-profit hospital's form of ownership.

Furthermore, because most non-profit hospitals are owned wholly or in-part by government or quasi-government entities, it would not be prudent to carve out exceptions or alternate regulations for hospitals that actually make up the majority of those subject to the rules. As the definition is currently written, however, it is not clear what would qualify a hospital as a "government hospital." Would that mean direct ownership by a governmental entity, such as a city, county, or state? Would it include hospitals owned by regulatory authorities established by governments but run independently? Would it include hospitals owned by a public/private partnership? Would it include private hospitals that use medical students and residents from public universities?

For these reasons, we would encourage the IRS to retain the language already included in §1.501(r)-1(b)(16) of the proposed regulations defining hospital organizations and not make a distinction for government hospitals. Likewise, we would not support any alternative methods that a so-called government hospital could use to satisfy the requirements of IRS code §501(r)(4) through (6).

26 CFR § 1.501(r)-4(a)(2): Eligibility Criteria and Basis for Calculating Amounts Charged to Patients

While we are disappointed that the ACA did not provide for minimum requirements for a hospital's financial assistance plan (FAP), we applaud the agency for requesting comments on whether a hospital's Community Health Needs Assessment (CHNA) should inform its FAP. Ideally, all non-profit hospitals should be held to minimum standards for their FAPs and their CHNAs should be used to address special needs beyond the minimum requirements for FAPs. Because there are no minimum standards, we would support tying the FAP to the CHNA and encourage the IRS to include additional regulations that mandate the reporting of how a hospital is using its FAP to respond to its CHNA. However, we are also concerned that a hospital may thus be able to use its CHNA as a means of avoiding certain forms of assistance. Therefore, we would advocate that a patient's eligibility for a hospital's FAP should be based on simple income qualifications, with additional special qualification categories, based on the CHNA, for patients who may not otherwise qualify based on income.

Furthermore, we would like to see the regulations clarify in §1.501(r)-4(b) that FAPs must be available to underinsured as well as well as uninsured patients. We receive frequent inquiries from consumers who have health insurance but who are nonetheless seriously indebted to hospitals due to large deductibles and co-pays. At most non-profit hospitals in Georgia, patients with any form of health insurance are not eligible for financial assistance. For example, we recently received an inquiry from an insured consumer who underwent multiple procedures for cancer at a hospital over the course of three years. Her calendar year deductible was $3,000, and along with co-pays, she now owes over $15,000. She was not eligible for financial assistance due to her insurance status, even though she only takes home $2,000 per month and spends $500 per month on prescription drugs. Fortunately, she was able to move in with her daughter to save money and has worked out a payment plan with the hospital; otherwise, she would have had to declare bankruptcy. In addition, according to a survey we conducted in 2010, 72% of underinsured consumers admitted to delaying care for fear of not being able to afford their portion of medical expenses. Given the potential for high out-of-pocket costs even for insured patients, the regulations should specifically preclude non-profit hospitals from automatically excluding insured patients from their FAPs. Eligibility should be based on the total amount of debt owed and one's ability to pay, regardless of insurance status.

26 CFR § 1.501(r)-4(a)(5): Widely Publicizing the FAP

Georgia Watch supports the inclusion of the requirement that the FAP not only be published in English but also in any language that is spoken primarily by at least 10 per cent of the community to be served by the hospital (§1.501(r)-4(a)(5)(B)). We would, however, go further and suggest that this section require publication in English and Spanish, as well as any other language spoken primarily by 10 per cent or more of the community. Spanish is the second most widely spoken language in the United States and is spoken by large portions of the population in almost every state. Even in states without a significant Hispanic community, there are enough Spanish speaking persons in the United States who can potentially travel that it would still be prudent for hospitals in these areas to have materials available in Spanish. Additionally, other federal and state laws, and regulations, such as Georgia's Indigent Care Trust Fund, already require hospital materials to be available in both English and Spanish; thus, adding this additional requirement to the regulations for FAPs would not unjustly burden hospitals. The IRS could also allow hospitals who find this requirement unduly burdensome to apply for waivers if they can show that Hispanics make up an insignificant portion of their service community.

