PA 21-129—sSB 683
Public Health Committee
Appropriations Committee

AN ACT CONCERNING HOSPITAL BILLING AND COLLECTION EFFORTS BY HOSPITALS AND COLLECTION AGENCIES

SUMMARY: This act extends certain hospital collection laws to cover entities that are owned by, or affiliated with, hospitals. By doing so, it prohibits these related entities, and not just hospitals, from (1) collecting from an uninsured patient more than the cost of providing health care services, (2) referring certain patients to collection agencies, and (3) continuing collection efforts in certain situations until they determine whether the patient is eligible for debt reduction or elimination.

It also limits or restricts when hospitals, these related entities, and collection agents may refer patients to credit rating agencies, foreclose a lien on a patient's primary residence, or garnish a patient's wages.

Additionally, the act makes several changes to laws on facility fees for outpatient services at hospital-based facilities. For example, it (1) expands the type of procedural codes for which hospitals, health systems, and hospital-based facilities may not charge facility fees in certain circumstances; (2) requires various patient notices to include information in 15 languages on free language assistance services; (3) expands certain existing reporting requirements; and (4) establishes new reporting requirements.

The act requires the Office of Health Strategy (OHS) to (1) within available appropriations, study certain matters regarding physician practices and oversight of practice mergers and acquisitions and (2) report to the Public Health Committee by February 1, 2023.

It also makes various minor, technical, and conforming changes.

EFFECTIVE DATE: October 1, 2022, except the OHS reporting provisions take effect upon passage.

§§ 1-3 — HOSPITAL DEBT COLLECTION

Definitions

The act extends certain hospital debt collection laws to cover entities that are owned by, or affiliated with, hospitals. For these purposes, the act defines "owned by" as owned by a hospital or health system when billed under the hospital's tax identification number. It defines "affiliated with" as:

1. being employed by a hospital or health system,
2. being under a professional services agreement with a hospital or health system that allows the hospital or health system to bill on the entity's

behalf, or
3. a clinical faculty member of a medical school who is affiliated with a hospital or health system in a manner that allows the hospital or health system to bill on the faculty member's behalf.

Collection Limits (§ 1)

Existing law prohibits hospitals from collecting from an uninsured patient more than the cost of providing the services. The act extends this prohibition to (1) all licensed hospitals, not just short-term general hospitals, and (2) entities owned by, or affiliated with, hospitals.

For these purposes, existing law generally defines an "uninsured patient" as someone with an income at or below 250% of the federal poverty level (FPL) (i.e., in 2021, $32,200 for an individual) who (1) applied for Medicaid but did not qualify and (2) is not eligible for coverage under Medicare or another governmental or private insurance plan.

Initiation of Debt Collection and Other Activities (§ 2)

Existing law generally prohibits a hospital from referring a patient's unpaid bill to a collection agent or initiating an action against a patient or his or her estate, unless it determined that the individual is uninsured and not eligible for a bed fund. (Generally, a hospital bed fund refers to gifts of money, stock, or other property to a hospital to provide free patient care.) The act extends these provisions to entities owned by or affiliated with hospitals. It also specifies that these provisions apply to all DPH-licensed hospitals.

The act also prohibits hospitals, entities owned by or affiliated with them, and collection agents who receive their referrals from taking the following actions related to a health care debt for services provided on or after October 1, 2022:

1. reporting a patient to a credit rating agency until at least a year after the patient receives a bill;
2. bringing an action to foreclose a lien that was filed on the patient's primary residence (see BACKGROUND, *Related Act*); or
3. if the patient is eligible for the hospital bed fund, attempting to garnish his or her wages to collect payment.

Existing law specifies that the restriction on hospital collection activities does not affect a hospital's ability to bring an action against a patient or an estate in certain circumstances. The act extends these provisions to (1) entities owned by, or affiliated with, hospitals and (2) the provisions described above (e.g., the provisions on garnishing wages). As a result, hospitals and other entities may bring an action against a patient or an estate:

1. to collect coinsurance, deductibles, or fees that are eligible for reimbursement through awards, settlements, or judgments; or
2. when payment or reimbursement has been made, or likely will be made, directly to the patient.

