

HOUSE No. 02780

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 passage of the accompanying bill:

An Act preventing unnecessary medical debt.

PETITION OF:

NAME:

DISTRICT/ADDRESS:

.....
James B. Eldridge

.....
Middlesex and Worcester

.....
Gloria L. Fox

.....
7th Suffolk

HOUSE No. 02780

By Mr. Sánchez of Boston, a petition (accompanied by bill, House, No. 2780) of Fox and Eldridge relative to preventing unnecessary medical debt through hospital and affiliate charity care policies Joint Committee on 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:

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

3 Chapter 118I

4 HOSPITAL AND AFFILIATE CHARITY CARE POLICIES

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

7 “High medical costs”, any of the following: (1) annual out-of-pocket costs incurred by the
8 individual at the hospital that exceed 10 per cent of the patient’s household income in the prior
9 12 months; (2) annual out-of-pocket expenses that exceed 10 per cent of the patient’s household
10 income, if the patient provides documentation of the patient’s medical expenses paid by the

11 patient or the patient's household in the prior 12 months; (3) a lower level determined by the
12 hospital under the hospitals charity care policy. High medical cost determinations do not apply
13 to low income patients at or below 200% of the federal poverty level.

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

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

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

23

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

30 Such reductions from charges for uninsured or underinsured patients with incomes at or below at
31 least 600 per cent of the federal poverty level shall result in a charge to such individual that does

32 not exceed the greater of the amount that would have been paid for the same service by the
33 highest volume payor for such service as defined by the Division of Health Care Finance and
34 Policy or the public payor rate whichever is less.

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

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

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

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

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

53 or other coverage;

54 (3) a statement that if the consumer does not have health

55 insurance coverage, the consumer may be eligible for Medicare,

56 Commonwealth Care, MassHealth, or other state-funded

57 programs designed to provide health coverage.

58 or charity care;

59 (4) a statement indicating how patients may obtain applications for the MassHealth program, the

60 Commonwealth Care Program, or Health Safety Net benefits, pursuant to Division of Health

61 Care Finance and Policy—Health Safety Net Eligible Services, 114.6 CMR 13.00 et seq, and that

62 the hospital will provide and affirmatively assist patients with these applications. The hospital

63 shall submit applications for state health care programs and benefits no later than 10 days from

64 the earliest date of service rendered to the patient. If the patient does not indicate coverage by a

65 third-party payer specified in subsection (a), or requests a discounted price or charity care, the

66 hospital shall provide an application for the MassHealth program, or other state-funded

67 programs designed to provide health coverage. This application shall be provided prior to

68 discharge if the patient has

69 been admitted or to patients receiving emergency or outpatient care; and

70 (5) information regarding the financially qualified patient and

71 charity care application, including the following:

72 (A) a statement that indicates that if the patient lacks, or has inadequate, insurance, and meets
73 certain low- and moderate-income requirements, the patient may qualify for discounted payment
74 or charity care and (B) the name and telephone number of a hospital employee or office from
75 whom or which the patient may obtain information about the hospital's discount payment and
76 charity care policies, and how to apply for that assistance.

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

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

94 amount of a debt a hospital may seek to recover from patients who are eligible under the
95 hospital's charity care policy or discount payment policy.

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

100 (d) For a patient that lacks coverage, or for a patient that provides information that he or
101 she may be a patient with high medical costs, as defined in this article, a hospital, any assignee of
102 the hospital, or other owner of the patient debt, including a collection agency, shall not report
103 adverse information to a consumer credit reporting agency. A hospital, any assignee, or other
104 owner of the patient debt shall not commence civil action against any patient at or under 200% of
105 the federal poverty level and shall not commence civil action against patients between 201-600%
106 federal poverty level, unless written approval is first obtained by the hospital board of directors.
107 .

108 (e) If a patient is attempting to qualify for eligibility under the hospital's charity care or
109 discount payment policy and is attempting in good faith to settle an outstanding bill with the
110 hospital by negotiating a reasonable payment plan or by making regular partial payments of a
111 reasonable amount, the hospital shall not send the unpaid bill to any collection agency or other
112 assignee, unless that entity has agreed to comply with this chapter.