We would also recommend that this section go even further and require hospitals to take reasonable steps to provide translation services, at no charge, to any individual who does not speak the languages in which a hospital's FAP is published. Such a requirement would be consistent with Title VI of the Civil Rights Act and Executive Order 11,366 which require such services be provided by all hospitals receiving federal funds, such as Medicaid and Medicare, for key hospital programs. Because such services are already required, the addition of this requirement to §1.501(r)-4(a)(5)(B) should not unduly burden hospitals.

In addition to requiring publication in Spanish and the availability of other interpretive services, we would also encourage the IRS to include a requirement in §1.501(r)-4(a)(5) that FAPs be made accessible to the visually impaired and other handicapped individuals in full accordance with ADA guidelines.

26 CFR § 1.501(r)-5(b): Amounts Generally Billed (AGB)

We agree with prior commenters who recommend requiring that hospital facilities use Medicare rates to determine AGB. This method is included in the proposed regulations as the prospective method detailed in § 1.501(r)-5(b)(2) and would provide the greatest amount of transparency and predictability for consumers, as well as hospitals. However, we are disappointed that the agency has given hospitals the option to use another method to determine AGB, namely that of "looking back" on a prior year's payments by insurance companies and/or Medicare. We believe this "look back" method detailed in §5(b)(1) of the proposed regulations would give hospitals too much leeway in determining AGB, permit hospitals to determine AGB in secret, and deprive consumers of any cost-predictability for hospital services.

As the NPRM points out, if hospitals were unhappy with the AGB percentage determined by the "look back" method, they could increase their gross charges, apply the AGB percentage as determined by prior insurance and/or Medicare payments to those increased gross charges, and thereby increase the amount billed to an indigent patient (Fed. Reg. vol. 77, no. 123, p. 38154, 3d column). However, if they were simply required to use Medicare payments to determine AGB, such a scenario would not be possible, because the amounts would already be set by Medicare codes. Furthermore, Medicare amounts are public information, whereas hospitals' contracts with insurance companies are proprietary; thus, the computation of AGB using

the "look back" method could be undertaken in virtual secrecy by a hospital with no public accountability. Finally, because Medicare payments are known, consumers could know ahead of time how much they would be charged for a procedure. Such would not be the case, however, when a hospital uses the "look back" method and averages insurance payment rates that are not public information. Moreover, such a method of computing AGB would vary by hospital, creating even less predictability for consumers.

Given our concerns with the "look back" method, we would recommend certain safeguards be required by hospitals that choose this method in order to protect indigent consumers. Hospitals should not be permitted to exclude Medicare payments from the determination of AGB. For most hospitals, Medicare accounts for such a substantial amount of revenue that it would be unrealistic not to factor in Medicare payments to the amounts that a hospital generally bills for services. Furthermore, because Medicare rates are usually lower than private insurance, excluding them from AGB calculation would only increase costs for consumers above what the average insured patient would have had to pay. Such a result would be inconsistent with the statutory phrase "amounts generally billed to individuals who have insurance" (IRS Code §501(r)(5)(a)).

We would also oppose allowing hospitals to compute AGB based on the "look back" method by using a representative sample of claims paid in full over the prior 12 months. Such an option would give hospitals even greater leeway to manipulate their computations than they already have under the proposed regulations. We have already expressed concern that the "look back" method currently described in §1.501(r)-5(b)(1) of the proposed regulations does not provide enough transparency or protections for consumers; allowing sampling to be used to determine AGB would only exacerbate this problem.

Finally, we are also concerned that the regulations could permit a hospital to raise its gross charges in order to compensate for having to apply the AGB percentage to a qualifying patient's bill. We would support additional safeguards in the regulations to prevent this occurrence. One such safeguard is mentioned in the NPRM (Fed. Reg. vol. 77, no. 123, p. 38155, 1st column) and would require applying the AGB percentage to current charges minus any increase in those charges since the AGB percentage was determined. Another possible safeguard would be to require hospitals that use the "look back" method to determine the AGB percentage on an annual basis and apply that percentage to subsequent charges for the next year so long as those charges represent no more than an increase consistent with the current rate of inflation. We appreciate the IRS identifying increases in gross charges as a potential problem for consumers and for being willing to institute safeguards to protect their interests.

26 CFR § 1.501(r)-5(d): Safe Harbor for Certain Charges in Excess of AGB

We applaud the IRS for providing protections for patients who for one reason or another may not have completed a timely application for financial assistance. However, we are disturbed that the sales of debt would not be included in the extraordinary collection actions (ECAs) that a hospital must reverse once it has determined that an individual is FAP eligible (Fed. Reg. vol. 77, no. 123, p. 38155, 2d column). We fear that excluding the sale of debt from the reversal requirements would encourage hospitals to quickly sell their debts to avoid compliance with the reversal requirements. We would, therefore, encourage the IRS to include the sale of debt as one of the ECAs that must be reversed once FAP eligibility has been established. Otherwise the protections afforded consumers are insufficient.

26 CFR § 1.501(r)-6(b): Extraordinary Collection Actions

We commend the IRS for making it clear in this section that the sale of debt to a collection agency is, in fact, an ECA. Whether simply referring debt to an outside agency (without an actual sale) is an ECA should be based on several factors. If a hospital, during the normal course of business, regularly uses the services of an outside agency for billing and collection purposes, and the hospital's agreement with that agency is such that the hospital can exercise control over the agency's practices at any time, then such referral of a delinquent patient's bill to it should not be considered an ECA, because under those circumstances, the hospital's actions would not be extraordinary. However, in the case of a hospital which normally does its own billing and collections, referring debt to a third party should be considered an ECA, because it would be outside of the hospital's normal pattern of debt collection. Furthermore, any contract with a third party collector that involves the hospital abdicating ultimate control should also be considered an ECA.

We are also pleased that the agency included debt reporting to credit agencies as an ECA; however, we are disappointed that several other common practices have not been included as ECAs in the regulations. Denying care based on prior non-payment, requiring a deposit prior to initiating care, and charging interest should all be considered ECAs and be prohibited during the entire 240 day application period. Each of these practices is already prohibited against patients at or below 200% of the federal poverty level in Georgia for hospitals that participate in the state's Indigent Care Trust Fund. Similar laws also exist in other states. In addition, the federal Emergency Medical Treatment and Active Labor Act, which requires hospitals to provide treatment to those in need of emergency care, contains similar prohibitions, most notably against denying care based on inability to pay, discussing payment while a patient is still in an emergency situation, and making decisions about treatment based on ability to pay. In keeping with the letter and spirit of these and other laws governing hospital emergency care, the regulations should specifically classify denying care based on prior nonpayment and requiring a deposit prior to initiating care as ECAs. Furthermore, the collection of interest is simply not fair during the time period (240 days) when a patient is permitted to apply for financial assistance and so should also be considered an ECA.

26 CFR § 1.501(r)-6(c): Reasonable Efforts

While we applaud the IRS for requiring the reversal of ECAs taken prior to a patient qualifying for financial assistance, we believe it would be more effective and less burdensome for all involved to simply prohibit all ECAs during the entire 240 day application period. The current language in the regulations leaves open the possibility that consumers could apply and qualify for assistance within the 240 day application period provided in §1.501(r)-6(c) but submit their applications after their bill had been sold to a collector (which is permissible after the 120 day notification period per §1.501(r)-6(c)(7)(iii)(B)). From our experience with consumer complaints, we know that once a bill gets sold to a collection agency, it is virtually impossible to help the consumer, because of the strong-arm tactics and limited focus of collectors, as well as the general irreversibility of debt sales. In fact, we advise consumers to do all they can to avoid any debt being sold to a collector.

Therefore, we argue that it is both unfair and illogical to allow ECAs, such as debt selling, after the 120 day notification period but during the remaining 120 days in the application period when a patient may still apply for assistance. If the regulations allow a patient 240 days to apply for assistance then there should be no negative consequences for a patient who takes full advantage of the time period allowed by the

regulations. Prohibiting ECAs during this time would also avoid the burden of a hospital having to reverse ECAs it had already taken. ECAs could still be allowed after the entire 240 day application period has expired so long as they are not prohibited by existing state or federal laws. At the very least, sales of debt should be prohibited during the 240 day application period, because they are generally not reversible.

Regarding a patient who received his first bill before discharge, the notification and application periods should be run from the date of discharge. We would support clarification in the regulations that these periods always start on the date of the first bill or the date of discharge, whichever comes last. In addition, the agency should seriously consider further requiring a grace period for the patient who is discharged after their first bill arrives and thus measure the notification and application periods from 10 days post discharge in those circumstances. Patients who have recently been discharged are still in a vulnerable state and may not be able to fully comprehend or appreciate their bill or the assistance that is available.

