The Patient Financial Assistance Act

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COMMUNITY CATALYST

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About Community Catalyst

Community Catalyst, based in Boston, Massachusetts, is a national non-profit advocacy organization that builds consumer and community participation in the U.S. health system to secure quality, affordable health care for all.

Since its founding in 1997, Community Catalyst has worked with organization representing disadvantaged constituencies in over 30 states to strengthen their ability to advocate for policy and system change in health and related human services. Its multi-disciplinary staff uses a capacity-building approach - providing community leaders, consumer organizations, policymakers and the participating public with policy analysis and strategic support that helps them create tangible improvements in the health of individuals, families and communities.

The *The Patient Financial Assistance Act* is part of Community Catalyst's *Community Benefit and Free Care Initiative*. Some of Community Catalyst's other projects are: the *Community Health Assets Project*, a joint undertaking with the West Coast Regional Office of Consumers Union, which works to preserve health care access in a market-driven health care environment; the *Prescription Access Litigation Project*, which works to lower prescription drug prices through class-action litigation and other strategies; the *Physician Diversity Project*, which works with consumers and community leaders to increase minority participation in the physician workforce; and *RealBenefits*™, a program that combines the use of innovative web-based technology with community outreach to improve access to crucial public health and human services for low-income families and individuals; and the Commonwealth Care Alliance.

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Guide to the Patient Financial Assistance Act

Introduction & Background

Community Catalyst is a national non-profit advocacy organization that builds consumer and community participation in the shaping of the U.S. health system to secure quality, affordable health care for all. We do this by providing a range of support - including policy and legal analysis, training, organizing, and organizational development -- to local and state grassroots and community-based organizations that are dedicated to improving health care access for the uninsured and other vulnerable populations.

The *The Patient Financial Assistance Act* (Act) is an outgrowth of work Community Catalyst began in 1999 with a number of community-based consumer organizations around the country that are concerned about the deteriorating health care safety net in their local communities. A particular focus had been access to hospital care for people who are uninsured or underinsured. With support from Community Catalyst, the organizations decided to test the safety net's strength by monitoring hospital free care practices in nine communities. The purpose was to determine how easy it is for consumers to get information from hospitals about free care. What the community groups found was that *few of the more than 60 hospitals surveyed had systems in place for informing people that free or reduced-price care was available*. Indeed, most of the hospitals indicated they while they would provide care, they would bill the patient for it regardless of his or her financial circumstances.

Hospital free care is the *ultimate* safety net in the United States. With more than 43 million uninsured people and a rapidly growing number of people who are underinsured, the need for free care has never been greater. The expectation that hospitals will provide at least some free care to those in need arises from a number of sources. In the case of non-profit hospitals, the obligation is rooted in their tax-exempt status. The *quid pro quo* for relieving an institution of its federal, state and local tax obligations is the expectation that it will provide benefits that address the health care needs of its broader community, and not just the patients that come through its doors. There is also a growing expectation that for-profit hospitals will provide some amount of free care because health care is an essential service and because they have an obligation to contribute to the fair distribution of these services to the public.

A number of the organizations that undertook community monitoring projects were able to negotiate significant improvements in local hospital free care practices. In

other cases though, there was little interest on the hospitals' part in addressing free care barriers. What became clear is that while voluntary efforts are an important and tangible demonstration of good faith, broader system change requires the development of uniform free care standards that apply to all hospitals within a jurisdiction. It was this realization that prompted us to develop the Act, which has three specific objectives:

- To level the playing field by requiring all hospitals - both non-profit and for-profit -- to abide by the same eligibility and reporting standards;
- To ensure a minimum level of access to hospital care - both inpatient and outpatient - for uninsured and underinsured individuals and families; and
- To provide a basis for public assessment of a hospital is commitment to the health and well-being of its local community.

A KEY ISSUE

A critical issue that is *not* addressed in the Act but which communities, policymakers, and other stakeholders must consider is the financing of free care. Even with uniform free care standards in place, some hospitals will provide much more free care than others. For example, hospitals that are located in areas with large numbers of uninsured inevitably will provide more free care than hospitals located in affluent suburbs. In a market-based system, hospitals providing large amounts of free care are disadvantaged in that it's harder for them to compete for paying customers with hospitals that have fewer free care expenses. A method for distributing the free care burden *across all hospitals* is essential to preservation of a safety net.

