House Bill 3349

Sponsored by COMMITTEE ON HEALTH CARE

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Requires hospitals and emergency departments to maintain written charity care policies meeting specified requirements.

A BILL FOR AN ACT

Relating to health care costs.

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) As used in sections 1 to 7 of this 2015 Act:

(a) "Billing entity" means a hospital, an affiliate or a subsidiary of a hospital or any external agency to which a hospital assigns a bill for collection.

(b) "Charity care" has the meaning given that term in ORS 442.200.

(c) "Federal poverty guidelines" means the federal poverty guidelines published and updated annually in the Federal Register by the United States Department of Health and Human Services.

(d) "Financially qualified person" means a patient:

(A)(i) Who is a self-pay patient; or

(ii) With high medical costs; and

(B) Who has a family income that does not exceed 350 percent of the federal poverty guidelines.

(e) "High medical costs" means any of the following:

(A) Annual out-of-pocket costs incurred by a patient for services provided at a hospital that exceed 10 percent of the patient's family income in the prior 12 months.

(B) Annual out-of-pocket medical expenses, including but not limited to hospital costs, that exceed 10 percent of the patient's family income in the prior 12 months, if the patient provides documentation of the medical expenses.

(C) Hospital costs or medical expenses at a lower percentage of the patient's family income as determined by a hospital in accordance with the hospital's charity care policy.

(f) "Hospital" includes:

(A) An acute inpatient care facility as defined in ORS 442.470; and

(B) If an acute care facility contracts with an outside entity to provide services in the facility's emergency department, the outside entity.

(g) "Medical assistance" has the meaning given that term in ORS 414.025.

(h) "Patient" means:

(A) An individual who receives health care at a hospital or emergency department; or

(B) A parent or other person who is financially responsible for the cost of the individual's

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

health care at a hospital or emergency department.

(i) "Patient's family" means:

(A) For persons 18 years of age and older, the patient's spouse and dependent children under 21 years of age, whether living at home or not.

(B) For persons under 18 years of age, the patient's parents, caretaker relatives and other children under 21 years of age of a parent or caretaker relative.

(j) "Person with high medical costs" means a patient:

(A) Whose family income is less than or equal to 350 percent of the federal poverty guidelines or a greater percentage as determined by a hospital; and

(B) Who does not qualify for a discounted rate for hospital care as a result of the patient's third-party coverage.

(k) "Rural hospital" means a type A hospital, a type B hospital or a rural critical access hospital, as defined in ORS 315.613.

(L) "Self-pay patient" means a patient who does not have health insurance or coverage under a self-insured employer plan, is not a beneficiary of a health care service contract or multiple employer welfare arrangement, does not receive medical assistance or Medicare and whose care is not compensable by workers' compensation, automobile insurance or other insurance as determined and documented by a hospital.

(2) A hospital shall comply with the provisions of this section as a condition of licensing under ORS 441.015.

(3)(a) A hospital shall maintain an understandable written policy regarding charity care. Except as provided in subsection (4) of this section, financially qualified persons and persons with high medical costs shall be eligible for charity care.

(b) The written charity care policy maintained by the hospital must explain the process used by the hospital to determine whether a patient is a financially qualified person or a person with high medical costs, and the process for a patient to seek review, if denied charity care, from the business manager, chief financial officer or other person designated in the charity care policy.

(c) If an acute care hospital contracts with a separate entity to provide emergency department services, the entity must have a written charity care policy that complies with sections 1 to 7 of this 2015 Act and with ORS 441.094.

(d) A charity care policy that requires a patient to pay a portion of the hospital costs may not require a payment that exceeds the amount the hospital is permitted to bill Medicare for the same service.

(4) A rural hospital may establish eligibility levels for charity care at greater than 350 percent of the federal poverty guidelines as appropriate to maintain the hospital's financial and operational integrity.

(5) In determining eligibility for charity care, a hospital may consider all of a patient's income and monetary assets, excluding:

(a) Retirement or deferred compensation plans qualified under the Internal Revenue Code;

(b) Nonqualified deferred compensation plans;

(c) The first $10,000 of a patient's monetary assets; and

(d) Fifty percent of a patient's monetary assets over the first $10,000.

(6)(a) A patient applying for charity care shall make every reasonable effort to provide

the billing entity with documentation of income and third-party liability for coverage. If the patient requests charity care and fails to provide information that is reasonable and necessary for the billing entity to make a determination of eligibility, the billing entity shall make its determination based on the information that is available.

(b) As documentation of income, a billing entity may require only recent pay stubs or income tax returns.

(c) A billing entity may require the patient to sign a release of information that authorizes the billing entity to obtain account information from financial or commercial institutions or other entities that hold or maintain the patient's monetary assets to verify the value of the assets.

