HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 425 Uninsured Hospital Patients
SPONSOR(S): Sobel
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 1988 (i)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Standards (Sub)		Rawlins	Collins
2) Health Care			
3) Health Appropriations (Sub)			
4) Appropriations			
5)			

SUMMARY ANALYSIS

Federal regulation dictates hospital-charging policies. Specifically, Medicare regulations require hospitals to keep a uniform price list for treatments and procedures for all patients, regardless of whether patients are covered by public or private insurance or are uninsured. Hospital officials contend that the pricing rule -- established in the 1960s to ensure that Medicare was not overcharged -- is outdated and prevents them from providing discounts to uninsured patients.

At the time of this analysis, a congressional investigation is pending on this issue. However, as a result of a congressional inquiry, the Office of the Inspector General (OIG), U.S. Department of Health and Human Services published a notice and concluded, the OIG believes that hospitals have the ability to provide relief to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing amounts. No OIG authority prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills. It has been suggested that two laws enforced by the OIG may prevent hospitals from offering discounted prices to uninsured patients.

Currently, Florida Statutes do not require a hospital to identify in its policies and procedures, arrangements for an uninsured patient. Patients in the state of Florida are legally responsible for their bills. This bill establishes procedures for uninsured hospital patients. Specifying that:

- ✓ Each hospital shall establish written policies and procedures for determining the capability of uninsured patients to pay for hospital-based medical services that must, at a minimum, provide for:
  - The collection and review of relevant financial information from the patient.
  - The assessment by the hospital, to the best of its ability, of the patient's eligibility for governmental or charitable assistance.
  - The offer to the patient of any discounts or extended payment terms or plans.
  - The delineation to the patient of the patient's responsibilities for payment and the consequences for failure to pay.
  - The notification to the patient of these policies and procedures shall be included in the patient's hospital bill.
- ✓ The term "patient" means an uninsured person who is in the process of being admitted, or in the case of emergency services and care has been admitted, to the hospital.

The bill provides for an effective date of upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[]	N/A[x]
2. Lower taxes?	Yes[]	No[]	N/A[x]
3. Expand individual freedom?	Yes[x]	No[]	N/A[]
4. Increase personal responsibility?	Yes[x]	No[]	N/A[]
5. Empower families?	Yes[x]	No[]	N/A[]

For any principle that received a “no” above, please explain:

B. EFFECT OF PROPOSED CHANGES:

PRESENT SITUATION

Federal regulation dictates hospital-charging policies. Specifically, Medicare regulations require hospitals to keep a uniform price list for treatments and procedures for all patients, regardless of whether patients are covered by public or private insurance or are uninsured. Hospital officials contend that the pricing rule -- established in the 1960s to ensure that Medicare was not overcharged -- is outdated and prevents them from providing discounts to uninsured patients. Patients with coverage through private insurers or government programs receive "steep discounts" negotiated by insurers, while for uninsured patients the "common practice" is to charge the full list price of services, which may be several times higher than what insurers are charged.

Currently, Florida Statutes do not require a hospital to identify in its policies and procedures, arrangements for an uninsured patient. Patients in the state of Florida are legally responsible for their bills. They have the legal right for an estimate of charges before a procedure, and a copy of their itemized bill at the time of discharge, pursuant to section 395.301, F.S. Florida Statutes do not require a hospital to assist in the arrangement for payment, or offer alternative payment arrangements. Hospitals in Florida are not required to determine the patient’s ability to pay if they are uninsured. Hospitals do not presently incur the responsibility of assisting patients in seeking out governmental or charitable assistance, nor do they legally have to offer patient discounts and extended payment terms for reimbursement. Notification to patients of their financial responsibility and consequences for the failure to pay is not a current requirement of hospitals in the state of Florida. Therefore, a hospital is not required to post or print the ramifications of failing to pay their bill to the public.

On July 16, 2003, the U.S. House of Representatives, House Energy and Commerce Subcommittee on Oversight and Investigations launched a formal probe into hospital billing and collection practices by sending a seven-page letter to 20 hospitals and health systems across the country. The subcommittee’s letters requested detailed information on finances, billing and collection practices, and charity care policies.

From October through November, 2004, the House Select Committee on Affordable Health Care for Floridians conducted public hearings around the state. In each city, public testimony was received from the Consejo de Latinos Unido Organization regarding the aggressive collection procedures used by some hospitals to collect debts owed by self-pay patient or the uninsured. Many cases were cited where homeowners were threatened with the loss of their home in the event the debt was not paid.