It is also important to acknowledge that hospitals cannot shoulder the burden of providing care to the uninsured and underinsured by themselves. While hospitals clearly have a responsibility to deliver some measure of free care, other parties also bear some responsibility for making sure it is available. There must be mechanisms - including explicit cost shifting, if necessary -- for ensuring that the burden of providing free care is shared equally among all stakeholders.

Increasing reliance on the marketplace to control health care costs has made it more difficult for hospitals to spread the cost of caring for the uninsured across their patient populations. Private third party payers, employers, and government have all contributed to the problem. Employer and insurance industry purchasing practices have reduced the subsidies that formerly helped finance hospital free care. And state and federal government - as major purchasers of health care, formulators of public policy, and allocators of scarce public resources - have done little to create incentives or hold hospitals accountable in connection with the provision of free care.

There are a number of free care financing mechanisms and approaches that should be considered. For example, public dollars such as Medicaid disproportionate share hospital (DSH) funds could be used more effectively to encourage hospitals to provide free care and to require hospital accountability

for funds received. Special taxes, e.g. sales, excise, provider, etc. could be levied to fund free care, and surcharges could be imposed on the hospital bills of private third-party payers. The funds obtained through these sources could be pooled and then redistributed.

Free care is not an adequate substitute for comprehensive health benefits. Moreover, focusing solely on strengthening the safety net is not a sustainable strategy in the long term. But until such time as there is universal coverage, all stakeholders will need to participate in addressing gaps in access. And while voluntary efforts should be encouraged, a standardized approach to free care such as the one contained in the Act, which applies to all hospitals and provides for regulatory oversight, is a more appropriate solution for the short term.

Section by Section Discussion

What follows is a section-by-section discussion of the Act. In addition to explaining certain provisions, this guide provides a context for some of the drafting choices. Although each jurisdiction is unique, the purpose here is to establish a "floor" for policymakers and other stakeholders.

SECTION I. LEGISLATIVE FINDINGS AND INTENT

The legislative findings and intent describe the problem the Act is intended to address and the approach, in broad terms, which the legislature is using to address it. Both legislative findings and intent provide context to those charged with interpreting the language of the Act, including regulators who are called on to administer it and courts that may be called on to adjudicate challenges to it. This section can - and should - be tailored to reflect the environment in the state that is considering adopting the Act. For example, drafters may wish to include data about the number of uninsured and underinsured within the state, or to reference a trend that has impacted the local safety net, such as the conversion of a number of hospitals to for-profit status or the closure of hospitals in areas that serve predominantly low-income people.

SECTION II. APPLICATION

This section identifies the parties that are subject to the provisions of the Act. In this case the parties are all hospitals as defined in Section III of the Act.

SECTION III. DEFINITIONS

Bad Debt (§III (C) and Free Care (§III (N)) - A definition of bad debt is included primarily to ensure it is distinguished - and reported separately – from free care. Bad debt is money owed for hospital services that the hospital expects to receive but which is never paid, typically after collection efforts have been made. A persistent difficulty in assessing hospital free care performance has been the hospital industry practice of combining free care and bad debt and reporting it as uncompensated care. This figure is then used as a proxy for hospital commitment to the underserved. In fact, most bad debt results from unpaid insurance claims rather than bills owed by individuals, so the uncompensated care figure may more accurately gauge the inefficiency of a hospital's collection efforts with regard to third-party payers.[1] More to the point, though, is that if the amount owed by an individual is characterized as bad debt, collection activities will follow. As numerous recent media stories have documented, this can lead to financial disaster for low- and moderate-income families.

In contrast, free care - which is also called "charity care" in some jurisdictions -- is care that an individual qualifies for based on institutional or statutory eligibility standards. The hospital does not bill patients when it determines they meet the eligibility standards. For purposes of this Act, individuals who satisfy the eligibility standards contained in Section IV are eligible for free care.

Charge (§III (D) and Cost (§III (F) - A definition of "Charge" is included primarily to distinguish it from the term "Cost." These two terms reflect a fundamental market concept. "Cost" is the amount of money a hospital has to spend to provide a service or supply. In contrast, a "Charge" is the price the hospital sets for a particular service or supply. The charge is the hospital's "list" - or "sticker" - price. Inevitably, the hospital charge for a particular service or set of services is higher than the hospital's cost.