Suspension of Debt Collection (§ 3)

Existing law requires hospitals and collection agents to discontinue collection efforts when they become aware that a hospital debtor received information that he or she is eligible for hospital bed funds, free or reduced-price hospital care, or any other program that would eliminate or reduce debt liability. They must refer the collection file for an eligibility determination, and collection cannot resume until the determination is made.

The act extends these provisions to entities owned by or affiliated with hospitals.

§ 4 — FACILITY FEES

The act makes several changes to facility fee laws. By law, a "facility fee" is any fee a hospital or health system charges or bills for outpatient hospital services provided in a hospital-based facility that is (1) intended to compensate the hospital or health system for its operational expenses and (2) separate from the provider's professional fee.

Facility Fee Limits (§ 4(l))

In some circumstances, existing law limits the facility fees that hospitals, health systems, and hospital-based facilities may charge for outpatient services provided off-site from a hospital campus. This includes a general prohibition on facility fees for outpatient services that use a current procedural terminology evaluation and management (CPT E/M) code. The act extends this prohibition to such services that use a current procedural terminology assessment and management (CPT A/M) code. As under existing law, these limits do not apply to (1) freestanding emergency departments or (2) Medicare or Medicaid patients or patients receiving services under a workers' compensation plan.

Under existing law and the act, a facility that violates these fee prohibitions has committed an unfair trade practice (see BACKGROUND).

Under prior law, if an insurance contract in effect on July 1, 2016, provided reimbursement for facility fees that were otherwise prohibited by law, the hospital or health system could continue to collect reimbursement from insurers for these fees until the contract expired. The act instead specifies that they may continue to collect this reimbursement until the earlier of the contract's expiration, renewal, or amendment.

Patient Notification Requirements (§ 4(b))

Under existing law, hospitals or health systems that charge facility fees must notify patients receiving outpatient services, in writing, about their potential financial liability. The notice must provide additional information when the hospital or health system (1) uses CPT E/M codes for these services and (2) expects to charge a separate fee for professional medical services. The act also applies the additional notice requirements if the hospital or health system uses

CPT A/M codes in these situations.

Generally, the notice must include, among other things, (1) the amount of the patient's potential financial liability or (2) an estimate, based on the facility's typical or average charges, if the exact type and extent of services are unknown or the terms of the patient's insurance coverage are not known with reasonable certainty.

As under existing law, the above notice requirements do not apply to Medicare or Medicaid patients or those receiving services under a workers' compensation plan.

Initial Billing Statements (§ 4(d))

By law, initial billing statements that include a facility fee generally must meet certain requirements, such as clearly identifying the facility fee as separate from the provider's professional fee, if any. These requirements do not apply to billing statements for Medicare or Medicaid patients or those receiving services under a workers' compensation plan.

Starting by October 15, 2022, the act requires each hospital, health system, and hospital-based facility to annually submit to OHS's Health Systems Planning Unit a sample of its billing statement with the required information. The sample must (1) represent the statement format that patients receive and (2) not contain patient identifying information.

Posted Notice (§ 4(h))

Under existing law, a hospital-based facility must prominently display a written notice in locations that are readily accessible and visible to patients, including patient waiting areas. The act specifically requires these facilities to post the notice in appointment check-in areas. It also requires each hospital-based facility, starting by October 1, 2022, to annually submit a copy of this notice to OHS's Health Systems Planning Unit.

By law, the notice must inform patients that (1) the facility is part of a hospital or health system (named on the notice) and (2) if the facility charges a facility fee, patients may incur a greater financial liability than if the facility was not hospital-based.

Tag Lines for Patient Notices, Billing Statements, and Posted Notices (§ 4(e), (h))

Starting October 1, 2022, the act requires the above notices (the facility fee notices, initial billing statement patient notices, and posted notices) to include tag lines in at least the top 15 languages spoken in the state, indicating that the notice is available in those languages. Under the act, a "tag line" is a short statement written in a non-English language, indicating the availability of free language assistance services.

