

HOUSE No. 1051

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:
<i>Jeffrey Sánchez</i>	<i>15th Suffolk</i>	<i>1/18/2013</i>
<i>Denise Andrews</i>	<i>2nd Franklin</i>	<i>1/31/2013</i>
<i>James B. Eldridge</i>	<i>Middlesex and Worcester</i>	<i>1/31/2013</i>
<i>Patricia D. Jehlen</i>	<i>Second Middlesex</i>	<i>1/30/2013</i>
<i>Jason M. Lewis</i>	<i>Fifth Middlesex</i>	<i>1/30/2013</i>
<i>Elizabeth A. Malia</i>	<i>11th Suffolk</i>	<i>1/31/2013</i>
<i>Denise Provost</i>	<i>27th Middlesex</i>	<i>1/31/2013</i>
<i>Benjamin Swan</i>	<i>11th Hampden</i>	<i>1/31/2013</i>
<i>Kay Khan</i>	<i>11th Middlesex</i>	
<i>Ruth B. Balse</i>	<i>12th Middlesex</i>	

HOUSE No. 1051

By Mr. Sánchez of Boston, a petition (accompanied by bill, House, No. 1051) of Jeffrey Sánchez and others relative to preventing unnecessary medical debt through hospital and affiliate charity care policies. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. 2780 OF 2011-2012.]

The Commonwealth of Massachusetts

In the Year Two Thousand Thirteen

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:

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

3 Chapter 118J

4 HOSPITAL AND AFFILIATE CHARITY CARE POLICIES

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

7 “High medical costs”, any of the following: (1) out-of-pocket costs charged to an
8 individual or other members of the patient’s household for inpatient or outpatient hospital
9 services in the prior 12 months and medical bills from any health care provider that, if paid,
10 would qualify as deductible medical expenses for federal income tax purposes that exceed 10 per
11 cent of the individual’s gross household income in the prior 12 months if the patient provides
12 documentation of such costs and bills; (2) a lower amount determined by a hospital under the
13 hospital’s financial assistance policy. Patients at or below 200 per cent of the federal poverty
14 level charged out-of-pocket medical costs are determined to have high medical costs. “Hospital”,
15 a hospital licensed under section 51 of chapter 111, the teaching hospital of the University of
16 Massachusetts Medical School or a psychiatric facility licensed under section 19 of chapter 19,

17 and any person, agency or organization affiliated with the hospital or by whom services were
18 rendered at the request of the hospital.

19 “Underinsured”, an individual whose health insurance plan, self-insurance health plan or
20 a medical assistance program does not pay, in whole or in part, for health services and who has
21 incurred high medical costs.

22 “Uninsured”, an individual who is not covered by a health insurance plan, a self-
23 insurance health plan, or a medical assistance program and has incurred high medical costs.

24 Section 2. Each hospital shall establish a written financial assistance policy that shall, at
25 a minimum, provide for reducing charges, including for coinsurance and for uncovered services,
26 otherwise applicable to underinsured and uninsured individuals and also, at the hospital’s
27 discretion, for reducing or discounting the collection of co-pays and deductible payments from
28 underinsured and uninsured individuals.

29 Such financial assistance policy shall provide reductions in charges for uninsured or
30 underinsured patients with a gross household income at or below 600 per cent of the federal
31 poverty level and shall result in charges no greater than amounts paid by MassHealth for the
32 services the patient is being charged for.

33 Section 3. (a) Each hospital shall make all reasonable efforts during the registration
34 process and thereafter to obtain from all patients, or their representatives, information about
35 whether private or public health insurance may fully or partially cover the charges for care
36 rendered by the hospital to the patient, including, but not limited to, any of the following: (1)
37 private health insurance; (2) Medicare; (3) the MassHealth program; (4) a commonwealth health
38 insurance connector subsidized plan; (5) Health Safety Net; or (6) other state-or federally-funded
39 programs designed to provide health coverage. Each hospital shall have an affirmative duty to
40 assist patients with applications for publicly-subsidized insurance programs in a timely manner
41 and consistent with applicable state or federal law, including but not limited to the Division of
42 Medical Assistance—Health Safety Net Eligible Services, 114.6 CMR 13.00 et seq..

43 (b) If a hospital bills a patient, the hospital shall provide the patient with a clear and
44 conspicuous notice, as a part of that billing, which is in plain English and in other languages
45 spoken by patients served by the hospital. Notice shall include all of the following:

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

47 (2) a request that the patient inform the hospital if the patient has health insurance
48 coverage,

49 Medicare, the MassHealth program, a commonwealth health insurance
50 connector subsidized plan, or other coverage;

51 (3) a statement that the patient may apply for publicly-funded
52 programs that may cover the patient's charges
53 or assistance under the hospital's financial assistance policy;

54 (4) a statement indicating how the patient may obtain applications for such programs
55 and that
56 the hospital will provide and affirmatively assist patients with these applications.
57 The
58 hospital shall submit applications for publicly-subsidized insurance programs no
59 later than
60 the date necessary to obtain coverage for the earliest date of service rendered to
61 the
62 patient. If the patient does not indicate coverage by a third-party payer specified
63 in
64 subsection (a)the hospital shall provide an application for the MassHealth program,
65 or
66 other publicly-subsidized insurance programs designed to provide health coverage.
67 This
68 application shall be provided prior to discharge if the patient has been admitted or is
69 receiving emergency or outpatient care; and

70 (5) a copy of the hospital's financial assistance policy, which should include the
71 following:

- 72 (i) eligibility criteria;
- 73 (ii) the discounts available under the policy;
- 74 (iii) the name and telephone number of a hospital employee or office from
75 whom or
76 which the patient may obtain further information about the hospital's
77 financial
78 assistance policy and instructions on how to apply for financial assistance.

79 Section 4. (a) Each hospital or other assignee, which is an affiliate or subsidiary of the
80 hospital, shall have a written policy about when and under whose authority patient debt is
81 advanced for collection, whether the collection activity is conducted by the hospital, an affiliate
82 or subsidiary of the hospital, or by an external collection agency. Hospital collection policies
83 shall be posted on the hospital's website and should include financial assistance and payment
84 plan policies. Such hospital policies should be filed with the attorney general, unless otherwise
85 filed pursuant to the Division of Medical Assistance—Health Safety Net Eligible Services, 114.6
86 CMR 13.00 et seq. The attorney general shall have the authority to take enforcement action
87 against hospitals that do not comply with this section.

88 (b) Each hospital or other assignee, which is an affiliate or subsidiary of the hospital,
89 shall establish a written policy defining standards and practices for the collection of debt, and
90 shall obtain a written agreement from any agency that collects hospital receivables that it will
91 adhere to the hospital's standards and practices. The policy shall not conflict with other
92 applicable laws, including but not limited to Division of Medical Assistance —Health Safety Net
93 Eligible Services, 114.6 CMR 13.00 et seq, and shall not be construed to create a joint venture
94 between the hospital and the external entity, or otherwise to allow hospital governance of an
95 external entity that collects hospital receivables.

96 (c) A hospital, any assignee of the hospital, or other owner of patient debt, including a
97 collection agency, shall not report adverse information to a consumer credit reporting agency
98 unless specifically approved by the hospital's board of directors. A hospital, any assignee of the
99 hospital, or other owner of patient debt shall not commence civil action against any patient at or
100 under 200 per cent of the federal poverty level, and shall not commence civil action against
101 patients between 201 and 600 per cent federal poverty level, unless written approval is first
102 obtained by the hospital board of directors.

103 (d) If a patient is attempting to qualify for eligibility under the hospital's financial
104 assistance policy or is attempting, in good faith, to settle an outstanding bill with the hospital by
105 negotiating a reasonable payment plan or by making regular partial payments of a reasonable
106 amount, the hospital shall not send the unpaid bill to any collection agency or other assignee,
107 unless that entity has agreed to comply with this chapter.

108 (e) This requirement does not preclude a hospital, collection agency, or other assignee
109 from pursuing reimbursement and any enforcement remedy or remedies from third-party liability
110 settlements, tortfeasors, or other legally responsible parties.

