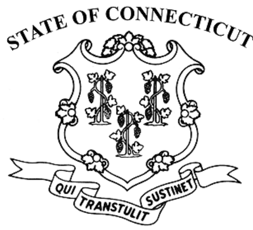

General Assembly

Amendment

January Session, 2021

LCO No. **7888**

Offered by:
SEN. LOONEY, 11th Dist.

To: Subst. Senate Bill No. **683** File No. 447 Cal. No. 279

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

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. Section 19a-673 of the general statutes is repealed and the
4 following is substituted in lieu thereof (*Effective October 1, 2021*):

5 (a) As used in this section:

6 (1) "Collection agent" has the same meaning as provided in section
7 19a-509b.

8 **[**(1)**]** (2) "Cost of providing services" means a hospital's published
9 charges at the time of billing, multiplied by the hospital's most recent
10 relationship of costs to charges as taken from the hospital's most recently
11 available annual financial filing with the unit.

12 **[**(2)**]** (3) "Hospital" **[**means an institution licensed by the Department
13 of Public Health as a short-term general hospital**]** has the same meaning

14 as provided in section 19a-490.

15 [(3)] (4) "Poverty income guidelines" means the poverty income
16 guidelines issued from time to time by the United States Department of
17 Health and Human Services.

18 [(4)] (5) "Uninsured patient" means any person who is liable for one
19 or more hospital charges whose income is at or below two hundred fifty
20 per cent of the poverty income guidelines who (A) has applied and been
21 denied eligibility for any medical or health care coverage provided
22 under the Medicaid program due to failure to satisfy income or other
23 eligibility requirements, and (B) is not eligible for coverage for hospital
24 services under the Medicare or CHAMPUS programs, or under any
25 Medicaid or health insurance program of any other nation, state,
26 territory or commonwealth, or under any other governmental or
27 privately sponsored health or accident insurance or benefit program
28 including, but not limited to, workers' compensation and awards,
29 settlements or judgments arising from claims, suits or proceedings
30 involving motor vehicle accidents or alleged negligence.

31 (b) No hospital or entity that is owned by or affiliated with such
32 hospital that has provided health care [services] to an uninsured patient
33 may collect from the uninsured patient more than the cost of providing
34 [services] such health care.

35 (c) Each collection agent [, as defined in section 19a-509b,] engaged in
36 collecting a debt from a patient arising from [services] health care
37 provided at a hospital shall provide written notice to such patient as to
38 whether the hospital deems the patient an insured patient or [an]
39 uninsured patient and the reasons for such determination.

40 Sec. 2. Section 19a-673b of the general statutes is repealed and the
41 following is substituted in lieu thereof (*Effective October 1, 2021*):

42 (a) No hospital, as defined in section 19a-490, or entity that is owned
43 by or affiliated with such hospital shall refer to a collection agent, as
44 defined in section 19a-509b, or initiate an action against an individual

45 patient or such patient's estate to collect fees arising from health care
46 provided at a hospital or entity that is owned by or affiliated with such
47 hospital on or after October 1, 2003, unless the hospital or entity that is
48 owned by or affiliated with such hospital has **[**made a determination
49 whether**]** determined that such individual patient is **[**(1)**]** an uninsured
50 patient, as defined in section 19a-673, as amended by this act, **[**and (2)
51 not eligible**]** who is ineligible for the hospital bed fund.

52 (b) On or after October 1, 2021, no hospital or entity that is owned by
53 or affiliated with such hospital, as defined in section 19a-490, and no
54 collection agent, as defined in section 19a-509b, that receives a referral
55 from a hospital or entity that is owned by or affiliated with such
56 hospital, shall:

57 (1) Report an individual patient to a credit rating agency, as defined
58 in section 36a-695, for a period of one year beginning on the date that
59 such patient first receives a bill for health care provided by the hospital
60 or entity that is owned by or affiliated with such hospital to such patient
61 on or after October 1, 2021;

62 (2) Initiate an action to foreclose a lien on an individual patient's
63 primary residence if the lien was filed to secure payment for health care
64 provided by the hospital or entity that is owned by or affiliated with
65 such hospital to such patient on or after October 1, 2021; or

66 (3) Apply to a court for an execution against an individual patient's
67 wages pursuant to section 52-361a, or otherwise seek to garnish such
68 patient's wages, to collect payment for health care provided by the
69 hospital or entity that is owned by or affiliated with such hospital to
70 such patient on or after October 1, 2021, if such patient is eligible for the
71 hospital bed fund.

