

HOUSE No. 2222

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:
<i>Jeffrey Sánchez</i>	<i>15th Suffolk</i>
<i>Carmine L. Gentile</i>	<i>13th Middlesex</i>
<i>Elizabeth A. Malia</i>	<i>11th Suffolk</i>

HOUSE No. 2222

By Mr. Sánchez of Boston, a petition (accompanied by bill, House, No. 2222) of Jeffrey Sánchez, Carmine L. Gentile and Elizabeth A. Malia 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. 1025 OF 2015-2016.]

The Commonwealth of Massachusetts

**In the One Hundred and Ninetieth General Court
(2017-2018)**

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.

15 "Hospital", a hospital licensed under section 51 of chapter 111, the teaching hospital of
16 the University of Massachusetts Medical School or a psychiatric facility licensed under section
17 19 of chapter 19, and any person, agency or organization affiliated with the hospital or by whom
18 services were 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 a
25 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 for emergency or other medically necessary care no
32 greater than amounts paid by MassHealth for the 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.

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

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

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

52 (2) a request that the patient inform the hospital if the patient has health insurance
53 coverage, Medicare, the MassHealth program, a commonwealth health insurance connector
54 subsidized plan, or other coverage;

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

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

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

67 (i) eligibility criteria;

68 (ii) the discounts available under the policy;

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

72 Section 4. (a) Each hospital or other assignee, which is an affiliate or subsidiary of the
73 hospital, shall have a written policy about when and under whose authority patient debt is
74 advanced for collection, whether the collection activity is conducted by the hospital, an affiliate
75 or subsidiary of the hospital, or by an external collection agency. Hospital collection policies
76 shall be posted on the hospital's website and should include financial assistance and payment
77 plan policies. Such hospital policies should be filed with the attorney general, unless otherwise
78 filed pursuant to the Division of Medical Assistance—Health Safety Net Eligible Services, 101
79 CMR 613 et seq. . The attorney general shall have the authority to take enforcement action
80 against hospitals that do not comply with this section.

81 (b) Each hospital or other assignee, which is an affiliate or subsidiary of the hospital,
82 shall establish a written policy defining standards and practices for the collection of debt, and
83 shall obtain a written agreement from any agency that collects hospital receivables that it will
84 adhere to the hospital's standards and practices. The policy shall not conflict with other
85 applicable laws, including but not limited to Division of Medical Assistance —Health Safety Net
86 Eligible Services, 101 CMR 613 et seq., and shall not be construed to create a joint venture
87 between the hospital and the external entity, or otherwise to allow hospital governance of an
88 external entity that collects hospital receivables.

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

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

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

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

104 (f) Any payment plans offered by a hospital shall be interest free. The hospital payment
105 plan may be declared no longer operative after the patient's failure to make all consecutive
106 payments due during a 90 day period. Before declaring the hospital payment plan is no longer
107 operative, the hospital, collection agency, or assignee shall make a reasonable attempt to contact
108 the patient by phone and give notice in writing warning that the payment plan may become
109 inoperative and of the opportunity to renegotiate the payment plan. Prior to the hospital payment
110 plan being declared inoperative, the hospital, collection agency, or assignee shall attempt to
111 renegotiate the terms of the defaulted payment plan, if requested by the patient. The hospital,
112 collection agency, or assignee shall not report adverse information to a consumer credit reporting
113 agency or commence a civil action against the patient or responsible party for nonpayment prior
114 to the time the payment plan is declared to be no longer operative. For purposes of this section,

115 the notice and phone call to the patient may be made to the last known phone number and
116 address of the patient.

117 (g) Nothing in this section shall be construed to diminish or eliminate any protections
118 consumers have under existing federal and state debt collection laws, or any other consumer
119 protections available under state or federal law, including but not limited to the Division of
120 Medical Assistance—Health Safety Net Eligible Services, 101 CMR 613 et seq. Each hospital is
121 further encouraged to establish procedures which exceed guidelines pursuant to the Attorney
122 General’s Office – Community Benefit Guidelines for Nonprofit Hospitals. If the patient fails to
123 make all consecutive payments for 90 days and fails to renegotiate a payment plan, this chapter
124 does not limit or alter the obligation of the patient to make payments on the obligation owing to
125 the hospital pursuant to any contract or applicable statute from the date that the extended
126 payment plan is declared no longer operative, as set forth in subsection (f).

