

**Before the  
FEDERAL COMMUNICATIONS COMMISSION  
Washington, D.C.**

In the Matter of	)	
	)	
Rural Heal Care	)	WC 02-60
Support Mechanism	)	
	)	

**REPLY COMMENTS OF VERIZON**

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**REPLY COMMENTS OF VERIZON**

**Introduction**

The Commission must reject suggestions to expand the rural health care program that are inconsistent with the Act, such as proposals to expand the list of eligible health care providers, fund programs that would make rural health care providers better than (rather than “reasonably comparable to”) their urban counterparts, or fund insular areas based on comparisons to rates outside the state. The Commission also should reject proposals for broad and expensive programs – such as subsidies for Internet access, or elimination of the maximum allowable distance restriction on distance-based subsidies – that would make the size of the universal service fund balloon. As Verizon pointed out in its opening comments, the \$400 million rural health care cap was set at a level much higher than warranted, and should be reduced to a more reasonable amount.<sup>1</sup> Before dramatically broadening the scope of the rural health care program, the Commission must first determine whether any new or additional subsidies are “necessary for the provision

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<sup>1</sup> See Verizon Comments, at 2-4. Indeed, the Commission recently acknowledged that in setting the cap, it vastly overestimated the demand for the rural health care program. See *Federal-State Joint Board on Universal Service*, Fifteenth Order on Reconsideration, 14 FCC Rcd 18756, ¶ 18 (1999) (“Fifteenth Universal Service Order”) (“Based upon the information in the record, we find that the Commission’s initial demand estimate was much too high”).

of health care services in a State,” 47 U.S.C. § 254(h)(1)(A). It also must balance health care providers’ requests with needs of telecommunications consumers, who will ultimately pay for the increasing costs associated with broader universal service demands.

**I. The Commission Does Not Have Unfettered Discretion or Funds for the Rural Health Care Program**

**A. The Commission Cannot Expand the Program in Ways that Are Contrary to the Language of the Act**

Many commenters’ suggestions for reform of the rural health care program appear to ignore the fact that, as the Commission has correctly noted, “we are bound by the language of the statute.”<sup>2</sup> No matter how well-intentioned these proposals may be, the simple fact remains that the Commission cannot change policy decisions that have been made by Congress. It is bound to administer the Act as written.

In considering what the statute allows, the Commission cannot forget that the Act states that rates for rural health care providers should be “comparable to” – not better than – those available to their urban counterparts. 47 U.S.C. § 254(h)(1)(A). Following that language, the Commission has repeatedly rejected suggestions that would give rural health care providers advantages urban health care providers did not have.<sup>3</sup> Thus,

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<sup>2</sup> See *Federal-State Joint Board on Universal Service*, Report and Order, 12 FCC Rcd 8776, ¶ 644 (1997) (“First Universal Service Order”) (subsequent history omitted).

<sup>3</sup> See, e.g., First Universal Service Order, ¶ 680 (rejecting unlimited distance-based subsidies because “urban health care providers are not exempted from distance charges in connection with the purchase of telecommunications services” and “blanket subsidization of distance-based charges for rural health care providers could result in inequalities between rural and urban health care providers”); Fifteenth Universal Service Order, ¶ 37 (rejecting proposal for statewide average discount percentages for rural base rates and distance sensitive charges, because it “would entitle some rural customers to rates below those paid by some urban customers, creating fairness problems

proposals that would give special privileges to rural health care providers that are not already enjoyed by urban providers (such as providing discounts for monthly Internet access service charges), or that would expand the program far beyond that which Congress intended (such as using it “as a national vehicle to promote national defense”) should be rejected.<sup>4</sup>

Likewise, regardless of the Commission’s view on the wisdom of expanding the list of eligible providers beyond what is currently enumerated in the Act – such as to allow nursing homes, hospices, home health agencies, emergency care facilities, or for-profit entities and others to participate<sup>5</sup> – as the Commission has previously found, the language of the Act simply does not permit such expansion.<sup>6</sup> The Act also does not allow an entity that has partially eligible and partially ineligible services to participate.<sup>7</sup>

Moreover, because the Act only allows rural health care providers to receive “rates that are reasonably comparable to rates charged for similar services in urban areas *in that State*,” 47 U.S.C. § 254(h)(1)(A) (emphasis added), the Commission cannot

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for those urban customers and arguably going farther with this mechanism than Congress intended” (footnote and citation omitted)).

