HOUSE DOCKET, NO. 2056 FILED ON: 1/15/2015

HOUSE . . . . . No. 1025

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*	*1/15/2015*
Denise Provost	*27th Middlesex*	*9/10/2019*
Marjorie C. Decker	*25th Middlesex*	*9/10/2019*
Ruth B. Balser	*12th Middlesex*	*9/10/2019*
Carmine L. Gentile	*13th Middlesex*	*9/10/2019*
Paul R. Heroux	*2nd Bristol*	*9/10/2019*
James B. Eldridge	*Middlesex and Worcester*	*9/10/2019*
Barbara A. L'Italien	*Second Essex and Middlesex*	*9/10/2019*
Christine P. Barber	*34th Middlesex*	*9/10/2019*
Elizabeth A. Malia	*11th Suffolk*	*9/10/2019*
Carlos Gonzalez	*10th Hampden*	*9/10/2019*
Paul McMurtry	*11th Norfolk*	*9/10/2019*

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HOUSE . . . . . No. 1025

By Mr. Sánchez of Boston, a petition (accompanied by bill, House, No. 1025) 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. *1051* OF 2013-2014.]

The Commonwealth of Massachusetts

In the One Hundred and Eighty-Ninth General Court
(2015-2016)

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 118I the following chapter:-

Chapter 118J

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) out-of-pocket costs charged to an individual or other members of the patient's household for inpatient or outpatient hospital services in the prior 12 months and medical bills from any health care provider that, if paid,

would qualify as deductible medical expenses for federal income tax purposes that exceed 10 per cent of the individual's gross household income in the prior 12 months if the patient provides documentation of such costs and bills; (2) a lower amount determined by a hospital under the hospital's financial assistance policy. Patients at or below 200 per cent of the federal poverty level charged out-of-pocket medical costs are determined to have high medical costs.

"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", an individual 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 who has incurred high medical costs.

"Uninsured", an individual 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 a written financial assistance policy that shall, at a minimum, provide for reducing charges, including for coinsurance and for uncovered services, otherwise applicable to underinsured and uninsured individuals and also, at the hospital's discretion, for reducing or discounting the collection of co-pays and deductible payments from underinsured and uninsured individuals.

Such financial assistance policy shall provide reductions in charges for uninsured or underinsured patients with a gross household income at or below 600 per cent of the federal

poverty level and shall result in charges for emergency or other medically necessary care no greater than amounts paid by MassHealth for the services the patient is being charged for.

Section 3. (a) Each hospital shall make all reasonable efforts during the registration process and thereafter to obtain from all patients, or their representatives, information about whether private or public health insurance may fully or partially cover the charges for care rendered by the hospital to the patient, including, but not limited to, any of the following: (1) private health insurance; (2) Medicare; (3) the MassHealth program; (4) a commonwealth health insurance connector subsidized plan; (5) Health Safety Net; or (6) other state-or federally-funded programs designed to provide health coverage.

(b) Each hospital shall: (1) Provide individual notice about programs of public assistance, including MassHealth, the Premium Assistance Payment Program Operated by the Health Connector, the Children's Medical Security Plan, and the Health Safety Net to patients during the registration process. This notice to the patient shall include notification that if the patient is eligible, programs of public assistance may cover charges not covered by private insurance; (2) have an affirmative duty to assist patients with applications for programs of public assistance in a timely manner and consistent with applicable state or federal law, including but not limited to the Division of Medical Assistance—Health Safety Net Eligible Services, 101 CMR 613 et seq.

(c) If a hospital bills a patient, the hospital shall provide the patient with a clear and conspicuous notice, as a part of that billing, which is 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, the MassHealth program, a commonwealth health insurance connector subsidized plan, or other coverage;

(3) a statement that the patient may apply for programs of public assistance that may cover the patient's charges or assistance under the hospital's financial assistance policy;

(4) a statement indicating how the patient may obtain applications for such programs and that the hospital will provide and affirmatively assist patients with these applications. The hospital shall submit applications for programs of public assistance no later than the date necessary to obtain coverage for 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)the hospital shall provide an application for the MassHealth program, or other programs of public assistance designed to provide health coverage. This application shall be provided prior to discharge if the patient has been admitted or is receiving emergency or outpatient care; and

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

(i) eligibility criteria;

(ii) the discounts available under the policy;

(iii) the name and telephone number of a hospital employee or office from whom or which the patient may obtain further information about the hospital's financial assistance policy and instructions on how to apply for financial assistance.

Section 4. (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 collection policies shall be posted on the hospital's website and should include financial assistance and payment plan policies. Such hospital polices should be filed with the attorney general, unless otherwise filed pursuant to the Division of Medical Assistance—Health Safety Net Eligible Services, 101 CMR 613 et seq. . The attorney general shall have the authority to take enforcement action against hospitals that do not comply with this section.

(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 practices. The policy shall not conflict with other applicable laws, including but not limited to Division of Medical Assistance —Health Safety Net Eligible Services, 101 CMR 613 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.

(c) A hospital, any assignee of the hospital, or other owner of patient debt, including a collection agency, shall not report adverse information to a consumer credit reporting agency unless specifically approved by the hospital's board of directors. A hospital, any assignee of the hospital, or other owner of patient debt shall not commence civil action against any patient at or under 200 per cent of the federal poverty level, and shall not commence civil action against

patients between 201 and 600 per cent federal poverty level, unless written approval is first obtained by the hospital board of directors.

(d) If a patient is attempting to qualify for eligibility under the hospital's financial assistance policy or 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.

(e) 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.

(f) Any payment plans offered by a hospital shall be interest free. The hospital 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 payment plan is no longer operative, the hospital, collection agency, or assignee shall make a reasonable attempt to contact the patient by phone and give notice in writing warning that the payment plan may become inoperative and of the opportunity to renegotiate the payment plan. Prior to the hospital payment plan being declared inoperative, the hospital, collection agency, or assignee shall attempt to renegotiate the terms of the defaulted 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 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.

(g) 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 Medical Assistance—Health Safety Net Eligible Services, 101 CMR 613 et seq. Each hospital is further encouraged to establish procedures which exceed guidelines pursuant to the Attorney General's Office – Community Benefit Guidelines for Nonprofit Hospitals. 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 (f).

Section 5. Any 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 financial assistance 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. This 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 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 payment plan may become inoperative, and of the opportunity to renegotiate the payment plan. Prior to the 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, collection agency, or assignee 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 per cent 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. 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 6. 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 7. (a) Before notification of a final bill collection from the hospital or other assignee, which is an affiliate or subsidiary of the hospital, the hospital or its assignee must conduct an audit of the patient's bill to determine eligibility under the hospital's financial assistance policy. 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; (3) the

MassHealth program; (4) a commonwealth health insurance connector subsidized plan; (5) Health Safety Net; or (6) other state or federally 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, the MassHealth program, a commonwealth health insurance connector subsidized plan, 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, the MassHealth program, a commonwealth health insurance connector subsidized plan, Health Safety Net, or assistance under the hospital's financial assistance policy;(4) a statement indicating how patients may obtain applications for the Medicare, the MassHealth program, a commonwealth health insurance connector subsidized plan, Health Safety Net, or the hospital's financial assistance policy and that the hospital will provide these applications; and (5) information regarding the financially qualified patient and financial assistance application, including the following: 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 assistance under the

hospital’s financial assistance policy; and the name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital’s financial assistance policy and how to apply for that assistance.

Section 8. (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 the following information within 30 days of a request for such information unless additional time is reasonably necessary: 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 to determine reasonable payment plan options for qualified patients.

(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 9. 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 patients 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 experienced by individuals transitioning between publicly subsidized health coverage programs. The commission shall examine such coverage gaps. The commission should also be charged with proposing policies to eliminate gaps in coverage for such individuals. 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 a representative of MassHealth, who shall serve as chairperson, 1 of whom shall be executive director of the commonwealth connector, 1 of whom shall be a representative of the Health Policy Commission, 1 of whom shall be a representative of the Center for Health Information and Analysis, 1 of whom shall be a representative of the Massachusetts Division of Unemployment Assistance, 1 of whom shall be executive representative of the group insurance commission, 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 a consumer representative appointed by the attorney general.

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 health care financing on or before December 31, 2016.