HOUSE DOCKET, NO. 3140 FILED ON: 1/21/2011

HOUSE . . . . . No. 2780

The Commonwealth of Massachusetts

PRESENTED BY:

Jeffrey Sánchez

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act preventing unnecessary medical debt.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Jeffrey Sánchez	*15th Suffolk*	*12/3/2012*
James B. Eldridge		*2/3/2011*
Gloria L. Fox	*7th Suffolk*	*2/4/2011*

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HOUSE . . . . . No. 2780

By Mr. Sánchez of Boston, a petition (accompanied by bill, House, No. 2780) of Jeffrey Sánchez, James B. Eldridge and Gloria L. Fox relative to preventing unnecessary medical debt through hospital and affiliate charity care policies. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act preventing unnecessary medical debt.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. The General Laws are hereby amended by inserting after chapter 118H, the following chapter:-

Chapter 118I

HOSPITAL AND AFFILIATE CHARITY CARE POLICIES

Section 1. For the purposes of this chapter, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"High medical costs", any of the following: (1) annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 per cent of the patient's household income in the prior 12 months; (2) annual out-of-pocket expenses that exceed 10 per cent of the patient's household income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's household in the prior 12 months; (3) a lower level determined by

the hospital under the hospitals charity care policy. High medical cost determinations do not apply to low income patients at or below 200% of the federal poverty level.

"Hospital", a hospital licensed under section 51 of chapter 111, the teaching hospital of the University of Massachusetts Medical School or a psychiatric facility licensed under section 19 of chapter 19, and any person, agency or organization affiliated with the hospital or by whom services were rendered at the request of the hospital.

"Underinsured", a patient whose health insurance plan, self-insurance health plan or a medical assistance program does not pay, in whole or in part, for health services and has incurred high medical costs.

"Uninsured", a patient who is not covered by a health insurance plan, a self-insurance health plan, or a medical assistance program and has incurred high medical costs.

Section 2. Each hospital shall establish policies and procedures for reducing charges, including for coinsurance and for uncovered services, otherwise applicable to low-income individuals without health insurance, or who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges, and also, at the hospital's discretion, for reducing or discounting the collection of co-pays and deductible payments from those individuals who can demonstrate an inability to pay such amounts.

Such reductions from charges for uninsured or underinsured patients with incomes at or below at least 600 per cent of the federal poverty level shall result in a charge to such individual that does not exceed the greater of the amount that would have been paid for the same service by

the highest volume payor for such service as defined by the Division of Health Care Finance and Policy or the public payor rate whichever is less.

Section 2. (a) Each hospital shall make all reasonable efforts to obtain from all patients or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the hospital to a patient, including, but not limited to, any of the following: (1) private health insurance; (2) Medicare; or (3) MassHealth program, the Commonwealth Care, Health Safety Net or other state-funded program designed to provide health coverage. Each hospital shall have an affirmative duty to assist patients with applications for public subsidized insurance programs in a timely manner and consistent with applicable state or federal law, including but not limited to the Division of Health Care Finance and Policy—Health Safety Net Eligible Services, 114.6 CMR 13.00 et seq,.

(b) If a hospital bills a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, as a part of that billing, the hospital shall provide the patient with a clear and conspicuous notice. The hospital shall provide such notice to all patients who are likely to incur expenses. Notices must be stand-alone, in plain English, and .in other languages spoken by patients served by the hospital. Notice shall include all of the following:

(1) a statement of charges for services rendered by the hospital;

(2) a request that the patient inform the hospital if the patient

has health insurance coverage, Medicare, Commonwealth Care, MassHealth,

or other coverage;

(3) a statement that if the consumer does not have health insurance coverage, the consumer may be eligible for Medicare, Commonwealth Care, MassHealth, or other state-funded programs designed to provide health coverage. or charity care;

(4) a statement indicating how patients may obtain applications for the MassHealth program, the Commonwealth Care Program, or Health Safety Net benefits, pursuant to Division of Health Care Finance and Policy—Health Safety Net Eligible Services, 114.6 CMR 13.00 et seq, and that the hospital will provide and affirmatively assist patients with these applications. The hospital shall submit applications for state health care programs and benefits no later than 10 days from the earliest date of service rendered to the patient. If the patient does not indicate coverage by a third-party payer specified in subsection (a), or requests a discounted price or charity care, the hospital shall provide an application for the MassHealth program, or other state-funded programs designed to provide health coverage. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care; and

(5) information regarding the financially qualified patient and charity care application, including the following:

(A) a statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain low- and moderate-income requirements, the patient may qualify for discounted

payment or charity care and (B) the name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's discount payment and charity care policies, and how to apply for that assistance.

Section 3. (a) Each hospital or other assignee which is an affiliate or subsidiary of the hospital shall have a written policy about when and under whose authority patient debt is advanced for collection, whether the collection activity is conducted by the hospital, an affiliate or subsidiary of the hospital, or by an external collection agency. Hospital policies should be transparent, consumer friendly, and include charity care and payment plan policies. Such hospital polices should be filed with and, as necessary, enforced by the Massachusetts Attorney General's Office, unless otherwise filed pursuant to the Division of Health Care Finance and Policy—Health Safety Net Eligible Services, 114.6 CMR 13.00 et seq. Hospital policies shall be posted on the hospital website. The Massachusetts Attorney General's Office shall have enforcement rights

(b) Each hospital or other assignee which is an affiliate or subsidiary of the hospital shall establish a written policy defining standards and practices for the collection of debt, and shall obtain a written agreement from any agency that collects hospital receivables that it will adhere to the hospital's standards and scope of practices. The policy shall not conflict with other applicable laws, including but not limited to Division of Health Care Finance and Policy—Health Safety Net Eligible Services, 114.6 CMR 13.00 et seq, and shall not be construed to create a joint venture between the hospital and the external entity, or otherwise to allow hospital governance of an external entity that collects hospital receivables. In determining the amount of a debt a hospital may seek to recover from patients who are eligible under the hospital's charity care policy or discount payment policy.

(c) At time of billing, each hospital shall provide a written summary which includes the same information concerning services and charges provided to all other patients who receive care at the hospital and the date the hospital timely submitted the patient's claim to a private or public payor.

(d) For a patient that lacks coverage, or for a patient that provides information that he or she may be a patient with high medical costs, as defined in this article, a hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall not report adverse information to a consumer credit reporting agency. A hospital, any assignee, or other owner of the patient debt shall not commence civil action against any patient at or under 200% of the federal poverty level and shall not commence civil action against patients between 201-600% federal poverty level, unless written approval is first obtained by the hospital board of directors.
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(e) If a patient is attempting to qualify for eligibility under the hospital's charity care or discount payment policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the hospital shall not send the unpaid bill to any collection agency or other assignee, unless that entity has agreed to comply with this chapter.

(f) This requirement does not preclude a hospital, collection agency, or other assignee from pursuing reimbursement and any enforcement remedy or remedies from third-party liability

settlements, tortfeasors, or other legally responsible parties.

(g) Any extended payment plans offered by a hospital to assist patients eligible under the hospital's charity care policy, discount payment policy, or any other policy adopted by the

hospital for assisting low-income patients with no insurance or high medical costs in settling outstanding past due hospital bills, shall be interest free. The hospital extended payment plan may be declared no longer operative after the patient's failure to make all consecutive

payments due during a 90 day period. Before declaring the hospital extended payment plan no longer operative, the hospital, collection agency, or assignee shall make a reasonable attempt to contact the patient by phone and, to give notice in writing, that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. Prior to the hospital extended payment plan being declared inoperative, the hospital, collection agency, or assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The hospital, collection agency, or assignee shall not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment prior to the time the extended payment plan is declared to be no longer operative. For purposes of this section, the notice and phone call to the patient may be made to the last known phone number and address of the patient.

(h) Nothing in this section shall be construed to diminish or eliminate any protections consumers have under existing federal and state debt collection laws, or any other consumer protections available under state or federal law, including but not limited to the Division of Health Care Finance and Policy—Health Safety Net Eligible Services, 114.6 CMR 13.00 et seq. Each hospital is further encouraged to establish procedures which exceed guidelines pursuant to the Massachusetts Attorney General’s Office – Community Benefit Guidelines for Nonprofit. If the patient fails to make all consecutive payments for 90 days and fails to renegotiate a payment plan, this chapter does not limit or alter the obligation of the patient to make payments on the

obligation owing to the hospital pursuant to any contract or applicable statute from the date that the extended payment plan is declared no longer operative, as set forth in subsection (g).

Section 4. Any extended payment plans offered by a hospital or other assignee which is an affiliate or subsidiary of the hospital to assist patients eligible under the hospital's charity care policy, discount payment policy, or any other policy adopted by the hospital or other assignee which is an affiliate or subsidiary of the hospital for assisting low-income patients with no insurance or high medical costs in settling outstanding past due hospital bills, shall be interest free. The hospital or other assignee which is an affiliate or subsidiary of the hospital extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during a 90-day period. Before declaring the extended payment plan no longer operative, the hospital, collection agency, or assignee shall make a reasonable attempt to contact the patient by phone and, to give notice in writing, that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. Prior to the hospital extended payment plan being declared inoperative, the hospital, collection agency, or assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The hospital, collection agency, or assignee shall not report adverse information to a consumer credit reporting agency. The hospital shall not commence a civil action against the patient or responsible party for nonpayment without obtaining written approval by the hospital’s Board of Directors. Under no circumstances shall a hospital initiate collection action against a patient who is at or below 200% of the federal poverty level or against any patient if the hospital has not submitted claims to an insurer or public program in timely manner. The monthly payment under such a plan shall not exceed 10 per cent of the gross monthly income of the patient. The rate of interest charged to the patient on the unpaid balance, if any,

shall not exceed the rate for a 90 day security issued by the United States Department of Treasury, plus .5 percent and no plan shall include an accelerator or similar clause under which a higher rate of interest is triggered upon a missed payment. If such policies and procedures include a requirement of a deposit prior to non-emergent, medically-necessary care, such deposit must be included as part of any financial aid consideration. Such policies and procedures shall be applied consistently to all eligible patients.

