HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 715 w/CS Self-Pay Patients
SPONSOR(S): Llorente and others
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 1958 (s); HB 415 (s)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Standards (Sub)	10 Y, 1 N	Rawlins	Collins
2) Health Care	14 Y, 6 N w/CS	Rawlins	Collins
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officials contend that the pricing rule -- established in the 1960s to ensure that Medicare was not overcharged -- is outdated and prevents them from providing discounts to uninsured patients.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. 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 s. 395.301, F.S.

This bill requires each hospital to develop and make available two payment allowance programs for qualified self-pay patients. The first program requires discounts based on household income with the discounted amount to be determined by the facility. The second program requires a facility to offer a discount to patients with household incomes of up to 300 percent of the federal poverty level at a rate of 200 percent of Medicare reimbursement rates.

The bill prohibits hospitals from pursuing certain civil remedies against such patients.

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 patients 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 reported. The AHA requested 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 claimed 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 make any financial counseling options at the hospitals "widely known." The AHA also suggested 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 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 it 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 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.

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[1] 42 U.S.C. § 1320a-7b(b)

[2] 42 U.S.C. § 1320a-7(b)(6)(A).

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 and 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.

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The bill provides legislative findings which specify that:

- The Legislature recognizes that 2.8 million Floridians are uninsured, which represents one of every five Florida residents aged 65 years or younger.
- The Legislature finds that the cost of providing care to the uninsured population in Florida hospitals is in excess of $1.5 billion.
- The Legislature intends to make health care more affordable and accessible to its uninsured residents.
- The Legislature intends to extend discounts for hospital services to low-income uninsured individuals who have established a domicile in this state as evidence by residing in and maintaining a place of abode in a Florida county which he or she recognizes and intends to maintain as his or her permanent home.

This bill requires each hospital to develop two programs of payment allowances for qualified self-pay patients. Each program provides the following:

- A program of payment allowances for qualified self-pay patients who are treated in the emergency room, admitted through the emergency room, or present for labor and delivery. All patients shall continue to be charged the same rate, but qualified self-pay patients shall be eligible for discounts based on family income. The discount shall be determined by each facility. The discount program shall not apply to patients who are eligible for, or enrolled in, private or public insurance plans providing hospital coverage, including indemnity plans, except high deductible plans.

- A program for payment allowances for patients with household incomes up to 300 percent of the federal poverty guidelines, who are qualified self-pay patients who are treated in the emergency room, admitted through the emergency room, or present for labor and delivery. All patients shall continue to be charged the same rate, but qualified self-pay patients shall be eligible for discounts based on family income. The discount program shall not apply to patients who are eligible for or enrolled in private or public insurance plans providing hospital coverage, including indemnity plans. The policy must include a minimum discount of 200 percent of Medicare rates and a description of the methodologies developed by the hospital for the following:

- ⇒ Identifying patients who may be eligible for a payment allowance, notifying them of the availability of the program, and providing appropriate information, including application forms, for a payment allowance.
- ⇒ Identifying public or private insurance or other payment mechanisms for which the patient might be eligible.
- ⇒ Determining the payment allowance or credit.
- ⇒ Notifying patients of their qualification either for a public source of payment or a discount pursuant to this program.
- ⇒ Developing payment plans and procedures preceding assignment of a patient's account to a third party or reporting nonpayment to a patient's consumer credit agency. For purposes of this program, these patients are considered as qualified self-pay patients.

A "qualified self-pay patient" is defined in the bill as any resident who has established a domicile in Florida, as evidenced by residing in a Florida county which he or she intends to maintain as his or her permanent home, with no public or private source of payment for medical services who would otherwise be expected to pay the hospital's billed charges. The term does not include:

- ⇒ Patients presenting for services that are not covered by Medicare, Medicaid, or workers' compensation in this state or elective, nonmedically necessary services.
- ⇒ Patients who fail to provide income and asset information to determine if the patient is eligible for public or private coverage or for a discount under this program.
- ⇒ Patients with discretionary assets in excess of 50 percent of the billed charges, with discretionary assets defined as the fair market value of personal savings, personal investments, and personal nonhomestead property. Discretionary assets shall not include personal automobiles or business assets.

The bill specifies that no hospital shall foreclose on homestead property that is owned by a qualified self-pay patient. No hospital shall seek a court order to issue a writ of bodily attachment to enforce payment of hospital bills for medical services provided to qualified self-pay patients.

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

C. SECTION DIRECTORY:

Section 1. Provides legislative findings.

Section 2. Amends s. 395.301, F.S., requires hospitals to develop and make available two payment allowance programs for qualified self-pay patients; provides program guidelines and requirements; provides exclusions; provides a definition of patients qualified for such programs; provides exceptions; prohibits hospitals from pursuing certain civil remedies against such patients and makes available a payment allowance program for certain patients; provides program guidelines and requirements; provides exclusions; provides a definition of patients qualified for such program; provides exceptions; and prohibits hospitals from pursuing certain civil remedies against such patients.

Section 3. 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:

The bill requires the development of hospital policies 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:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 10, 2004, the Subcommittee on Health Standards considered HB 715, adopted a strike all amendment, and reported the bill favorably to the Health Care Committee. The strike all amendment differs from the original bill in that it provides legislative findings regarding the uninsured.

On March 23, 2004, the Committee on Health Care adopted a substitute strike all amendment and reported the bill favorably with a committee substitute. The substitute amendment differs from the original bill in that it amends the legislative findings and creates two discount programs for uninsured patients. One program provides for a discount of 200 percent of the Medicare reimbursement rate patients with household incomes up to 300% of the federal poverty level. The other program requires the facility to develop a discount for patients based on the household incomes for the patients who are above 300 percent of the federal poverty level.