72 **[**(b)**]** (c) Nothing in **[**this**]** subsection (a) or (b) of this section shall
73 affect **[**a hospital's**]** the ability of a hospital or entity that is owned by or
74 affiliated with such hospital to initiate an action against an individual
75 patient or such patient's estate to collect coinsurance, deductibles or fees
76 arising from health care provided at a hospital or entity that is owned

77 by or affiliated with such hospital where such coinsurance, deductibles
78 or fees may be eligible for reimbursement through awards, settlements
79 or judgments arising from claims, suits or proceedings. In addition,
80 nothing in [this section] said subsections shall affect [a hospital's] the
81 ability of a hospital or entity that is owned by or affiliated with such
82 hospital to initiate an action against an individual patient or such
83 patient's estate where payment or reimbursement has been made, or
84 likely is to be made, directly to the patient.

85 Sec. 3. Section 19a-673d of the general statutes is repealed and the
86 following is substituted in lieu thereof (*Effective October 1, 2021*):

87 If, at any point in the debt collection process, whether before or after
88 the entry of judgment, a hospital [, a consumer collection agency acting
89 on behalf of the hospital, an attorney representing the hospital or any
90 employee or agent of the hospital] or entity that is owned by or affiliated
91 with such hospital, as defined in section 19a-490, or a collection agent,
92 as defined in section 19a-509b, becomes aware that a debtor from whom
93 the hospital or entity that is owned by or affiliated with such hospital is
94 seeking payment for [services] health care rendered receives
95 information that the debtor is eligible for hospital bed funds, free or
96 reduced price hospital services [,] or any other program which would
97 result in the elimination of liability for the debt or reduction in the
98 amount of such liability, [the] such hospital [, collection agency,
99 attorney, employee or agent] or entity that is owned by or affiliated with
100 such hospital or collection agent shall promptly discontinue all
101 collection efforts against such debtor for such health care and refer the
102 collection file for such health care to [the] such hospital [for
103 determination of such eligibility. The] or entity that is owned by or
104 affiliated with such hospital until such hospital or entity determines
105 whether such debtor is eligible for such elimination or reduction. Such
106 collection [effort] efforts shall not resume until such hospital or entity
107 makes such determination. [is made.]

108 Sec. 4. Section 19a-508c of the general statutes is repealed and the
109 following is substituted in lieu thereof (*Effective from passage*):

110 (a) As used in this section:

111 (1) "Affiliated provider" means a provider that is: (A) Employed by a
112 hospital or health system, (B) under a professional services agreement
113 with a hospital or health system that permits such hospital or health
114 system to bill on behalf of such provider, or (C) a clinical faculty member
115 of a medical school, as defined in section 33-182aa, that is affiliated with
116 a hospital or health system in a manner that permits such hospital or
117 health system to bill on behalf of such clinical faculty member;

118 (2) "Campus" means: (A) The physical area immediately adjacent to a
119 hospital's main buildings and other areas and structures that are not
120 strictly contiguous to the main buildings but are located within two
121 hundred fifty yards of the main buildings, or (B) any other area that has
122 been determined on an individual case basis by the Centers for Medicare
123 and Medicaid Services to be part of a hospital's campus;

124 (3) "Facility fee" means any fee charged or billed by a hospital or
125 health system for outpatient services provided in a hospital-based
126 facility that is: (A) Intended to compensate the hospital or health system
127 for the operational expenses of the hospital or health system, and (B)
128 separate and distinct from a professional fee;

129 (4) "Health system" means: (A) A parent corporation of one or more
130 hospitals and any entity affiliated with such parent corporation through
131 ownership, governance, membership or other means, or (B) a hospital
132 and any entity affiliated with such hospital through ownership,
133 governance, membership or other means;