111 (f) Any payment plans offered by a hospital shall be interest free. The hospital payment
112 plan may be declared no longer operative after the patient's failure to make all consecutive
113 payments due during a 90 day period. Before declaring the hospital payment plan is no
114 longer operative, the hospital, collection agency, or assignee shall make a reasonable attempt to

115 contact the patient by phone and give notice in writing warning that the payment plan may
116 become inoperative and of the opportunity to renegotiate the payment plan. Prior to the hospital
117 payment plan being declared inoperative, the hospital, collection agency, or assignee shall
118 attempt to renegotiate the terms of the defaulted payment plan, if requested by the patient. The
119 hospital, collection agency, or assignee shall not report adverse information to a consumer credit
120 reporting agency or commence a civil action against the patient or responsible party for
121 nonpayment prior to the time the payment plan is declared to be no longer operative. For
122 purposes of this section, the notice and phone call to the patient may be made to the last known
123 phone number and address of the patient.

124 (g) Nothing in this section shall be construed to diminish or eliminate any protections
125 consumers have under existing federal and state debt collection laws, or any other consumer
126 protections available under state or federal law, including but not limited to the Division of
127 Medical Assistance—Health Safety Net Eligible Services, 114.6 CMR 13.00 et seq. Each
128 hospital is further encouraged to establish procedures which exceed guidelines pursuant to the
129 Attorney General’s Office – Community Benefit Guidelines for Nonprofit Hospitals. If the
130 patient fails to make all consecutive payments for 90 days and fails to renegotiate a payment
131 plan, this chapter does not limit or alter the obligation of the patient to make payments on the
132 obligation owing to the hospital pursuant to any contract or applicable statute from the date that
133 the extended payment plan is declared no longer operative, as set forth in subsection (f).

134 Section 5. Any payment plans offered by a hospital or other assignee, which is an
135 affiliate or subsidiary of the hospital, to assist patients eligible under the hospital's financial
136 assistance policy , discount payment policy, or any other policy adopted by the hospital or other
137 assignee, which is an affiliate or subsidiary of the hospital, for assisting low-income patients with
138 no insurance or high medical costs in settling outstanding past due hospital bills, shall be interest
139 free. This payment plan may be declared no longer operative after the patient's failure to make all
140 consecutive payments due during a 90-day period. Before declaring the payment plan no longer
141 operative, the hospital, collection agency, or assignee shall make a reasonable attempt to contact
142 the patient by phone and, to give notice in writing, that the payment plan may become
143 inoperative, and of the opportunity to renegotiate the payment plan. Prior to the payment plan
144 being declared inoperative, the hospital, collection agency, or assignee shall attempt to
145 renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The
146 hospital, collection agency, or assignee shall not report adverse information to a consumer credit
147 reporting agency. The hospital, collection agency, or assignee shall not commence a civil action
148 against the patient or responsible party for nonpayment without obtaining written approval by the
149 hospital’s Board of Directors. Under no circumstances shall a hospital initiate collection action
150 against a patient who is at or below 200 per cent of the federal poverty level or against any
151 patient if the hospital has not submitted claims to an insurer or public program in timely manner.
152 The monthly payment under such a plan shall not exceed 10 per cent of the gross monthly
153 income of the patient. If such policies and procedures include a requirement of a deposit prior to

154 non-emergent, medically-necessary care, such deposit must be included as part of any financial
155 aid consideration. Such policies and procedures shall be applied consistently to all eligible
156 patients.

157 Section 6. The hospital or other assignee, which is an affiliate or subsidiary of the
158 hospital, shall not pursue legal action for non-payment of a medical bill against uninsured
159 patients who have clearly demonstrated that they have neither sufficient income nor assets to
160 meet their financial obligations, provided the patient has complied with this chapter.

161 Section 7. (a) Before notification of a final bill collection from the hospital or other
162 assignee, which is an affiliate or subsidiary of the hospital, the hospital or its assignee must
163 conduct an audit of the patient's bill to determine eligibility under the hospital's financial
164 assistance policy. Each hospital shall make all reasonable efforts to obtain from the patient or
165 his or her representative information about whether private or public health insurance or
166 sponsorship may fully or partially cover the charges for care rendered by the hospital to a patient,
167 including, but not limited to, any of the following: (1) private health insurance; (2) Medicare; (3)
168 the MassHealth program; (4) a commonwealth health insurance connector subsidized plan; (5)
169 Health Safety Net; or (6) other state or federally funded programs designed to provide health
170 coverage.