127 Section 5. Any payment plans offered by a hospital or other assignee, which is an affiliate
128 or subsidiary of the hospital, to assist patients eligible under the hospital's financial assistance
129 policy, discount payment policy, or any other policy adopted by the hospital or other assignee,
130 which is an affiliate or subsidiary of the hospital, for assisting low-income patients with no
131 insurance or high medical costs in settling outstanding past due hospital bills, shall be interest
132 free. This payment plan may be declared no longer operative after the patient's failure to make all
133 consecutive payments due during a 90-day period. Before declaring the payment plan no longer
134 operative, the hospital, collection agency, or assignee shall make a reasonable attempt to contact
135 the patient by phone and, to give notice in writing, that the payment plan may become
136 inoperative, and of the opportunity to renegotiate the payment plan. Prior to the payment plan
137 being declared inoperative, the hospital, collection agency, or assignee shall attempt to

138 renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The
139 hospital, collection agency, or assignee shall not report adverse information to a consumer credit
140 reporting agency. The hospital, collection agency, or assignee shall not commence a civil action
141 against the patient or responsible party for nonpayment without obtaining written approval by the
142 hospital's Board of Directors. Under no circumstances shall a hospital initiate collection action
143 against a patient who is at or below 200 per cent of the federal poverty level or against any
144 patient if the hospital has not submitted claims to an insurer or public program in timely manner.
145 The monthly payment under such a plan shall not exceed 10 per cent of the gross monthly
146 income of the patient. If such policies and procedures include a requirement of a deposit prior to
147 non-emergent, medically-necessary care, such deposit must be included as part of any financial
148 aid consideration. Such policies and procedures shall be applied consistently to all eligible
149 patients.

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

154 Section 7. (a) Before notification of a final bill collection from the hospital or other
155 assignee, which is an affiliate or subsidiary of the hospital, the hospital or its assignee must
156 conduct an audit of the patient's bill to determine eligibility under the hospital's financial
157 assistance policy. Each hospital shall make all reasonable efforts to obtain from the patient or his
158 or her representative information about whether private or public health insurance or sponsorship
159 may fully or partially cover the charges for care rendered by the hospital to a patient, including,
160 but not limited to, any of the following: (1) private health insurance; (2) Medicare; (3) the

161 MassHealth program; (4) a commonwealth health insurance connector subsidized plan; (5)
162 Health Safety Net; or (6) other state or federally funded programs designed to provide health
163 coverage.

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

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

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

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

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

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

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

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

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

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

211 SECTION 2. There shall be a special commission to investigate and study coverage gaps
212 experienced by individuals transitioning between publicly subsidized health coverage programs.
213 The commission shall examine such coverage gaps. The commission should also be charged with
214 proposing policies to eliminate gaps in coverage for such individuals. The examination shall
215 include, but shall not be limited to, MassHealth, the commonwealth connector, the models from
216 other states and best practices for management of public coverage. The commission shall consist
217 of 14 members, 1 of whom shall be appointed by the senate president, 1 of whom shall be
218 appointed by the speaker of the house, 1 of whom shall be appointed by the minority leader of
219 the senate, 1 of whom shall be appointed by the minority leader of the house of representatives, 1
220 of whom shall be a representative of MassHealth, who shall serve as chairperson, 1 of whom
221 shall be executive director of the commonwealth connector, 1 of whom shall be a representative
222 of the Health Policy Commission, 1 of whom shall be a representative of the Center for Health
223 Information and Analysis, 1 of whom shall be a representative of the Massachusetts Division of
224 Unemployment Assistance, 1 of whom shall be executive representative of the group insurance
225 commission, 1 of whom shall be a representative of the Massachusetts Association of Health
226 Plans, Inc., 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts,
227 Inc., 1 of whom shall be a representative of the Massachusetts health and Hospital Association,

228 Inc., 1 of whom shall be a representative of the Massachusetts Medical Society, and at least 1 of
229 whom shall be a consumer representative appointed by the attorney general.

230 The commission shall report its findings and recommendations together with legislation,
231 if any, to the clerks of the house of representatives and senate and the joint committee on health
232 care financing on or before December 31, 2018.