Section 5. The hospital or other assignee which is an affiliate or subsidiary of the hospital shall not pursue legal action for non payment of a medical bill against uninsured patients who have clearly demonstrated that they have neither sufficient income nor assets to meet their financial obligations provided the patient has complied with this chapter.

Section 6. (a) Before notification of a final bill collection from the hospital or other assignee which is an affiliate or subsidiary of the hospital, these staff must conduct an audit of the patient's bill to determine eligibility for any of the available discount or charity care programs. Each hospital shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the hospital to a patient, including, but not limited to, any of the following: (1) private health insurance; (2) Medicare; or (3) MassHealth, Commonwealth Care, Health Safety Net or other state-funded programs designed to provide health coverage.

(b) In attempts to conduct the audit through phone or face-to-face conversation, the hospital or other assignee which is an affiliate or subsidiary of the hospital, shall attempt to contact the patient by telephone and email, if email contact information is available.

(c) Upon conducting the audit and/or if a patient has not been reached within 14 days, if a hospital or other assignee which is an affiliate or subsidiary of the hospital, bills a patient who has not provided proof of coverage by a third party by the time the notification of the final bill is sent, as a part of that billing, the hospital shall provide the patient with a clear and conspicuous notice that includes all of the following: (1) A statement of charges for services rendered by the hospital; (2) a request that the patient inform the hospital if the patient has health insurance coverage, Medicare, MassHealth, Commonwealth Care, Health Safety Net, or other coverage; (3) a statement that if the consumer does not have health insurance coverage, the consumer may be eligible for Medicare, MassHealth, Commonwealth Care, Health Safety Net, or charity care.

(4) a statement indicating how patients may obtain applications for the Medicare, MassHealth, Commonwealth Care, Health Safety Net, or charity care programs and the and that the hospital will provide these applications; and (5) information regarding the financially qualified patient and charity care application, including the following: (A) a statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or charity care and (B) the name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital or other assignee which is an affiliate or subsidiary of the hospital's discount payment and charity care policies, and how to apply for that assistance.

Section 7. (a) To receive the protection and benefits of this act, a patient responsible for paying a medical bill must act reasonably and cooperate in good faith with the hospital by providing the hospital or other assignee which is an affiliate or subsidiary of the hospital, with all of the reasonably requested financial and other relevant information and documentation needed

to determine the patient's eligibility under the hospital's financial assistance policy and reasonable payment plan options to qualified patients within 30 days of a request for such information.

(b) To receive the protection and benefits of this act, a patient responsible for paying a medical bill shall communicate to the hospital or other assignee which is an affiliate or subsidiary of the hospital any material change in the patient's financial situation that may affect the patient's ability to abide by the provisions of an agreed upon reasonable payment plan or qualification for financial assistance within 30 days of the change.

Section 8. During the admission or as soon as practicable thereafter, the hospital or other assignee which is an affiliate or subsidiary of the hospital must provide an insured patient with written notice that:

(1) the patient may receive separate bills for services provided by health care professionals affiliated with the hospital;

(2) if applicable, some hospital staff members may not be participating providers in the same insurance plans and networks as the hospital;

(3) if applicable, the patient may have a greater financial responsibility for services provided by health care professionals at the hospital who are not under contract with the patient’s health care plan; and

(4) questions about coverage or benefit levels should be directed to the patient’s health plan and the patient’s certificate of coverage

SECTION 2. There shall be a special commission to investigate and study coverage gaps in public coverage. The commission shall examine coverage gaps in public coverage. The special commission should also be charged with eliminating gaps in public coverage for patients. The examination shall include, but shall not be limited to, MassHealth, the Commonwealth Connector, the models from other states and best practices for management of public coverage. The commission shall consist of 14 members, 1 of whom shall be appointed by the senate president, 1 of whom shall be appointed by the speaker of the house, 1 of whom shall be appointed by the minority leader of the senate, 1 of whom shall be appointed by the minority leader of the house of representatives, 1 of whom shall be executive director of the Commonwealth Connector, who shall serve as chair, 1 of whom shall be a representative of the Division of Health Care Finance and Policy, 1 of whom shall be a representative of MassHealth 1 of whom shall be a representative of the Massachusetts Division of Unemployment Assistance., 1 of whom shall be the executive director of the group insurance commission, 1 of whom shall be, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts Medical Society, and at least 1 of whom shall be consumer representative.

The commission shall report its findings and recommendations together with legislation, if any, to the clerks of the house of representatives and senate and the joint committee on public health not on or before December 31, 2012.