134 (5) "Hospital" has the same meaning as provided in section 19a-490;

135 (6) "Hospital-based facility" means a facility that is owned or
136 operated, in whole or in part, by a hospital or health system where
137 hospital or professional medical services are provided;

138 <u>(7) "Payer mix" means the proportion of different sources of payment</u>
139 <u>received by a hospital or health system, including, but not limited to,</u>

140 Medicare, Medicaid, other government-provided insurance, private
141 insurance and self-pay patients;

142 **[**(7)**]** (8) "Professional fee" means any fee charged or billed by a
143 provider for professional medical services provided in a hospital-based
144 facility; **[**and**]**

145 **[**(8)**]** (9) "Provider" means an individual, entity, corporation or health
146 care provider, whether for profit or nonprofit, whose primary purpose
147 is to provide professional medical services; and

148 (10) "Tagline" means a short statement written in a non-English
149 language that indicates the availability of language assistance services
150 free of charge.

151 (b) If a hospital or health system charges a facility fee utilizing a
152 current procedural terminology evaluation and management (CPT
153 E/M) code or assessment and management (CPT A/M) code for
154 outpatient services provided at a hospital-based facility where a
155 professional fee is also expected to be charged, the hospital or health
156 system shall provide the patient with a written notice that includes the
157 following information:

158 (1) That the hospital-based facility is part of a hospital or health
159 system and that the hospital or health system charges a facility fee that
160 is in addition to and separate from the professional fee charged by the
161 provider;

162 (2) (A) The amount of the patient's potential financial liability,
163 including any facility fee likely to be charged, and, where professional
164 medical services are provided by an affiliated provider, any professional
165 fee likely to be charged, or, if the exact type and extent of the
166 professional medical services needed are not known or the terms of a
167 patient's health insurance coverage are not known with reasonable
168 certainty, an estimate of the patient's financial liability based on typical
169 or average charges for visits to the hospital-based facility, including the
170 facility fee, (B) a statement that the patient's actual financial liability will

171 depend on the professional medical services actually provided to the
172 patient, (C) an explanation that the patient may incur financial liability
173 that is greater than the patient would incur if the professional medical
174 services were not provided by a hospital-based facility, and (D) a
175 telephone number the patient may call for additional information
176 regarding such patient's potential financial liability, including an
177 estimate of the facility fee likely to be charged based on the scheduled
178 professional medical services; and

179 (3) That a patient covered by a health insurance policy should contact
180 the health insurer for additional information regarding the hospital's or
181 health system's charges and fees, including the patient's potential
182 financial liability, if any, for such charges and fees.

183 (c) If a hospital or health system charges a facility fee without
184 utilizing a current procedural terminology evaluation and management
185 (CPT E/M) code for outpatient services provided at a hospital-based
186 facility, located outside the hospital campus, the hospital or health
187 system shall provide the patient with a written notice that includes the
188 following information:

189 (1) That the hospital-based facility is part of a hospital or health
190 system and that the hospital or health system charges a facility fee that
191 may be in addition to and separate from the professional fee charged by
192 a provider;

193 (2) (A) A statement that the patient's actual financial liability will
194 depend on the professional medical services actually provided to the
195 patient, (B) an explanation that the patient may incur financial liability
196 that is greater than the patient would incur if the hospital-based facility
197 was not hospital-based, and (C) a telephone number the patient may call
198 for additional information regarding such patient's potential financial
199 liability, including an estimate of the facility fee likely to be charged
200 based on the scheduled professional medical services; and

201 (3) That a patient covered by a health insurance policy should contact
202 the health insurer for additional information regarding the hospital's or

203 health system's charges and fees, including the patient's potential
204 financial liability, if any, for such charges and fees.