In December 2003, the American Hospital Association (AHA) asked the Centers for Medicare and Medicaid to change or clarify pricing schedule rules so that hospitals can give discounts to uninsured patients without "fearing they might be violating Medicare rules," the Wall Street Journal reports. The AHA requests that Medicare create a "safe harbor" rule allowing hospitals to discount charges for uninsured patients without jeopardizing their relationships with the program. The request also asks that a new advisory process be established to help hospitals quickly get decisions on whether and how they could offer discounts to the uninsured. The AHA also claims that Medicare rules, "create a very strong presumption that hospitals must use aggressive efforts to collect from all patients," such as collection letters, liens on property or court action. The AHA has urged its 4,800 member hospitals to adopt "fair billing and collection practices," as well as making any financial counseling options at the hospitals "widely known." The AHA also suggests that its members make publicly available "specific information in a meaningful format about what they charge for services" to help patients understand billing practices.

In January 22, 2004, the Congressional House Energy and Commerce Subcommittee on Oversight and Investigations requested of Tommy G. Thompson, Secretary, U.S. Department of Health and Human Services (HHS), to provide the Committee with the following information and documents by February 6, 2004:

- ✓ Do any federal regulations prohibit, complicate or otherwise impact a hospital's ability to offer discounted rates to uninsured patients?
- ✓ Do any federal regulations make a "practical requirement that a hospital bill all patients according to the same schedule of charges, regardless of who provides their coverage," as the AHA claims?
- ✓ Do providers risk, in any way, reduction or suspension of payments under either the inpatient or outpatient prospective payment system of Medicare if they reduce, in any manner, their "schedule of charges" or "charge master" rates?
- ✓ Do any federal regulations, including, but not limited to, those concerning Medicare bad debt, expect or encourage hospitals to be "aggressive in their collection efforts," as the AHA claims?
- ✓ Are such collection efforts required for all patients for whom adequate documentation is not available, or cannot be obtained, to demonstrate and establish proof of indigence?
- ✓ Do reasonable collection efforts under such federal regulations include:
  - ⇒ phone calls or letters threatening lawsuits or referral to a collection agent;
  - ⇒ use of debt collection agents;
  - ⇒ wage garnishment;
  - ⇒ contacting employers;
  - ⇒ property and/or home liens;
  - ⇒ lawsuits; or
  - ⇒ credit reporting?
- ✓ What program memoranda or other such guidance has HHS provided in this regard?
- ✓ Does HHS dispute any statements or claims made in the AHA's December 16, 2003 letter or related white paper?
- ✓ Is HHS conducting, or has it ever conducted, any studies, reports or investigations on these issues?

- ✓ Is HHS considering providing, or has it ever provided, any statements or guidance on these issues to patients or any entity in the health care industry?
- ✓ Is HHS considering any rule changes relating to these issues and, if so, please provide the status of all such rule changes and please produce copies thereof?
- ✓ Does HHS have any recommendations to Congress relating to these issues?

At the time of this analysis, the congressional investigation is still opened. However, as a result of this inquiry, the Office of the Inspector General (OIG), U.S. Department of Health and Human Services published a notice and concluded that for the following reasons, the OIG believes that hospitals have the ability to provide relief to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing amounts. The notice specified that:

No OIG authority prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills. It has been suggested that two laws enforced by the OIG may prevent hospitals from offering discounted prices to uninsured patients. However, the OIG disagrees and addresses each law in terms of:

> **The Federal Anti-Kickback Statute**.[1] The Federal anti-kickback statute prohibits a hospital from giving or receiving anything of value in exchange for referrals of business payable by a Federal health care program, such as Medicare or Medicaid. The Federal anti-kickback statute does not prohibit discounts to uninsured patients who are unable to pay their hospital bills. However, the discounts may not be linked in any manner to the generation of business payable by a Federal health care program. Discounts offered to underinsured patients potentially raise a more significant concern under the anti-kickback statute, and hospitals should exercise care to ensure that such discounts are not tied directly or indirectly to the furnishing of items or services payable by a Federal health care program. As discussed below, the statute and regulations offer means to reduce or waive coinsurance and deductible amounts to provide assistance to underinsured patients with reasonably verified financial need.
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> **Section 1128 (b))(6)(A) of the Social Security Act**.[2] This law permits -but does not require - the OIG to exclude from participation in the Federal health care programs any provider or supplier that submits bills or requests for payment to Medicare or Medicaid for amounts that are substantially more than the provider's or supplier's usual charges. The statute contains an exception for any situation in which the Secretary finds "good cause" for the substantial difference. The statute is intended to protect the Medicare and Medicaid programs -and taxpayers - from providers and suppliers that routinely charge the programs substantially more than their other customers.