<sup>4</sup> See, e.g., Comments of Arizona Telemedicine Program, at 1, 3.

<sup>5</sup> See, e.g., Comments of American Hospital Association, at 4 (requesting the Commission to fund some of these entities, but acknowledging that, “[t]his recommendation may require a statutory legislative change”).

<sup>6</sup> See Fifteenth Universal Service Order, ¶ 48 (“We find that, given the specific categories of health care providers listed in section 254(h)(5)(B), if Congress had intended to include nursing homes, hospices, or other long-term facilities, and emergency medical service facilities, it would have done so explicitly. Thus, we find that the definition of ‘health care provider’ does not include nursing homes, hospices, or other long-term care facilities, and emergency medical services facilities”).

<sup>7</sup> See Verizon Comments, at 11-13; see generally Fifteenth Universal Service Order, ¶ 49 (stating that ineligible nursing homes should not be allowed to receive benefits from the rural health care program just because they are affiliated with eligible entities).

designate surrogate out-of-state urban locales for comparison for remote, insular areas that are “relatively rural all over.” NPRM, ¶¶ 49-50. One commenter argues that the Commission could use the language of the Act regarding “advanced telecommunications services and information services” to “support telemedicine links between a rural area in one state and an urban area in another.”<sup>8</sup> However, the Commission cannot use general language from the advanced services portion of the Act to rewrite the specific application of the rural-urban subsidy set forth in § 254(h)(1)(A).<sup>9</sup> Congress specified that the method for calculating rural health care subsidies is to compare the rural rates to urban rates “in that State.” *Id.* The Act defines the term “State” as including “the District of Columbia and the Territories and possessions,” 47 U.S.C. § 153(40), and thus requires that insular territory rates be made comparable within the territory. When Congress intended to grant subsidies to insular areas, it had no trouble stating its intentions. *See* 47 U.S.C. § 254(b)(3) (referencing consumers “in all regions of the Nation, including low-income consumers and those in rural, *insular*, and high cost areas” (emphasis added)). Given that Congress defined “State” to include “the Territories,” specifically stated that the rural-urban comparison for telecommunications services should be only to other areas “in the State,” and demonstrated that it knew how to specify treatment for “insular areas” when it so intended, the Commission should not attempt to circumvent this direction.<sup>10</sup>

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<sup>8</sup> *See* Comments of the American Samoa Telecommunications Authority, at 9 & n. 19 (quoting 47 U.S.C. § 254(h)(2)(A)).

<sup>9</sup> *See Morales v. TransWorld Airlines, Inc.*, 504 U.S. 374, 384 (1992) (“It is a commonplace of statutory construction that the specific governs the general . . .”).

<sup>10</sup> *See generally Texas Office of Public Utility Counsel v. FCC*, 183 F.3d 393, 443 n. 96 (5<sup>th</sup> Cir. 1999) ((quoting 73 Am. Jur.2d, Statutes, § 211 (1995)) (“The expression of one thing implies the exclusion of another. Hence, a statute that mandates a thing to be done in a given manner . . . normally implies that it shall not be done in any other manner . . .”).

Contrary to American Samoa’s arguments, the *Texas OPUC* case does not support the comparison of insular areas to urban rates outside the state. *See* American Samoa Comments, at 10-11. The portion of the case it cites states only that the “advanced services” portion of the Act can be used to supply universal service support for “non-telecommunications entities that provide internet access and internal connections to schools and libraries.” *Texas OPUC*, 183 F.3d at 443-44. It says nothing about using the advanced services section to overwrite the specific terms of § 254(h)(2)(A).