26 CFR § 1.501(r)-6(c)(2): Notifications about the FAP

We agree that once a hospital receives an FAP application from an individual, the hospital should no longer be required to notify that individual about the FAP. However, we reiterate our position that all ECAs should be prohibited during the entire 240 day application period, whether an individual has responded to FAP notifications or not.

26 CFR § 1.501(r)-6(c)(3): Incomplete FAP Applications

We applaud the IRS for giving individuals who submit an incomplete FAP application an additional 30 days to submit a complete application. One way that the regulations could encourage timely submission of complete applications is to require that hospitals include, as part of their FAP notification, details of the consequences of submitting an incomplete application. In that way, patients would be encouraged to submit a complete application, knowing full well what the consequences would be of not doing so. It may even be best for this information to be given to patients or their representatives orally with their hospital discharge instructions. It is our experience that patients often become inundated with so many bills and written statements that the most important information can be lost in the fine print. The consequences of submission of an incomplete application should be made clear up front.

26 CFR § 1.501(r)-6(c)(4): Complete FAP Applications

While we understand a hospital's need to reasonably manage its finances, we do not understand why a hospital would need any more flexibility than that already allowed under the regulations for collecting a patient's debt. Even during the 240 day application period when ECAs should be prohibited, we would support a hospital's right to use other methods to collect its debt, such as sending a patient a bill or calling a patient by telephone to make reasonable inquiries. After the 240 day period, a hospital would be free to use any legal means to collect the debt, including ECAs. We do not perceive a need for any further flexibility during this 240 day period as 240 days is shorter than the period it takes most hospitals to be fully compensated for care anyway, whether from insurance or individual payments.

If information apart from the FAP application is used to determine eligibility, it should only be allowed when in the patient's favor. Most of the time, it will be in consumers' best interests to have eligibility for financial

assistance determined by the information contained in the current application. The only exception would be when a hospital automatically qualifies a certain class of patients as eligible. Such a classification could be made for those receiving some form of government assistance, such as food stamps or TANF, for example. However, we would not support any automatic disqualifications for assistance based on information not included in the application. Furthermore, hospitals should not be allowed to use a prior application to disqualify a patient. Patients' life situations change frequently, especially those who live in poverty, and eligibility should be determined by the patient's financial situation at the time assistance is requested, unless a recently submitted prior application would already qualify the patient for assistance.

26 CFR § 1.501(r)-6(c)(6): Waivers

We commend the IRS for prohibiting the use of waivers to determine notification and eligibility of a hospital's FAP. Patients have so many papers to sign when they are admitted to a hospital that it is not fair to expect them to fully understand the financial implications of a waiver. We appreciate the agency's efforts to look out for consumers by including in the regulations this important consumer protection.

26 CFR § 1.501(r)-6(c)(7): Agreements With Other Parties

As we have stated previously, we encourage the IRS to prohibit all ECAs, including debt-selling, during the entire 240 day application period. As we have also previously stated, during the application period, referral of a debt (without sale) to a third party should only be allowed if the hospital normally engages a third party to handle its billing and collection processes. In addition, third party debt collectors should be obligated to abide by all the regulations a hospital would have had to follow if it were doing its own debt collections.

Conclusion

In summary, we believe the IRS has proposed strong regulations that will clarify the provisions of the Patient Protection and Affordable Care Act pertaining to non-profit hospitals, while also protecting patients. However, we believe some further consumer protections are necessary and respectfully request that you consider our comments on the effects of these regulations on consumers. We also respectfully ask to be notified of any public hearings. If you have further questions, please feel free to contact me by email at brencher@georgiawatch.org or by phone at 404-525-1085. Thank you again for considering our comments.

Sincerely,

Bill Rencher, JD, MPH
Director, Health Access Program

We are joined in support of these comments by the following Georgia health advocates:

Cindy Zeldin	Stephanie Davis	Jeff Cornett, RN, MSN
Executive Director	Executive Director	Director of Training, Research, & Advocacy
Georgians for a Health Future	Georgia Women for a Change	Hemophilia of Georgia