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

116 (g) Any extended payment plans offered by a hospital to assist patients eligible under the
117 hospital's charity care policy, discount payment policy, or any other policy adopted by the
118 hospital for assisting low-income patients with no insurance or high medical costs in settling
119 outstanding past due hospital bills, shall be interest free. The hospital extended payment plan
120 may be declared no longer operative after the patient's failure to make all consecutive
121 payments due during a 90 day period. Before declaring the hospital extended payment plan no
122 longer operative, the hospital, collection agency, or assignee shall make a reasonable attempt to
123 contact the patient by phone and, to give notice in writing, that the extended payment plan may
124 become inoperative, and of the opportunity to renegotiate the extended payment plan. Prior to the
125 hospital extended payment plan being declared inoperative, the hospital, collection agency, or
126 assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if
127 requested by the patient. The hospital, collection agency, or assignee shall not report adverse
128 information to a consumer credit reporting agency or commence a civil action against the patient
129 or responsible party for nonpayment prior to the time the extended payment plan is declared to
130 be no longer operative. For purposes of this section, the notice and phone call to the patient may
131 be made to the last known phone number and address of the patient.

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

139 plan, this chapter does not limit or alter the obligation of the patient to make payments on the
140 obligation owing to the hospital pursuant to any contract or applicable statute from the date that
141 the extended payment plan is declared no longer operative, as set forth in subsection (g).

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

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

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

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

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

185 (c) Upon conducting the audit and/or if a patient has not been reached within 14 days, if a
186 hospital or other assignee which is an affiliate or subsidiary of the hospital, bills a patient who
187 has not provided proof of coverage by a third party by the time the notification of the final bill is
188 sent, as a part of that billing, the hospital shall provide the patient with a clear and conspicuous
189 notice that includes all of the following: (1) A statement of charges for services rendered by the
190 hospital; (2) a request that the patient inform the hospital if the patient has health insurance
191 coverage, Medicare, MassHealth, Commonwealth Care, Health Safety Net, or other coverage;
192 (3) a statement that if the consumer does not have health insurance coverage, the consumer may
193 be eligible for Medicare, MassHealth, Commonwealth Care, Health Safety Net, or charity care.
194 (4) a statement indicating how patients may obtain applications for the Medicare, MassHealth,
195 Commonwealth Care, Health Safety Net, or charity care programs and the and that the hospital
196 will provide these applications; and (5) information regarding the financially qualified patient
197 and charity care application, including the following: (A) a statement that indicates that if the
198 patient lacks, or has inadequate, insurance, and meets certain low- and moderate-income
199 requirements, the patient may qualify for discounted payment or charity care and (B) the name
200 and telephone number of a hospital employee or office from whom or which the patient may
201 obtain information about the hospital or other assignee which is an affiliate or subsidiary of the
202 hospital's discount payment and charity care policies, and how to apply for that assistance.

203 Section 7. (a) To receive the protection and benefits of this act, a patient responsible for paying a
204 medical bill must act reasonably and cooperate in good faith with the hospital by providing the
205 hospital or other assignee which is an affiliate or subsidiary of the hospital, with all of the
206 reasonably requested financial and other relevant information and documentation needed to
207 determine the patient's eligibility under the hospital's financial assistance policy and reasonable
208 payment plan options to qualified patients within 30 days of a request for such information.

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

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

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

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

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

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

226 SECTION 2. There shall be a special commission to investigate and study coverage gaps in
227 public coverage. The commission shall examine coverage gaps in public coverage. The special
228 commission should also be charged with eliminating gaps in public coverage for patients. The
229 examination shall include, but shall not be limited to, MassHealth, the Commonwealth
230 Connector, the models from other states and best practices for management of public coverage.
231 The commission shall consist of 14 members, 1 of whom shall be appointed by the senate
232 president, 1 of whom shall be appointed by the speaker of the house, 1 of whom shall be
233 appointed by the minority leader of the senate, 1 of whom shall be appointed by the minority
234 leader of the house of representatives, 1 of whom shall be executive director of the
235 Commonwealth Connector, who shall serve as chair, 1 of whom shall be a representative of the
236 Division of Health Care Finance and Policy, 1 of whom shall be a representative of MassHealth
237 1 of whom shall be a representative of the Massachusetts Division of Unemployment
238 Assistance., 1 of whom shall be the executive director of the group insurance commission, 1 of
239 whom shall be, 1 of whom shall be a representative of the Massachusetts Association of Health
240 Plans, Inc., 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts,
241 Inc., 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of
242 whom shall be a representative of the Massachusetts Medical Society, and at least 1 of whom
243 shall be consumer representative.

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