**B. The Commission Should Not Adopt Broad New Proposals Without First Determining the Cost and Whether the Proposals Are Necessary to Make Rural and Urban Rates Comparable**

Many commenters have offered proposals for broad expansion of the rural health care program, even using universal service funds for such purposes as creating a “comprehensive and integrated National Public Health Infrastructure,” or using the program “as a national vehicle to promote national defense, through providing incentives to promote safety of life and property through the use of wire and radio communications.”<sup>11</sup> However, as stated in section I.A. above, many of these suggestions ignore the fact that the purpose of the rural health care program is actually very narrow – to provide rural health care providers rates that are “reasonably comparable to” urban rates. They also largely ignore the issue of what these plans will cost. As Commissioner Powell has recently recognized, “the cost of these programs is ultimately borne by American consumers. Accordingly, . . . we must balance the needs of funding these programs against the real burden that our contribution requirements could impose on

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<sup>11</sup> *See, e.g.*, Comments of Kingston eHealth, at 2-4; Comments of Arizona Telemedicine Program, at 3.

consumers if we do not manage those requirements carefully.”<sup>12</sup> In other words, while the Commission should keep in mind the needs of rural health providers to access “necessary” telecommunications services at reasonable rates, it also must balance that goal with one of the basic principles of universal service: “Quality services should be available at just, reasonable, and affordable rates.” 47 U.S.C. § 254(b)(1).

The latest estimates by the Universal Service Administrative Company (“USAC”) project that “program demand and administrative expenses for the third quarter of 2002 will be approximately \$1.505370 billion.” *See Wireline Competition Bureau Announces No Change In Third Quarter 2002 Universal Service Contribution Factor*, Public Notice, CC Docket No. 96-45, DA 02-1409, at 2 (rel. June 13, 2002). That translates to more than \$6 billion a year – approximately \$500 million per year higher than the estimates given just the quarter before. *See Proposed Second Quarter 2002 Universal Service Contribution Factor*, Public Notice, 17 FCC Rcd 4451 (2002) (estimated total program costs were \$5.541 billion on an annual basis). And that burden is only likely to grow, as the Commission is facing requests to increase the services included, and the funding size, of the universal service program.<sup>13</sup> Especially at a time when there is “increasing upward

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<sup>12</sup> *Schools and Libraries Universal Service Support Mechanism*, First Report and Order, Separate Statement of Chairman Michael K. Powell Approving in Part and Concurring in Part, CC Docket No. 02-6, FCC 02-175 (rel. June 13, 2002).

<sup>13</sup> *See, e.g., MAG Plan for Regulation of Interstate Services of Non-Price Cap ILECs and IXCs*, 16 FCC Rcd 19613, ¶ 9 (2001); *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, NPRM and Order, FCC 02-41, ¶¶ 16-17 (rel. Feb. 15, 2002); *Maine PUC and Vermont PSC Petition for Reconsideration*, CC Docket No. 96-45 (filed Feb. 22, 2002); *Rural Health Care Support Mechanism*, 17 FCC Rcd 7806 (2002).

pressure” on universal service contributions,<sup>14</sup> the Commission should not be exploring ways to creatively and dramatically expand universal service costs.

## **II. It Is Not “Economically Reasonable” To Create Broad Subsidies for Internet Access, and the Commission Must Not Create Rules that Would Skew Market and Investment Decisions**

Several commenters argued that the rural health care program should provide support for Internet access charges. A couple of these commenters appear to argue that the subsidy should be made available to *all* health care providers – not just those in rural areas.<sup>15</sup> However, the Act states that “access to advanced telecommunications and information services” should be made available only if “technically feasible and *economically reasonable*.” 47 U.S.C. § 254(h)(2)(A) (emphasis added). These commenters do not estimate the price tag if Internet access subsidies were made available to all health care providers, and one would expect it to be exorbitant. In fact, the Joint Board recently rejected the idea of recommending an expansion of the definition of “universal service” to include universal access to advanced or high-speed services precisely because it “would be contrary to the public interest due to the high cost of requiring deployment of such services.”<sup>16</sup> Again, the Commission should not be exploring methods to dramatically increase subsidies in ways that no one has demonstrated are necessary, and which would come at the expense of telecommunications carriers and their customers.