(d) Information obtained by a billing entity under this subsection may not be used to collect the debt for which charity care is requested, but may be used in the collection of other debts owed to the billing entity.

(7) A patient may request charity care at any time.

SECTION 2. (1) A hospital shall provide each patient with a written notice containing information about the availability of charity care, including but not limited to:

(a) A statement that the patient may qualify for discounted or free care if the patient lacks, or has inadequate, insurance and meets other eligibility requirements;

(b) The eligibility requirements and the Internet address of the website where the patient may download an application for charity care; and

(c) The telephone number and electronic mail address for an employee or office from which the person may obtain an application for charity care and further information about the charity care policy.

(2) The notice must be printed in English and in any other languages spoken by 10 percent or more of the residents in the community served by the hospital. Any written correspondence regarding an application for charity care must be in the language spoken by the patient.

(3) A hospital must post a clearly written and easily understood notice of the hospital's charity care policy in locations that are visible to the public, including but not limited to all of the following:

(a) The emergency department, if any.

(b) The billing office.

(c) The admitting office.

(d) Outpatient settings.

SECTION 3. (1) A hospital shall make all reasonable efforts to obtain from a patient information about whether a third party may fully or partially cover the charges for care provided to the patient, including but not limited to any of the following:

(a) Private health insurance.

(b) Medicare.

(c) Medical assistance.

(2) If a patient has not provided proof of coverage by a third party at the time the care is provided or upon discharge, the bill shall include, clearly and conspicuously, all of the following:

(a) A statement of charges for services.

(b) A request that the patient inform the hospital if the patient has health insurance

coverage, Medicare, medical assistance or other coverage.

(c) A statement that, if the patient does not have health insurance coverage, the patient may be eligible for medical assistance or charity care.

(d) An explanation of how to apply for medical assistance and charity care.

(e) The notice described in section 2 of this 2015 Act.

(3) If a patient does not indicate that the patient has third party coverage before the patient is discharged from the hospital or emergency department, the hospital or emergency department shall provide the patient, prior to or upon discharge, with:

(a) An application for medical assistance; and

(b) An application for charity care.

SECTION 4. (1) A hospital shall maintain a written policy prescribing the standards and practices for the collection of debt, and shall obtain a written agreement from any external agency that collects patient debt that the agency will adhere to the written standards and practices. The policy may not conflict with other applicable laws and shall not be construed to create a joint venture between the hospital and the external agency or otherwise allow a hospital to govern the external agency that collects the hospital's patient debts. The hospital or external agency may consider only income and monetary assets, as limited by section 1 of this 2015 Act, in determining the amount of debt that may be recovered.

(2) The written policy described in subsection (1) of this section shall include a designation of who has authority to advance a patient debt for collection, and whether the collection activity is conducted by the hospital, an affiliate or subsidiary of the hospital, or by an external agency.

(3) A bill for hospital or emergency department services shall include the same information concerning services and charges provided to all other patients who receive care at the hospital or emergency department.

(4) If a patient lacks health insurance coverage or provides information indicating that the patient may be a financially qualified person or a person with high medical costs, a billing entity may not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment less than 150 days after the initial billing.

(5) If a patient is attempting to qualify for charity care or is attempting in good faith to settle an outstanding bill by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the bill may not be assigned to a collection agency unless the collection agency has agreed to comply with this section.

(6) A billing entity shall not, in dealing with patients eligible for charity care, use any of the following means of collection:

(a) A lien on a primary residence.

(b) A wage garnishment, except by a court order on a motion served on the patient and supported by a declaration or affidavit filed by the movant identifying the basis for concluding that the patient has the ability to make payments on the judgment under the wage garnishment. The court, in deciding the motion, shall consider the size of the judgment and additional information provided by the patient prior to, or at, the hearing concerning the patient's ability to pay, including information about probable future medical expenses based on the current condition of the patient and other obligations of the patient.

(c) Send notice of or conduct a sale of the patient's primary residence during the life of

the patient or the patient's spouse or during the period a child of the patient is a minor, or a child of the patient who has attained the age of majority still requires care and resides in the dwelling as the child's primary residence. If the patient owns more than one dwelling, the primary residence shall be the dwelling that is the patient's homestead, as that term is used in ORS 18.395.

(7) This section does not preclude a billing entity from pursuing reimbursement and any enforcement remedy from any third parties that may be liable for the costs.

(8) Any extended payment plan offered under a charity care policy may not charge interest. The billing entity may not find a patient to be in default on an extended payment plan until:

(a) The patient has failed to make all consecutive payments due during a 90-day period;

(b) The billing entity has made a reasonable attempt to contact the patient by telephone at the patient's last known telephone number, and to give notice in writing at the patient's last known address, that the extended payment plan is in default;

(c) The billing entity has notified the patient of the opportunity to renegotiate the extended payment plan; and

(d) The billing entity has attempted to renegotiate the terms of the defaulted extended payment plan, if requested by the patient.