205 (d) [On and after January 1, 2016, each] Each initial billing statement
206 that includes a facility fee shall: (1) Clearly identify the fee as a facility
207 fee that is billed in addition to, or separately from, any professional fee
208 billed by the provider; (2) provide the corresponding Medicare facility
209 fee reimbursement rate for the same service as a comparison or, if there
210 is no corresponding Medicare facility fee for such service, (A) the
211 approximate amount Medicare would have paid the hospital for the
212 facility fee on the billing statement, or (B) the percentage of the hospital's
213 charges that Medicare would have paid the hospital for the facility fee;
214 (3) include a statement that the facility fee is intended to cover the
215 hospital's or health system's operational expenses; (4) inform the patient
216 that the patient's financial liability may have been less if the services had
217 been provided at a facility not owned or operated by the hospital or
218 health system; and (5) include written notice of the patient's right to
219 request a reduction in the facility fee or any other portion of the bill and
220 a telephone number that the patient may use to request such a reduction
221 without regard to whether such patient qualifies for, or is likely to be
222 granted, any reduction. Not later than October 1, 2021, and annually
223 thereafter, each hospital, health system and hospital-based facility shall
224 submit to the Health Planning Unit of the Office of Health Strategy a
225 sample of a billing statement issued by such hospital, health system or
226 hospital-based facility that complies with the provisions of this
227 subsection and which represents the format of billing statements
228 received by patients. Such billing statement shall not contain patient
229 identifying information.

230 (e) The written notice described in subsections (b) to (d), inclusive,
231 and (h) to (j), inclusive, of this section shall be in plain language and in
232 a form that may be reasonably understood by a patient who does not
233 possess special knowledge regarding hospital or health system facility
234 fee charges. On and after October 1, 2021, such written notice shall
235 include taglines in at least the top fifteen languages spoken by
236 individuals with limited English proficiency in the geographic area of

237 the hospital-based facility.

238 (f) (1) For nonemergency care, if a patient's appointment is scheduled
239 to occur ten or more days after the appointment is made, such written
240 notice shall be sent to the patient by first class mail, encrypted electronic
241 mail or a secure patient Internet portal not less than three days after the
242 appointment is made. If an appointment is scheduled to occur less than
243 ten days after the appointment is made or if the patient arrives without
244 an appointment, such notice shall be hand-delivered to the patient when
245 the patient arrives at the hospital-based facility.

246 (2) For emergency care, such written notice shall be provided to the
247 patient as soon as practicable after the patient is stabilized in accordance
248 with the federal Emergency Medical Treatment and Active Labor Act,
249 42 USC 1395dd, as amended from time to time, or is determined not to
250 have an emergency medical condition and before the patient leaves the
251 hospital-based facility. If the patient is unconscious, under great duress
252 or for any other reason unable to read the notice and understand and
253 act on his or her rights, the notice shall be provided to the patient's
254 representative as soon as practicable.

255 (g) Subsections (b) to (f), inclusive, and (l) of this section shall not
256 apply if a patient is insured by Medicare or Medicaid or is receiving
257 services under a workers' compensation plan established to provide
258 medical services pursuant to chapter 568.

259 (h) A hospital-based facility shall prominently display written notice
260 in locations that are readily accessible to and visible by patients,
261 including patient waiting or appointment check-in areas, stating: (1)
262 That the hospital-based facility is part of a hospital or health system, (2)
263 the name of the hospital or health system, and (3) that if the hospital-
264 based facility charges a facility fee, the patient may incur a financial
265 liability greater than the patient would incur if the hospital-based
266 facility was not hospital-based. On and after October 1, 2021, such
267 written notice shall include taglines in at least the top fifteen languages
268 spoken by individuals with limited English proficiency in the

269 geographic area of the hospital-based facility. Not later than October 1,
270 2021, and annually thereafter, each hospital-based facility shall submit
271 a copy of the written notice required by this subsection to the Health
272 Systems Planning Unit of the Office of Health Strategy.

273 (i) A hospital-based facility shall clearly hold itself out to the public
274 and payers as being hospital-based, including, at a minimum, by stating
275 the name of the hospital or health system in its signage, marketing
276 materials, Internet web sites and stationery.

277 (j) A hospital-based facility shall, when scheduling services for which
278 a facility fee may be charged, inform the patient (1) that the hospital-
279 based facility is part of a hospital or health system, (2) of the name of the
280 hospital or health system, (3) that the hospital or health system may
281 charge a facility fee in addition to and separate from the professional fee
282 charged by the provider, and (4) of the telephone number the patient
283 may call for additional information regarding such patient's potential
284 financial liability.