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<sup>14</sup> See *Schools and Libraries Universal Service Support Mechanism*, First Report and Order, CC Docket No. 02-6, FCC 02-175, ¶ 2 (rel. June 13, 2002).

<sup>15</sup> See, e.g., Comments of Alliance Information Management, Inc., at 2.

<sup>16</sup> *Federal-State Joint Board on Universal Service*, Recommended Decision, CC Docket No. 96-45, FCC 02J-1, ¶ 15 (rel. July 10, 2002) (“Joint Board Recommended Decision”).

If the Commission were to instead provide Internet access subsidies only to rural health care providers, that would be more affordable than universal health care provider access. However, it still would likely be very expensive. As the Joint Board noted, a recent National Exchange Carrier Association (NECA) Rural Broadband Cost Study “estimated that it would cost \$10.9 billion to upgrade the rural study area lines in NECA’s common line pool to DSL capability to meet an assured demand of only 20 percent of the population.” Joint Board Recommended Decision, ¶ 15 (footnote omitted). And this estimate “did not include other expenditures necessary to provide high-speed services, such as digital subscriber line equipment, transport, or maintenance.” *Id.* (footnote omitted). During the last funding year, the schools and libraries portion of the fund committed spending approximately \$229 million per year just for support for Internet access. *See* USAC Schools & Libraries, Funding Commitments, *available at* <http://www.sl.universalservice.org/funding/y4/national.asp>. While those estimates do not detail the cost that would be incurred to provide Internet access support for rural health care providers, they underscore the fact that universal broadband access can be expensive, and its costs should be understood before broad new policy initiatives are unveiled.

In addition, funding Internet access for rural health care providers would present significant problems. The Commission asks whether, if rural health care providers receive support for Internet access charges, it should be in the form of “a percentage discount on Internet access charges, analogous to the operation of the schools and libraries support mechanism” or, alternatively, “should include a rural-urban comparison of the sort required under section 254(h)(1)(A).” NPRM, ¶ 23. A discounted program,

such as that used for schools and libraries, is not consistent with the Act, because in many cases rural health care providers already have broadband rates that are reasonably comparable to urban rates.<sup>17</sup> Thus, a discount rule for rural health care providers would treat them better than urban providers, which is not what the Act intended. *See generally* section I, *supra*.<sup>18</sup> Indeed, the specification that rural health care providers receive “comparable” rates is in direct contrast to the language used to support discounts to schools and libraries, as the Act specifies that those entities should receive rates that are “less than the amounts charged for similar services to other parties.” 47 U.S.C. § 254(h)(1)(B) (emphasis added). The Commission recognized as much when it previously rejected discounts to rural health care providers for other services, on the grounds that the discounts “would entitle some rural customers to rates below those paid by some urban customers, creating fairness problems for those urban customers and arguably going farther with this mechanism than Congress intended.”<sup>19</sup>

The Commission could instead provide support for rural health care providers’ Internet access only in an amount necessary to make the rural rate “reasonably comparable” to the urban rate. However, there is no current evidence that such a subsidy is generally “necessary for the provision of health care services in a State.” *See* 47

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<sup>17</sup> *See generally* Fifteenth Universal Service Order, ¶ 32 (“In light of the entire record now before us, we determine that most of the base rates for telecommunications service elements charged to rural health care providers are already reasonably comparable to those charged in urban areas”).