Hospital charges have been described as "marketing fictions designed to allow a hospital to offer substantial 'discounts.'"[2] There are no legal constraints on how high hospitals set their charges. Virtually no one pays charges though, *except* people who have no insurance. Private third-party payers are able to negotiate discounts because they can guarantee hospitals a steady flow of patients. The federal and state governments - which set Medicare and Medicaid rates, respectively - can pretty much tell hospitals how much they will pay them. In contrast, the uninsured don't have anyone negotiating on their behalf, so they end up being charged the highest rates.

The Act uses the terms "cost" and "charge" in both the billing and the reporting context. For example, patients who are eligible for financial assistance under Section IV of the Act are to be billed at cost for any out-of-pocket financial responsibility. In Sections X and XI of the Act - the sections that address hospital reporting -- hospitals generally are required to report both free care and bad debt at cost. This is intended to ensure that the data is not inflated, which could result in a misleading picture of hospital commitment to the underserved.

Collection Action (§III (E)) - Collection actions are defined broadly to include any activity undertaken by a hospital, an agent of a hospital, or a purchaser of patient accounts. Recent media stories highlight aggressive hospital collection tactics that result in substantial harm to individuals and families.[3] In some cases hospitals have claimed they had no control over certain collection tactics because they were undertaken by outside attorneys retained by the hospital, or by outside collection agencies to which the hospital sold the account. The Act's broad definition of collection activity makes it clear that a hospital can't evade accountability in that way. Specific requirements with respect to collection activity are contained in Section VI of the Act.

The Department (§III (H)) - Although we have assigned oversight responsibility for the Act to the department of health or its equivalent, a drafter should determine whether this is the appropriate agency within his or her own state's government agency structure.

Hospital (§III (P)) - "Hospital" is broadly defined both to ensure a reasonable degree of access to different kinds of medical care and to make sure that all entities providing hospital care are covered by the provisions of the Act. The need for free care is likely to arise in a range of contexts, including instances where psychiatric care or rehabilitation care is medically necessary. In many cases the individual who needs these more specialized services is eligible for coverage through a government program, or has private health insurance that will cover most, if not all, of the expense. But there will be instances when free care may be the only alternative. To ensure that it will be available, the Act defines "hospital" to include all public and private hospitals, including psychiatric and rehabilitation facilities. It would cover so-called "boutique" hospitals as well. If public facilities with an explicit mission to serve the low-income and uninsured are already providing free care consistent with all the requirements of the Act, it may be appropriate for drafters to exclude them. Such exceptions should only be made, however, where the mission is clear and the public hospital's behavior conforms to the mission.

Medically Necessary Services (Section III (R)) - The broad definition of medically necessary services is intended to ensure that free care is not limited to a subset of services provided by the hospital, such as emergency or outpatient services.[4] The definition includes prescription drugs because they have assumed such a central - and critical – role in modern medical treatment. A potential issue, however, is that patients will still be responsible for the cost of services that are provided in the hospital but not billed for by or through the hospital. Where this is the case, hospitals should be encouraged to use their influence (e.g. the granting of staff privileges, selective contracting with suppliers, etc.) to persuade these other providers to adopt the same free care policies that hospitals are subject to.

SECTION IV: FREE CARE ELIGIBILITY CATEGORIES

Section IV contains the eligibility criteria for the three forms of financial assistance: full free care, partial free care, and medical hardship assistance. It recognizes the fact that the cost of hospital care is prohibitive even for some middle-income families. *The financial eligibility criteria are intended as floors only.* Drafters should ensure that financial eligibility criteria are realistic in relation to the cost of living in their jurisdiction. The Federal Poverty Guidelines (FPG) *are the same* in each of the 48 contiguous states and the District of Columbia despite the fact that there are substantial variations in the cost of living among the states.[5]

It is important to note that the eligibility criteria utilized here are pegged to family income rather than the size of the hospital bill. Some hospitals provide financial assistance to patients by reducing their hospital bills a certain percentage, or by reducing the bill to the lowest rate the hospital has negotiated with managed care providers. The difficulty with this approach is that it may still result in an unreasonably high bill for an uninsured or underinsured person. In a recent study of Chicago hospital rates, uninsured patients were charged $12,240 per hospital stay on average. The comparable cost for a patient covered by a managed care organization was $4,930.[6] The typical uninsured person has an income that is under 200% FPG - or less than $17,960 for a family of one.[7] Using the Chicago data, if the hospital offers to reduce the bill of an uninsured person with an income under 200% FPG to the lowest rate it charges any customer, the individual would still owe almost $5,000. In contrast, that

individual would be entitled to full free care under this Act.

Full Free Care

Full free care is available to patients who are residents of the state where the law is enacted and whose family income is equal to or less than 200% of FPG. It is also available to non-state residents in the same income range who receive urgent care or emergency care as defined by the Act. Eligibility for full free care is based solely on family income. *There is no asset test for either full or partial free care because research suggests people in these income brackets have very limited assets.*[8] To require documentation would be administratively burdensome for the hospital with very little, if any, pay off.

Partial Free Care

Partial free care is available to patients who are residents of the state where the law is enacted and whose family income ranges from 201% to 400% of FPG. Like full free care, partial free care is available to non-state residents whose family income is in the 201-400% FPG range and who receive urgent care or emergency care. Eligibility for partial free care is based solely on family income. For reasons described above, there is no asset test.

In contrast to eligibility for full free care though, an individual who qualifies for partial free care is required to pay a deductible. The deductible amount suggested here is 20% of the difference between the patient's family income and 200% of FPG. The following example illustrates how the deductible is arrived at:

A family of three has an annual family income of $35,000.

Two hundred percent of the Federal Poverty Guidelines (FPG) for a family of three is $31,340.

$35,000 (family income) - $31,340[9] (200% FPG for a family of 3) = $3,660

$3,660 x 20% = $732 annual family deductible

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Once the family in the example above has incurred hospital expenses that exceed $732, it is eligible for free care. Families who are eligible for partial free care are liable for only one deductible per year. Thus even if there are multiple hospitalizations, the family is responsible for satisfying the deductible amount only once on an annual basis. Families may satisfy the deductible if they have incurred medical expenses from providers other than the hospital in the same calendar year, but it is their responsibility to document those expenses. Hospitals are not prohibited from initiating collection actions in connection with the deductible.

Medical Hardship Assistance

Medical hardship assistance is available to patients who do not qualify for full or partial free care.

This category of relief is targeted to families with incomes above 400% of FPG who've incurred medical bills in amounts that threaten family financial stability. To qualify for medical hardship assistance, family medical bills must exceed 25% of family income for the calendar year, and family assets must be insufficient to cover the amount. Thus, in contrast to eligibility requirements for full or partial free care, an asset test is used in determining eligibility for medical hardship assistance. This is because there's a greater likelihood that other assets are available at the higher income levels that trigger eligibility for medical hardship assistance. In order, however, to ensure that a family is left with some cushion, certain assets are excluded. For example, the primary home and primary motor vehicle are excluded. Burial contracts and a certain amount of life insurance and retirement assets are excluded. Finally, there is a general exclusion for $4,000 of other assets for an individual, $6,000 for a two-person family, and $1,500 of other assets for each additional family member.

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Mr. and Mrs. Smith and their 10-year old son do not have health insurance. Mrs. Smith has breast cancer.
The family income is $65,000, which is above 400% FPG (or $62,680).
Medical bills for Mrs. Smith's treatment during the calendar year are $20,000.
Do medical bills exceed 25% of family income? Yes -- $65,000 x 25% = $16,250.
Excess medical expenses = $3,750 ($20,000 - $16,250 = $3,750)
Are there available assets? Yes -- $8,000 in the son's college savings account.
Are any of those savings excluded in the calculation? Yes. The law excludes $7,500 of the $8,000.
Available assets = $500.
Do available assets ($500) exceed the excess medical expenses ($3,750)? No.

Eligibility is determined through a two-step process. First, the hospital determines whether medical bills exceed 25% of family income. If they do, then family assets - with some exclusions -- are evaluated. If available assets cover the "gap" between a family's medical bills and 25% of family income, then medical hardship assistance is *not* available. If a gap remains, then medical hardship assistance is available to the extent of the gap.

Just as there is a deductible for families that qualify for partial free care, there is a medical hardship assistance contribution. The medical hardship contribution is equal to 25% of the patient's family income plus any available assets. The family is not required to pay hospital expenses beyond this amount. The following example illustrates the eligibility determination process for medical hardship assistance:

Billing of Uninsured and Underinsured Patients Who Do Not Qualify For Free Care

The final feature in Section IV of the Act is intended to provide some degree of financial protection to families that are ineligible for any category of free care but who nevertheless are faced with substantial hospital bills. It provides that families with incomes up to 500% of FPG shall be billed by the hospital at cost, *not at the hospital's charges*. This provision addresses the often substantial difference between hospital costs and hospital charges that is described above. An alternative to billing at cost might be to bill at the lowest rate charged by the hospital to public and private purchasers, although this rate could be higher than the hospital's cost. Eligibility for this favorable billing treatment is capped because there may be uninsured or underinsured people who have substantial resources who can afford to pay charges.

SECTION V: ELIGIBILITY PROCESS

This Section outlines the process hospitals must use to identify those eligible for free care. When a patient presents for hospital care and either requests free care or otherwise indicates that he or she is uninsured or underinsured, the hospital must screen the person to see if he or she either qualifies for - or is already enrolled in – any type of public or private coverage program. This section places an affirmative duty on the hospital to identify other potential coverage sources once it has any information that a patient may require assistance. Both recent media coverage and the experience of community members who participated in monitoring local hospitals suggest that hospitals often don't do any sort of screening. The result has been that many uninsured and underinsured people don't find out they may be eligible for assistance until they are well into --- or even after -- the collection process. And sometimes it turns out that an individual is already enrolled in a coverage program although he or she may not realize that.

If the hospital determines that a patient may be eligible for some other coverage program, it is required to encourage the patient to apply, *and* it is required to assist the patient in the application process. However a refusal on the part of a patient to apply for another coverage program does not disqualify the person from applying for - or receiving - free care if otherwise eligible. This is because people sometimes have legitimate concerns (e.g. immigration status, privacy concerns related to domestic violence, etc.) about the application process for government programs.

A goal of the Act is to make the free care application process uniform across all hospitals. An important aspect of that is to require hospitals to use a standard application form developed by the administering agency. And because of rapidly changing demographics, it is important that the application form be available in languages that are spoken by substantial numbers of people in the state. It is more efficient for the state agency to undertake this task than for each individual hospital to do so.

The administering agency is also responsible for specifying the forms of documentation that applicants need to verify state residency, income, and, for purposes of medical hardship assistance, family assets. The Act provides, however, that documentation requirements may not function as a barrier to free

care. Thus when no other documentation is available, the agency shall require hospitals to accept affidavits from the applicant. In addition, applicants for free care are not required to provide social security numbers. This provision is included to ensure that undocumented immigrants are not deterred from seeking necessary medical care.

The section requires hospitals to make free care eligibility determinations no more than 14 days after they receive a completed application. The time frame reflects an attempt to balance the administrative demands on hospitals with the need of the patient to know that he or she has a safety net. Once a person or family is approved for free care, eligibility extends for one year from the effective date, unless there are changes to family income or insurance status which the make the person or family ineligible.

SECTION VI: COLLECTION ACTION

The purpose of this section is to preserve the right of hospitals to pursue payment for their services where appropriate, while at the same time protecting health care consumers from certain types of collection practices. As mentioned earlier, the financial consequences of some hospital billing and collection practices on individuals and families have been well-documented in recent media coverage.[10] This section sets minimum standards for hospital collection policies, and it requires that each hospital make its policy available to the public. It also requires hospitals to ensure that the same collection policy standards are adopted by any entity the hospital contracts with, sells an account to, or otherwise utilizes in the collection process.

Some of the recent media stories on hospital collection practices suggest that hospital leadership often is unaware of the types of collection activities its own facilities are engaged in. This section of the Act is intended to address that information gap by requiring governing board participation in some collection-related matters. This ensures accountability at the highest levels of hospital leadership and governance. For example, hospital governing boards are required to review and approve collection policies as well as the hiring of outside collection agents. In addition, the governing board's express approval is required for some of the more financially harmful types of collection actions. They include: any action to place a lien on or foreclose on property, any wage garnishment, and any attachment of a bank account or other personal property belonging to the patient or the person who is responsible for a patient's bill.

This section also requires that notices of collection actions be provided in languages that are spoken by significant numbers of people who live within the hospital's service area. It is important to ensure that non-English speaking individuals and families who owe a hospital money are aware of what is happening and are able to seek financial assistance or negotiate a reasonable payment plan before the collection process has gone too far.

The section also exempts from collection actions individuals who are eligible for government assistance or free care, and those who have pending applications for the same. And if a collection action is initiated and the person subsequently is found to be eligible for free care, the hospital is required to refund any money the individual may already have paid. It must also take immediate steps to correct

any adverse information reported to a credit rating agency.

Finally, this section addresses bill payment plans. A persistent problem reported by those who owe hospitals money is pressure from the hospital to enter into payment arrangements that are unrealistic in light of income and expenses. Often this pressure is applied before the hospital has made any determination regarding eligibility for financial assistance. Sometimes, however, it is applied after eligibility is clear. This section provides that a hospital may offer payment plans only after it has determined that an individual is not eligible for free care. It also requires hospitals to enter into reasonable payment arrangements - i.e. arrangements that take into account the patient's income and other financial obligations. Interest rates on payment plans are limited to 3% per annum or the Consumer Price Index, whichever is lower. The limit on interest rates reflects the fact that medical bills are a special type of consumer debt. Generally, people get sick or need medical treatment through no fault of their own. They should not be charged exorbitant interest rates for debts they don't undertake voluntarily. Finally, hospitals are required to provide general information on the difference between the interest rate it charges in connection with a payment plan and the rate charged by credit care companies and banks that finance consumer debt. Hospitals increasingly are encouraging people to put their hospital bills on their credit cards. The hospital receives its payment promptly, but the consumer sees his or her medical debt expand very quickly. This provision is intended to let consumers make informed decisions with respect to bill payment method.

SECTION VII. PATIENT RIGHTS AND RESPONSIBILITIES

This section specifies patients' rights and corresponding responsibilities in connection with requests for financial assistance. It acknowledges that while patients have a right to expect certain hospital actions, there also are reciprocal responsibilities which reflect, in part, the need to ensure that free care resources are targeted appropriately. For example, it's the patient's responsibility to provide all necessary documentation and to inform the hospital of any change in income or coverage status.

SECTION VIII. GRIEVANCE AND APPEAL

This section provides a mechanism for appealing a hospital's decision to deny financial assistance. An appeal process is necessary because the consequences of medical debt can be devastating to individual and family well-being. In this two step process, the first forum is the Department. Complaints need to be in writing, and hospital responses must also be in writing. The Department has the authority - based on the information provided to it by the parties - to uphold, reverse, or modify a hospital decision on a free care application. If either party is unhappy with the Department's determination, it can appeal the decision to court through the state's administrative procedures act.

SECTION IX. NOTIFICATION

Two persistent problems identified by community organizations that monitored local hospitals are (1) the failure of hospitals to publicize the availability of free care, and (2) the failure of hospitals to train staff to provide information and assistance with respect to the hospital's free care policies and proce-

dures. The goal of this section is to ensure that patients have meaningful opportunities *at multiple points* along the admission, treatment, billing and collection continuum to learn about –and apply for – free care. In addition to posting signs and providing notices to patients, the section also requires hospitals to train staff about free care. Finally, this section also requires hospitals to publicize the availability of free care within the broader community. Because research suggests that some people avoid seeking care altogether if they think they will incur medical debt, it is important to publicize the availability of free care *outside* of the hospital since some people may never make it through the hospital doors in the first place.[11]

SECTION X. REPORTING

This section requires hospitals to report certain data to the agency that administers the Act. The data allow the agency to assess individual hospital compliance with the Act. They also allow the agency to identify any patterns in hospital action on free care applications that might suggest the existence of inappropriate barriers or improper diversion of uninsured and underinsured patients. Moreover, the data will allow for meaningful comparisons of the provision of free care among hospitals. For example, it requires hospitals to differentiate between free care and bad debt and to report both of those figures at cost - as opposed to charges. It also requires them to report the sum of their net patient service revenue plus investment income. When the Department compares the amount of free care provided to this latter figure and reports the data as it is required to do in Section XI, it will be possible for the public to get a sense of each hospital's free care performance relative to its revenue. This will allow for an "apples to apples" comparison among hospitals.

The reporting requirements are also intended to elicit information from hospitals on the amount of funds they receive - or otherwise have access to - for the purpose of subsidizing their free care expenses. Specifically, hospitals are required to report the amount of funds they receive through the federal Medicare and Medicaid "disproportionate share hospital" programs which are programs that provide additional funds to hospitals that serve significant numbers of low-income patients. Hospitals are also required to report information on the amount of philanthropic funds - called "hospital bed funds" in some places - that are earmarked to defray the hospital expenses of patients who don't have the resources to pay their hospital bills.