(9) A billing entity may not report adverse information to a consumer credit reporting agency or commence a civil action against a patient for failing to make payments on an extended payment plan before the billing entity has completed all of the required actions in subsection (8) of this section.

(10) If a patient makes a reasonable effort to notify the billing entity that the patient has initiated an appeal of an adverse benefit determination, as defined in ORS 743.801, denial of Medicare coverage or denial of medical assistance, the billing entity may not undertake collection actions until the patient:

(a) With respect to an adverse benefit determination, has exhausted or is deemed to have exhausted the internal appeal process under ORS 743.804, and exhausted or has failed to apply for an external review under ORS 743.857;

(b) With respect to the denial of medical assistance, has received a final order in a contested case or dismissal of the appeal; or

(c) Has received an order from an administrative law judge on the denial of the Medicare claim.

(11) This section shall not be construed to diminish or eliminate any protections for consumers under existing federal and state debt collection laws, or any other consumer protections available under state or federal law. If a billing entity has complied with the requirements of subsection (8) of this section, this section does not limit or alter the obligation of the patient to make payments on the obligation owing to the billing entity under any contract or applicable statute from the date that the billing entity has complied with the requirements of subsection (8) of this section.

SECTION 5. (1) Prior to commencing collection activities against a patient, a billing entity shall provide the patient with a clear and conspicuous written notice containing a summary of:

(a) Sections 1 to 7 of this 2015 Act;

(b) ORS 646.639;

(c) The Fair Debt Collection Practices Act (Public Law 95-109, 15 U.S.C. 1692 et seq.); and

(d) A statement that the Federal Trade Commission enforces the federal act and an explanation of the procedure for filing a complaint with the commission, including the toll-free telephone number and Internet website of the commission.

(2) The summary required by subsection (1) of this section must include, but is not limited to, a statement that nonprofit credit counseling services may be available in the area and an explanation that state and federal law:

(a) Requires a debt collector to treat a debtor fairly;

(b) Prohibits debt collectors from making false statement or threats of violence, or using obscene or profane language;

(c) Prohibits a debt collector from making improper communications with third parties, including the patient's employer;

(d) Prohibits a debt collector, except under unusual circumstances, from contacting a debtor before 8:00 a.m. or after 9:00 p.m.;

(e) Prohibits a debt collector from giving information about a debt to a person, other than the debtor, the debtor's attorney or the debtor's spouse; and

(f) Allows a debt collector to contact another person to confirm the debtor's location or to enforce a judgment.

(3) The notice required by this section must also be included in any document mailed to the patient that indicates that collection activities may begin.

SECTION 6. (1) A hospital shall provide to the Oregon Health Authority, in the manner prescribed by the authority, the hospital's charity care policy, the application form for charity care, an explanation of the application procedures for charity care and the process for reviewing a denial of charity care. The hospital shall provide the information whenever the hospital significantly changes the information and, at least biennially, shall provide the information or notify the authority that no changes were made.

(2) The authority shall make the information provided under this section readily available to the public.

SECTION 7. (1) Sections 1 to 7 of this 2015 Act do not prohibit a hospital from uniformly imposing charges from its established charge schedule or published rates or preclude the recognition of a hospital's established charge schedule or published rates for purposes of applying any payment limit, interim payment amount or other payment calculation based upon a hospital's rates or charges under the medical assistance program, the Medicare program, workers' compensation or other federal, state or local public program of health benefits. A health care service contractor, insurer or any other person liable for the cost of a patient's care may not reduce the amount it would otherwise reimburse a claim for hospital services because a hospital has waived, or will waive, collection of all or a portion of the patient's bill for hospital services in accordance with the hospital's charity care policy, notwithstanding any contractual provision.

(2) The amounts paid by patients under a charity care policy shall not constitute a hospital's uniform, published, prevailing or customary charges, the hospital's usual fees to the general public or the hospital's charges to the medical assistance program, and may not be used to calculate a hospital's median non-Medicare or medical assistance charges for purposes of any payment limit under the federal Medicare program, the medical assistance program or any other publicly financed health care program.

(3) If any requirement in sections 1 to 7 of this 2015 Act results in a federal determination that a hospital's established charge schedule or published rates are not the hospital's customary or prevailing charges for services, the requirement shall be inoperative for all hospitals, including but not limited to a hospital that is licensed and operated by a county or a hospital authority pursuant to ORS 441.525 to 441.595.

SECTION 8. Sections 1 to 7 of this 2015 Act apply to charges billed for hospital and emergency department services received on or after the effective date of this 2015 Act.