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

174 (c) Upon conducting the audit and/or if a patient has not been reached within 14 days, if a
175 hospital or other assignee, which is an affiliate or subsidiary of the hospital, bills a patient who
176 has not provided proof of coverage by a third party by the time the notification of the final bill is
177 sent, as a part of that billing, the hospital shall provide the patient with a clear and conspicuous
178 notice that includes all of the following: (1) A statement of charges for services rendered by the
179 hospital; (2) a request that the patient inform the hospital if the patient has health insurance
180 coverage, Medicare, the MassHealth program, a commonwealth health insurance connector
181 subsidized plan, Health Safety Net, or other coverage; (3) a statement that if the consumer does
182 not have health insurance coverage, the consumer may be eligible for Medicare, the MassHealth
183 program, a commonwealth health insurance connector subsidized plan, Health Safety Net, or
184 assistance under the hospital's financial assistance policy;(4) a statement indicating how patients
185 may obtain applications for the Medicare, the MassHealth program, a commonwealth health
186 insurance connector subsidized plan, Health Safety Net, or the hospital's financial assistance
187 policy and that the hospital will provide these applications; and (5) information regarding the
188 financially qualified patient and financial assistance application, including the following: a
189 statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain
190 low- and moderate-income requirements, the patient may qualify for assistance under the
191 hospital's financial assistance policy; and the name and telephone number of a hospital

192 employee or office from whom or which the patient may obtain information about the hospital's
193 financial assistance policy and how to apply for that assistance.

194 Section 8. (a) To receive the protection and benefits of this act, a patient responsible for
195 paying a medical bill must act reasonably and cooperate in good faith with the hospital by
196 providing the hospital or other assignee, which is an affiliate or subsidiary of the hospital, with
197 the following information within 30 days of a request for such information unless additional time
198 is reasonably necessary: all of the reasonably requested financial and other relevant information
199 and documentation needed to determine the patient's eligibility under the hospital's financial
200 assistance policy and to determine reasonable payment plan options for qualified patients.

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

206 Section 9. During the admission or as soon as practicable thereafter, the hospital or other
207 assignee, which is an affiliate or subsidiary of the hospital, must provide patients with written
208 notice that:

209 (1) the patient may receive separate bills for services provided by health care
210 professionals

211 affiliated with the hospital;

212 (2) if applicable, some hospital staff members may not be participating providers in the
213 same

214 insurance plans and networks as the hospital;

215 (3) if applicable, the patient may have a greater financial responsibility for services
216 provided by

217 health care professionals at the hospital who are not under contract with the patient's
218 health

219 care plan; and

220 (4) questions about coverage or benefit levels should be directed to the patient's health
221 plan and

222 the patient's certificate of coverage

223 SECTION 2. There shall be a special commission to investigate and study coverage gaps
224 experienced by individuals transitioning between publicly subsidized health coverage programs.
225 The commission shall examine such coverage gaps. The commission should also be charged with
226 proposing policies to eliminate gaps in coverage for such individuals. The examination shall
227 include, but shall not be limited to, MassHealth, the commonwealth connector, the models from
228 other states and best practices for management of public coverage. The commission shall
229 consist of 14 members, 1 of whom shall be appointed by the senate president, 1 of whom shall be
230 appointed by the speaker of the house, 1 of whom shall be appointed by the minority leader of
231 the senate, 1 of whom shall be appointed by the minority leader of the house of representatives, 1
232 of whom shall be a representative of MassHealth, who shall serve as chairperson, 1 of whom
233 shall be executive director of the commonwealth connector, 1 of whom shall be a representative
234 of the Health Policy Commission, 1 of whom shall be a representative of the Center for Health
235 Information and Analysis, 1 of whom shall be a representative of the Massachusetts Division of
236 Unemployment Assistance, 1 of whom shall be executive representative of the group insurance
237 commission, 1 of whom shall be a representative of the Massachusetts Association of Health
238 Plans, Inc., 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts,
239 Inc., 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of
240 whom shall be a representative of the Massachusetts Medical Society, and at least 1 of whom
241 shall be a consumer representative.

242 The commission shall report its findings and recommendations together with legislation,
243 if any, to the clerks of the house of representatives and senate and the joint committee on public
244 health on or before December 31, 2014.