In choosing which languages to include, the hospital or heath system must use either:

1. the list published by the federal Department of Health and Human Services, in connection with specified non-discrimination provisions under the Patient Protection and Affordable Care Act, or
2. the top 15 languages spoken in the facility's geographic area, as determined by the hospital or health system.

Notice of Certain Transactions (§ 4(k))

Under existing law, if a transaction materially changes the business or corporate structure of a physician group practice and establishes a hospital-based facility at which facility fees could be billed, the hospital or health system purchasing the practice must notify each patient the practice served in the previous three years.

The act adds to the notice contents the (1) purchased facility's full legal and business name and (2) acquisition date.

Starting by July 1, 2023, the act requires each hospital-based facility that was subject to such a transaction (i.e., materially changing the structure of a group practice) during the prior calendar year to report on patient volume. Specifically, these facilities must annually report to the Health Systems Planning Unit on the number of patients they served in the prior three years.

Reporting (§ 4(m))

Existing law requires each hospital and health system to annually report to OHS on the facility fees it charged or billed the prior year at hospital-based facilities outside a hospital campus. Beginning with reports due July 1, 2023, the act (1) specifies that they must report on a form prescribed by the OHS executive director and (2) modifies the required information for these reports.

Prior law required the reports to include the number, total amount, and range of allowable facility fees paid at each facility by Medicare, Medicaid, and private insurance policies. The act instead requires this information to be disaggregated by payer mix, including not just the payment sources listed above but also other government-provided insurance and self-pay patients.

Existing law requires the reports to include the amount of the hospital's or health system's facility fee revenue from these facilities, per facility and in the aggregate. The act additionally requires the reports to include the amount of facility fees charged.

Under existing law, the reports must describe the 10 procedures or services that generated the most facility fee revenue. The act (1) specifies that this applies to gross revenue and (2) requires this information to be disaggregated by CPT code for each such procedure or service.

Existing law requires the reports to include the total revenue derived from these fees for each such procedure or service. The act requires this for both gross and net revenue, and additionally requires reporting on patient volume for these procedures and services.

The act also requires the reports to include the (1) top 10 procedures or

services, not just procedures, for which facility fees are charged, based on patient volume, and (2) gross and net revenue for them.

As under existing law, the OHS executive director must publish the reported information, or post a link to it, on OHS's website.

§ 5 — OHS STUDY ON PHYSICIAN PRACTICES

The act requires OHS to do the following, within available appropriations:

1. study ways to improve oversight and regulation of physician practice mergers and acquisitions to improve health care quality and choice in the state, including reviewing laws on (a) transaction notice and reporting and (b) certificate of need guidelines and definitions;
2. study ways to ensure the viability of physician practices; and
3. develop legislative recommendations to improve reporting and oversight of physician practice mergers and acquisitions, including whether any of the above referenced laws need to be amended.

By February 1, 2023, the OHS executive director must report to the Public Health Committee on the study's outcome and any legislative recommendations.

BACKGROUND

Related Act

Connecticut law exempts certain property from court judgment. With some exceptions, PA 21-161 increases the homestead exemption to $250,000; under prior law, the exemption was $125,000 for judgments arising from hospital services and $75,000 for other judgments.

Connecticut Unfair Trade Practices Act (CUTPA)

The law prohibits businesses from engaging in unfair and deceptive acts or practices. CUTPA allows the consumer protection commissioner to issue regulations defining what constitutes an unfair trade practice, investigate complaints, issue cease and desist orders, order restitution in cases involving less than $10,000, enter into consent agreements, ask the attorney general to seek injunctive relief, and accept voluntary statements of compliance. It also allows individuals to sue. Courts may issue restraining orders; award actual and punitive damages, costs, and reasonable attorney's fees; and impose civil penalties of up to $5,000 for willful violations and $25,000 for a violation of a restraining order.