The OIG has never excluded or attempted to exclude any provider or supplier for offering discounts to uninsured or underinsured patients. However, to provide additional assurance to the industry, the OIG recently proposed regulations that would define key terms in the statute. Among other things, the proposed regulations would make clear that free or substantially reduced charges to uninsured persons would not affect the calculation of a provider's or supplier's "usual" charges, as the term "usual charges" is used in the exclusion provision.

The OIG is currently reviewing the public comments to the proposed regulations. Until such time as a final regulation is promulgated or the OIG indicates its intention not to promulgate a final rule, it will continue to be the OIG's enforcement policy that when calculating their "usual charges" for purposes of

[1] 42 U.S.C. § 1320a-7b(b)
[2] 42 U.S.C. § 1320a-7(b)(6)(A).

section 1128 (b)(6)(A), individuals and entities do not need to consider free or substantially reduced charges to uninsured patients or underinsured patients who are self-paying patients for the items or services furnished.

The exclusion provision does not require a hospital to charge everyone the same price; nor does it require a hospital to offer Medicare or Medicaid its "best price." However, hospitals cannot routinely charge Medicare or Medicaid substantially more than they usually charge others. In addition to the two laws discussed above, it has been suggested that hospitals are reluctant to give discounts to uninsured patients because the OIG requires hospitals to engage in vigorous collection efforts against uninsured patients. This misperception may be based on some limited OIG audits of specific hospitals' compliance with Medicare's bad debt rules. The bad debt rules and regulations, including the scope of required collection efforts, are established by the Centers for Medicare & Medicaid Services ("CMS"). No OIG rule or regulation requires a hospital to engage in any particular collection practices.

In a response to the over-charging allegations, several states -- including Connecticut, Illinois and New York -- are proposing legislation addressing disparities in hospital charges and collection practices.

At the industry level, hospital chains, such as Missouri-based Ascension Health and Tennessee-based HCA, are set to launch discount plans for uninsured or low-income patients, while California-based Tenet Healthcare has considered such plans.

HB 425

This bill establishes procedures for uninsured hospital patients. Specifying that:

⇒ Each hospital shall establish written policies and procedures for determining the capability of uninsured patients to pay for hospital-based medical services that must, at a minimum, provide for:
   - The collection and review of relevant financial information from the patient.
   - The assessment by the hospital, to the best of its ability, of the patient's eligibility for governmental or charitable assistance.
   - The offer to the patient of any discounts or extended payment terms or plans.
   - The delineation to the patient of the patient's responsibilities for payment and the consequences for failure to pay.
   - The notification to the patient of these policies and procedures shall be included in the patient's hospital bill.

⇒ The term "patient" means an uninsured person who is in the process of being admitted, or in the case of emergency services and care has been admitted, to the hospital.

C. SECTION DIRECTORY:

Section 1. Creates s. 395.3012, F.S., requiring hospitals to establish certain policies and procedures to determine a patient's ability to pay for certain services; providing criteria; requiring notification of a patient of such policies and procedures; and providing a definition.

Section 2. Provides for an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This will require the development of hospital policy and procedures specifically for uninsured patients.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

According to the Agency for Health Care Administration, the proposed legislation conflicts with existing state laws or rules to the extent that the language in (3) of the legislation appears to suggest that "emergency care and treatment" is inpatient in nature, when in fact, the emergency department of a hospital is an outpatient facility with no licensed inpatient beds.

The proposed legislation conflicts with existing federal law or regulations to the extent that federal law and regulations relating to Medicare/Medicaid recognize "emergency care and services" delivered in the emergency department of a hospital to be outpatient in nature, rather than inpatient as is arguably suggested by the current language in (3) of the proposed legislation.

The agency suggests the following amendment:

On Page 2, lines 31 through 34, strike said lines and insert:

"For purposes of this section, the term 'patient' means an uninsured person who is in the process of being admitted, or who, after and as a result of having received emergency services and care, is being admitted to the hospital."

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES