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Testimony
from the National Health Law Program

Internal Revenue Service
Public Hearing on Proposed Regulations
26 C.F.R. Part 1
"Additional Requirements for Charitable Hospitals"
[REG-130266-11]
1545-BK57

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Good morning and I would like to thank you for the opportunity to testify today. My name is Mara Youdelman and I am the Managing Attorney for the Washington DC office of the National Health Law Program. The National Health Law Program or NHeLP is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. NHeLP provides technical support to direct legal services programs, community-based organizations, the private bar, providers and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people.

It is critical that low-income and underserved individuals have access to emergency and medically necessary care at charitable hospitals, particularly if some states do not expand Medicaid eligibility as required by the Affordable Care Act (ACA). The requirements contained in ACA § 9007 are a much-needed step to increase transparency and ensure that no person is deterred from accessing needed hospital care because of cost.

Language Services: The primary focus of my testimony today will be language access. Almost 20% of the population speaks a language other than English at home. Over 24 million, or 8.7% of the population, speak English less than very well and should be considered limited English proficient (LEP) for healthcare purposes. This includes 47% of Spanish speakers, 33% of speakers of other Indo-European languages, 49% of speakers of Asian and Pacific Islander languages, and 30% of speakers of other languages.

To meet the requirement of the Internal Revenue Code that Financial Assistance Plans (FAPs) be "widely publicized" within the community served by the organization, charitable hospitals must ensure that limited English proficient (LEP) individuals know of and understand the benefits of the hospital's FAP and related documents. We urge the IRS to require that hospitals do this for populations that use, or are eligible to use, the charitable hospital's services. Given existing requirements for providing language services under Title VI, as well as the nondiscrimination provision of the Affordable Care Act, we believe IRS' regulations should adopt the same thresholds these hospitals should already utilize for translating "vital documents". We believe the FAP certainly is a vital document for individuals who are uninsured and need assistance paying their medical bills.

The proposed rule only includes a percentage threshold for requiring charitable hospitals to translate FAP materials. It merely requires translation of notices when 10% of the community served by the hospital population is LEP. First, we believe a 10% threshold is too high, especially when many hospitals are already subject to guidance from HHS' Office for Civil Rights that expects translation of vital documents when a language group is 5% or 1,000 individuals.

A 10% threshold used in conjunction with a county-level service area would lead to an exemption from translating FAP materials for every non-profit hospital in 27 States. Only 177 counties in the mainland United States would contain hospitals required to translate materials. As one example, not a single hospital in the city of Chicago – a diverse metropolis and the third largest city in the United States – would be required to translate FAP materials using a ten percent threshold. Yet there are 461,000 Spanish speakers in Chicago alone. We thus request that IRS adopt a dual threshold – consistent with longstanding HHS guidance that governs hospitals – with both a numeric and percentage alternative. IRS should require translation of the charitable hospital's financial assistance plan documents when either the numeric or percentage threshold is met. We recommend that IRS require hospitals to translate FAP materials for each LEP language group that constitutes five percent *or* 500 of the individuals eligible to be served. Using a 5% or 500 LEP individual threshold and a county-level service area would require, respectively, 565 counties in 37 states and 1,284 counties in all 50 states plus the District of Columbia.

We used county-level data as an example since the regulations do not define "community served," a critical term. We recommend that IRS define the term in a way that leads to an accurate representation of both of individuals who use the hospital facility as well as individuals that are *eligible* to use the hospital facility but may not currently. We further request that IRS define "community served" in a manner that does not exempt hospitals from translating FAP documents for many LEP individuals because IRS uses too narrow or too broad a geographic area for LEP populations to ever meet the thresholds for translation. Instead, we suggest that the definition take into account the variability between hospital facilities. For example, using a "county" as a threshold for charity hospitals may be both under- and over-inclusive, depending on the hospital. And as noted earlier, the use of a county-level standard by HHS for defining translation of appeals notices and the Summary of Benefits and Coverage results in very few requirements for translation, although this is also directly affected by having a high percentage threshold and no alternate numeric threshold.

Further, the proposed rule does not address the provision of oral language assistance, which is an essential method for ensuring effective communication with LEP individuals, especially if translated materials are unavailable or LEP individuals have questions about translated materials. We request that the provision of oral language assistance be addressed in rulemaking in a way that is consistent with previous HHS guidance.

Limitations on Charges: I would also like to spend a bit of time addressing how the proposed rule address limitations on charges. NHeLP strongly recommends against adopting the proposed rule's interpretation of 501(r)-5(a), which limits the prohibition on the use of gross charges to those patients eligible under the hospital's FAP. This interpretation is not in accordance with either the goals or plain language of ACA § 9007. The relevant section of § 9007 is broken down into two paragraphs. Paragraph (A) limits amounts charged for emergency or medically necessary care *provided to individuals eligible for assistance under the financial assistance policy* to not more than the lowest amounts charged to individuals with insurance covering such case. Paragraph (B) simply prohibits the use of gross charges. As a matter of statutory construction, the language in paragraph (A), limiting its reach only to individuals eligible under the hospital's FAP, applies only to that paragraph. Paragraph (B), which does not contain that limitation, applies to all hospital patients. There is absolutely no reason to limit the use of gross charges only to those patients that qualify for the hospital's FAP, particularly since there is no federal rule dictating what those FAPs must cover. Failing to prohibit the use of gross charges for all patients would mean that those individuals who are "too rich" to qualify for a particular hospital's FAP but "too poor" to be able to pay the cost of care will be charged an inflated gross charge, rather than a cost they may be able to afford. This absurd result is contrary to the intent of § 9007.

Additional Issues: In addition, we also make the following recommendations which are addressed in more detail in our formal comments on the proposed regulation:

- ***Scope***: The proposed requirements 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 who provide care in a hospital.
- ***Amounts Generally Billed***: The methods used to calculate the Amounts Generally Billed (AGB) must provide consumers and the general public with maximum transparency and fairness in the cost of care and should be based on Medicare fee-for-service payment rates alone, and not include private payer rates.
- ***Extraordinary Collection Actions***: We commend IRS for extending the prohibition on extraordinary collection actions (ECA) to include ECAs against any individual who has accepted or is requires to accept responsibility for a covered individual's hospital bills. We further support the proposed rule's requirement that a hospital facility will be deemed to have engaged in an ECA if any purchaser of the individual's debt or any debt collection agency or other party to which the hospital facility has referred the individual's debt has engaged in an ECA against the individual. However, we strongly suggest that causing an individual's arrest be prohibited in any and all circumstances related to the collection of a medical debt for purposes of this rule, including where that arrest is for contempt of court or similar action.
- ***Government Hospitals*:** We do not support any exceptions or special rules for government hospitals. No such exceptions are permitted by the language of § 9007, and IRS has no discretionary authority to create them.

Finally, we also would like to note our support for the testimony of Families USA and Community Catalyst. In conclusion, we thank you for the opportunity to provide testimony today and look forward to working with the IRS to finalize and implement the regulations pursuant to § 9007.

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