<sup>18</sup> Sections 254(h)(1)(A) and 254(h)(2)(A) should be read together, and should be read with other provisions of the Act (such as § 254(b)) which state that rural and urban rates should be “reasonably comparable.” *See generally* *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 132-33 (2000) (“A court must . . . interpret the statute as a symmetrical and coherent regulatory scheme, and fit, if possible, all parts into a harmonious whole.” (citation and internal quotation marks omitted)).

<sup>19</sup> Fifteenth Universal Service Order, ¶ 37 (footnote and citation omitted).

U.S.C. § 254(h)(1)(A). In addition, rules regarding a rural-urban broadband comparison, if not properly crafted, could easily violate competitive neutrality, stifle competition, or skew market decisions by rural health care providers and investment decisions by telecommunications carriers in ways that are wasteful of universal service funds. *See generally* Joint Board Recommended Decision, ¶¶ 16-17 (refusing to recommend a change in the definition of “universal service” because of similar concerns). For example, in areas where there is no cable modem or DSL available, the only way to get that service to a rural health care provider may be through expansion or upgrading of a carrier’s network. This could mean expensive network build-outs, causing the provider to add miles of fiber or cable and specialized equipment just to serve one health care provider. However, if the Commission were to subsidize such expansive land-based broadband solutions at the same rates as generic urban prices, this easily could become a very expensive proposition.<sup>20</sup> Moreover, if the rural health care provider already had access to alternative broadband technologies – such as satellite service – such a subsidy would be unnecessary and would waste universal service dollars.<sup>21</sup> Such an approach also would not be competitively neutral, because it would create disincentives for carriers to invest in creating cheaper methods of delivery of services to rural areas, and,

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<sup>20</sup> *See generally* Joint Board Recommended Decision, ¶ 15 (noting that Qwest estimated that it would cost \$2 billion for it to offer DSL throughout its service areas in four states).

<sup>21</sup> If improperly framed, the Commission’s rules might create incentives for a customer to make such a wasteful investment. For example, if a newly built cable modem network was funded so as to make it the same price as standard urban cable modem rates, it normally would be cheaper to the customer than satellite service, because satellite service tends to be the same price in urban and rural areas, so there is normally no subsidy for the satellite service.

conversely, could encourage inefficient infrastructure investment for services that (absent a universal service subsidy) would not be economically viable.

The Commission should not provide subsidies for Internet access, because there is no evidence that such subsidies are “necessary” and the problems and costs associated with such a program have not been adequately explored. *See generally* Joint Board Recommended Decision, ¶¶ 15-17. If, however, the Commission does provide rural health care funds for broadband support, it should do so only for rural providers, and only in an amount necessary to make rural rates “reasonably comparable” to urban rates, and in a way that does not skew market incentives. Moreover, if such a program is implemented, the Commission should require *all* broadband providers contribute to the rural health care portion of the universal service fund.<sup>22</sup>

### **III. The Commission Should Not Adopt a General Functional Equivalence Test**

Regardless of the approach the Commission takes to broadband services, as stated in Verizon’s opening comments, the Commission should not adopt a categorical functional equivalent approach for all telecommunications services, because it would be largely unnecessary, difficult to administer, and invite abuse and fraud. *See* Verizon Comments, at 8-11. None of the commenters who proposed such a system offered any concrete suggestions of how it could be administered in a way that would not impose massive administrative costs, and would limit the potential for waste and abuse. If there

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<sup>22</sup> Verizon has also proposed that the Commission have broadband providers contribute to the schools and libraries portion of the fund. *See* Verizon Comments, Contribution NPRM, at 23-25 (filed Apr. 22, 2002). Currently, only DSL providers must contribute to the universal service fund based on broadband revenues. *See Appropriate Framework for Broadband Access to the Internet over Wireline Facilities, Universal Service Obligations of Broadband Providers*, CC Docket No. 02-33, Notice of Proposed Rulemaking, FCC 02-42, ¶¶ 65-79 (rel. Feb. 15, 2002).

truly are remote rural locations that require functional equivalence in order to obtain reasonably priced services, the Commission should consider those applications on a case-by-case basis. However, it should not open the door to a far-flung general policy that would be costly to administer, wasteful of universal service funds, and, in most cases, completely unnecessary.