285 (k) (1) **[**On and after January 1, 2016, if any transaction, as**]** If any
286 transaction described in subsection (c) of section 19a-486i, results in the
287 establishment of a hospital-based facility at which facility fees **[**will
288 likely**]** may be billed, the hospital or health system, that is the purchaser
289 in such transaction shall, not later than thirty days after such transaction,
290 provide written notice, by first class mail, of the transaction to each
291 patient served within the **[**previous**]** three years preceding the date of
292 the transaction by the health care facility that has been purchased as part
293 of such transaction. On and after January 1, 2022, such hospital or health
294 system shall, not later than thirty days after such transaction, provide
295 written notice by first class mail, or any other method, to each patient
296 served within the three years preceding the date of the transaction by
297 the health care facility that has been purchased as part of such
298 transaction.

299 (2) Such notice shall include the following information:

300 (A) A statement that the health care facility is now a hospital-based

301 facility and is part of a hospital or health system, the health care facility's
302 full legal and business name and the date of such facility's acquisition
303 by a hospital or health system;

304 (B) The name, business address and phone number of the hospital or
305 health system that is the purchaser of the health care facility;

306 (C) A statement that the hospital-based facility bills, or is likely to bill,
307 patients a facility fee that may be in addition to, and separate from, any
308 professional fee billed by a health care provider at the hospital-based
309 facility;

310 (D) (i) A statement that the patient's actual financial liability will
311 depend on the professional medical services actually provided to the
312 patient, and (ii) an explanation that the patient may incur financial
313 liability that is greater than the patient would incur if the hospital-based
314 facility were not a hospital-based facility;

315 (E) The estimated amount or range of amounts the hospital-based
316 facility may bill for a facility fee or an example of the average facility fee
317 billed at such hospital-based facility for the most common services
318 provided at such hospital-based facility; and

319 (F) A statement that, prior to seeking services at such hospital-based
320 facility, a patient covered by a health insurance policy should contact
321 the patient's health insurer for additional information regarding the
322 hospital-based facility fees, including the patient's potential financial
323 liability, if any, for such fees.

324 (3) A copy of the written notice provided to patients in accordance
325 with this subsection shall be filed with the Health Systems Planning
326 Unit of the Office of Health Strategy, established under section 19a-612.
327 Said unit shall post a link to such notice on its Internet web site.

328 (4) A hospital, health system or hospital-based facility shall not collect
329 a facility fee for services provided at a hospital-based facility that is
330 subject to the provisions of this subsection from the date of the

331 transaction until at least thirty days after the written notice required
332 pursuant to this subsection is mailed to the patient or a copy of such
333 notice is filed with the Health Systems Planning Unit, whichever is later.
334 A violation of this subsection shall be considered an unfair trade
335 practice pursuant to section 42-110b.

336 (5) Not later than July 1, 2022, and annually thereafter, each hospital-
337 based facility that was the subject of a transaction, as described in
338 subsection (c) of section 19a-486i, during the preceding calendar year
339 shall report to the Health Systems Planning Unit the number of patients
340 served by such hospital-based facility in the preceding three years and
341 the number of patients to whom notice was sent in accordance with the
342 provisions of this subsection.

343 (l) Notwithstanding the provisions of this section, no hospital, health
344 system or hospital-based facility shall collect a facility fee for (1)
345 outpatient health care services that use a current procedural
346 terminology evaluation and management (CPT E/M) code or
347 assessment and management (CPT A/M) code and are provided at a
348 hospital-based facility located off-site from a hospital campus, or (2)
349 outpatient health care services provided at a hospital-based facility
350 located off-site from a hospital campus, received by a patient who is
351 uninsured of more than the Medicare rate. Notwithstanding the
352 provisions of this subsection, in circumstances when an insurance
353 contract that is in effect on July 1, 2016, provides reimbursement for
354 facility fees prohibited under the provisions of this section, a hospital or
355 health system may continue to collect reimbursement from the health
356 insurer for such facility fees until the date of expiration, renewal or
357 amendment of such contract, whichever such date is the earliest. A
358 violation of this subsection shall be considered an unfair trade practice
359 pursuant to chapter 735a. The provisions of this subsection shall not
360 apply to a freestanding emergency department. As used in this
361 subsection, "freestanding emergency department" means a freestanding
362 facility that (A) is structurally separate and distinct from a hospital, (B)
363 provides emergency care, (C) is a department of a hospital licensed
364 under chapter 368v, and (D) has been issued a certificate of need to

365 operate as a freestanding emergency department pursuant to chapter
366 368z.

367 (m) (1) Each hospital and health system shall report not later than July
368 1, [2016] 2022, and annually thereafter to the executive director of the
369 Office of Health Strategy, on a form prescribed by the executive director,
370 concerning facility fees charged or billed during the preceding calendar
371 year. Such report shall include (A) the name and [location] address of
372 each facility owned or operated by the hospital or health system that
373 provides services for which a facility fee is charged or billed, (B) the
374 number of patient visits at each such facility for which a facility fee was
375 charged or billed, (C) the number, total amount and range of allowable
376 facility fees paid at each such facility [by Medicare, Medicaid or under
377 private insurance policies] disaggregated by payer mix, (D) for each
378 facility, the total amount of facility fees charged and the total amount of
379 revenue received by the hospital or health system derived from facility
380 fees, (E) the total amount of facility fees charged and the total amount of
381 revenue received by the hospital or health system from all facilities
382 derived from facility fees, (F) a description of the ten procedures or
383 services that generated the greatest amount of facility fee gross revenue,
384 disaggregated by current procedural terminology category (CPT) code
385 for each such procedure or service and, for each such procedure or
386 service, patient volume and the total amount of gross and net revenue
387 received by the hospital or health system derived from facility fees, and
388 (G) the top ten procedures or services for which facility fees are charged
389 based on patient volume and the gross and net revenue received by the
390 hospital or health system for each such procedure or service. For
391 purposes of this subsection, "facility" means a hospital-based facility
392 that is located outside a hospital campus.

393 (2) On and after July 1, 2023, and annually thereafter, each hospital
394 and health system shall include in the report required under subdivision
395 (1) of this subsection (A) the number of patients who contacted the
396 hospital or health system to request a reduction of a facility fee for the
397 preceding calendar year, disaggregated by payer mix, (B) the number of
398 such patients who received a reduction of a facility fee, disaggregated

399 by payer mix, (C) the total amount of facility fees charged to patients
400 who requested reductions of facility fees, disaggregated by payer mix,
401 and (D) the total amount of reduced facility fees charged to such
402 patients, disaggregated by payer mix.

403 **[**(2)**]** (3) The executive director shall publish the information reported
404 pursuant to subdivision (1) of this subsection, or post a link to such
405 information, on the Internet web site of the Office of Health Strategy.

406 Sec. 5. (*Effective from passage*) (a) The Office of Health Strategy shall,
407 within available appropriations:

408 (1) Study methods to improve oversight and regulation of mergers
409 and acquisitions of physician practices to improve health care quality
410 and choice in Connecticut, including, but not limited to, a review of
411 sections 19a-486i, 19a-639 and 19a-630 of the general statutes; and

412 (2) Develop legislative recommendations to improve reporting and
413 oversight of physician practice mergers and acquisitions, including, but
414 not limited to, the necessity for any amendments to section 19a-486i,
415 19a-639 or 19a-630 of the general statutes.

416 (b) Not later than February 1, 2022, the executive director of the Office
417 of Health Strategy shall report, in accordance with the provisions of
418 section 11-4a of the general statutes, to the joint standing committee of
419 the General Assembly having cognizance of matters relating to public
420 health regarding the outcome of the study and any recommendations
421 for legislative action as a result of such study."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2021*	19a-673
Sec. 2	*October 1, 2021*	19a-673b
Sec. 3	*October 1, 2021*	19a-673d
Sec. 4	*from passage*	19a-508c
Sec. 5	*from passage*	New section