#### **IV. The Commission Should Not Change the Definition of Urban Areas or Eliminate the Maximum Allowable Distance Limits**

Some commenters have advocated eliminating the comparison of rural health care rates to the closest city of 50,000, arguing that the Commission should instead let the applicable urban rate be determined by reference to any city in the State.<sup>23</sup> Similarly, some have called for the elimination of the “MAD” – the maximum allowable distance calculation used to set an upper limit on subsidies for distance-based charges.<sup>24</sup> The Commission should reject both of these suggestions, because they are inconsistent with the Act’s purpose, and would create improper financial incentives.

The Commission’s rules on both the MAD and the comparison to the closest city of 50,000 go hand-in-hand to ensure that the rates rural health care providers pay for telecommunications services are “reasonably comparable to” – rather than better than – urban rates. 47 U.S.C. § 254(h)(1)(A). Indeed, as the Commission specifically found, “limiting support to connections to the nearest large city in the state is consistent with Congress’s intent to make rural and urban rates comparable, rather than making rural

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<sup>23</sup> See, e.g., Comments of Joseph Tracey, Missouri Telehealth Network, et al., at 6.

<sup>24</sup> See *id.*; see also Comments of Telehealth Idaho, at 7.

health care providers better off than their urban counterparts.” *First Universal Service Order*, ¶ 678.

Eliminating the MAD would be especially problematic, as it would go far beyond the level of support anticipated by the Act, and could easily open up the program to enormous waste. When originally setting the MAD, the Commission agreed with commenters who argued “that establishing a maximum distance for which a rural health care provider can receive support should protect against an otherwise natural tendency for a subsidized rural provider to request telemedicine connections to far flung areas in search of the real or imagined ‘expert’ in the field.” *First Universal Service Order*, ¶ 678 (footnote and internal quotation marks omitted). As commenters pointed out then, without the MAD, the rural health care program could find itself subsidizing, for instance, the distance-based charges for connections from all rural health care providers in the country to specialists at the Mayo Clinic (Minnesota) or Johns Hopkins (Maryland).<sup>25</sup> Certainly, such subsidies would be far beyond what are “necessary for the provision of health care services in a State.” 47 U.S.C. § 254(h)(1)(A). Of course, as the Commission pointed out in its original order, a rural health care provider is free to connect to cities that are at a greater distance than the MAD. *First Universal Service Order*, ¶ 679. However, the current rules ensure that such a decision will be based on the same cost-benefit considerations used by urban health care providers, and will not result in excessive spending of funds that are “free” to the rural health care provider. *See id.*

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<sup>25</sup> See April 16, 1997 letter from Mary L. Henze, Bell South, to William F. Caton, FCC, CC Docket No. 96-45, and attached ex parte presentation of BellSouth, SBC Communications, Pacific Telesis Group, and Ameritech, at 2.

**V. The Commission Should Not Mandate Discounted Billing, and Should Not Penalize the Carriers For Delays in Reimbursement from the Rural Health Care Division**

A few commenters argued that the Commission should limit the time that telecommunications providers have to complete forms for the rural health care program to 90 days, and order that if the provider does not complete the form within 90 days, it must continue to provide services, but cannot bill for them until the form is completed.<sup>26</sup> Moreover, these commenters argue that 90 days after the rural health care provider fills out its portion of the form, the telecommunications carrier should be allowed to bill only for the discounted portion of the services – *i.e.*, at the rate comparable to urban rates – and should refund the discounted portion of the first 90 days worth of service. *Id.* These comments are misguided, because they wrongly blame providers for much of the delay in reimbursement, and attempt to shift all costs of the program onto the telecommunications providers. The Commission should reject these proposals. If it wants to speed payments to health care providers, it should do so through streamlining the application process, and by authorizing payments from the Rural Health Care Division (RHCD) to be paid directly to the health care provider, rather than requiring that they be funneled through the carrier.

It is true that 90 days often may be a workable timeframe for a carrier to complete the Form 468 required for providing service to a health care provider, and in most cases Verizon completes these forms in 90 days or less. Indeed, Verizon, like other providers, has an incentive to complete these forms in a timely manner.<sup>27</sup> However, there are cases

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<sup>26</sup> See, *e.g.*, Comments of Joseph Tracey, Missouri Telehealth Network, et al., at 8-9.

<sup>27</sup> All rural health care providers are telecommunications customers, and Verizon – like other carriers – values its customers and tries to make them satisfied. There are also concrete financial incentives to filling out the form in a timely manner. If

in which complicating factors make a 90 day deadline unworkable. For example, if more than one telecommunications carrier is providing service to a health care provider, each carrier must fill out a separate form. They may need to coordinate with each other, which delays the process. Often, there are delays for the telecommunications carrier because it needs to obtain information from the applicant.

Regardless of whether the Commission decides to require carriers to turn around forms in a 90 day period, it should not impose draconian penalties, such as requiring carriers to provide services without pay, for failure to meet the allotted time. Indeed, because the carrier often requires assistance from the health care provider in completing the necessary paperwork, such a rule could slow down the application process, by giving applicants incentives to delay giving information to the carrier, on the hopes of receiving free service during the period of delay. A carrier that is chronically late filling out the form likely will lose business, and should be instructed to improve its processes. But legitimate delays in what can be a complex administrative process should not be punished. If the program begins imposing punitive measures on carriers that experience occasional delays, the new rules will create disincentives for these carriers to compete for rural health care business.

The Commission also should not mandate discounted billing, especially not on the abbreviated time schedule suggested by these commenters. As an initial matter, the proposals suggest that the carriers be required to provide discounts before the carrier knows how much of a subsidy ultimately will be approved, or even whether any subsidy

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the applicant cannot get timely reimbursement from the program, there is the danger it will discontinue or limit the services ordered from the provider. The rural health care provider has the option to choose another carrier to provide these services.

will exist at all. Commenters who suggest such a plan apparently do not recognize that much of the delay in receiving funds comes not from the provider, but from the time it takes for the RHCD to process the applications. After a carrier fills out the required paperwork and returns it to the customer, it takes time – generally, at least four months, and sometimes more – for the carrier to receive reimbursement from the program.

Requiring carriers to provide discounted billing before the subsidy has been approved and the amount established by the RHCD unfairly places all costs of the rural health care program on the carriers. If the carrier provides discounted billing and the subsidy ultimately is not approved – or is approved in an amount less than what is requested by the applicant – this is money that the carrier may never recover. Such a system is likely to dramatically discourage telecommunications providers from bidding for rural health care program business.

Even without the unworkable time constraints, the Commission should not mandate a discounted billing system. Commenters that argued applicants should be allowed to mandate a particular billing method offered little or no analysis (and perhaps have insufficient understanding) of the costs that would be imposed on service providers if they were under a generalized requirement to offer discounted billing. Directly billing the customer for only the non-discounted portion of products and services often imposes high costs on the provider, both in terms of the cost of providing free financing until the refund comes through and in terms of bills that become uncollectible if the discounts are not approved. *See generally* Verizon’s Comments, Schools and Libraries, CC Docket No. 02-6, at 7-11 (filed Apr. 5, 2002).

If the Commission wishes to expedite funds to the applicant, it should work on ways to streamline the application process, in order to shorten both the time it takes for applicants and providers to fill out paperwork, and the time it takes for the RHCD to process the forms. The Commission also could authorize payment of the subsidy directly to the applicant, which will speed delivery of the funds.

**Conclusion**

The Commission should not change the rules in ways that would be contrary to the Act, that would dramatically increase the cost of the universal service program, or that would invite waste, abuse, or fraud.

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