Finally, the data provided by hospitals has valuable ancillary uses. It could, for example, inform policymakers about the health access environment in the state. If free care expenses are significant, it might suggest that the state's Medicaid program is too limited, or that there are insufficient primary care sites.

SECTION XI. REGULATORY OVERSIGHT

This section outlines the duties of the agency charged with administration and enforcement of the Act. A critical issue identified through the free care monitoring work and by other advocates is the lack of easily interpreted public information on hospital free care performance. Thus in addition to ensuring

overall compliance with the Act, a critical agency function is to issue an annual report that specifies the amount of free care provided in the prior year by each hospital, in a way that allows for the comparison among hospitals described above. With the exception of a few states that impose community benefit reporting requirements, hospitals typically have not been compelled to provide free care information in a manner or format that is easy for the public to make sense of. This section addresses that critical shortcoming. A potential result of making this information publicly available is the establishment of a dialogue between the hospitals and their communities on free care and other local health access concerns. This kind of engagement offers the opportunity for each side to identify issues of importance and concern, and provides a mechanism for the groups to work together toward solutions that are mutually beneficial.

SECTION XII. PENALTIES

This section provides the administering agency with some clout in ensuring hospital compliance with the Act's provisions. If a hospital refuses to comply with provisions of the Act, the administering agency may impose a monetary penalty of not less than $1,000 for each failure to comply.

SECTION XIII. PRIVATE RIGHT OF ACTION

This section provides a remedy to individuals and families that suffer harm as a result of a hospital's failure to comply with a provision of the Act. As discussed previously, there is substantial documentation of the harm - both medical and financial – that low- and moderate income individuals and families can suffer when free care is not readily available. This section is intended to serve as an additional incentive for hospital compliance with the Act as well as a form of redress for individuals who suffer harm that is attributable to non-compliance.

SECTION XIV. SEVERABILITY

This section ensures that if for any reason any portion of the Act is found invalid or unconstitutional, the rest of the Act remains effective. It is a standard provision in most legislation.

Endnotes

[1] Cinda Becker, "Balance Past Due," Modern Healthcare, September 22, 2003.

[2] Morrissey, M.A., Wedig, G.J., Hassan, M., "Do Nonprofit Hospitals Pay their Way?" Health Affairs, 15:4 (Winter 1996).

[3] See e.g. "Uncharitable Care: Yale-New Haven Hospital's Charity Care and Collection Practices," Connecticut Center for a New Economy, January 2003; Lucette Lagnado, "How a Local Agency Challenged Hospitals' Collections Tactics," The Wall Street Journal, October 30, 2003.

[4] HCA, the largest for-profit hospital chain in the country, recently committed to providing free care to patients with incomes up to 200% of poverty, but free care is limited to "non-elective" services. i.e. emergency services. The definition utilized in the Act is intended to ensure that a full array of services is available.

[5] A useful resource for information on the self-sufficiency standard - that is, the income necessary for an individual or family to adequately meet basic needs without public or private assistance - is the organizational website for Wider Opportunities for Women, www.wowonline.org.

[6] "Uninsured Pay Twice As Much," Chicago Tribune, January 27, 2003.

[7] Kaiser Family Foundation, "The Uninsured and Their Access to Health Care," (February 2002), www.kff.org.

[8] See, e.g. Weissman, J., Dryfoos, P., and London, K., "Income Levels Of Bad-Debt and Free-Care Patients In Massachusetts Hospitals," Health Affairs, 18:4, July/August 1999.

[9] Based on the 2004 Federal Poverty Guidelines issued by the U.S. Department of Health and Human Services on February 13, 2004.

[10] See, e.g. "Uncharitable Care: Yale-New Haven Hospital's Charity Care and Collections Practices," Connecticut Center for a New Economy (January 2003); Lucette Lagnado, "Hospitals Try Extreme Measures to Collect Their Overdue Debts," Wall Street Journal, October 30, 2003.

[11] See, e.g. The Access Project, "The Consequences of Medical Debt," Boston, MA (February 2003), www.accessproject.org.

The Patient Financial Assistance Act

I. LEGISLATIVE FINDINGS AND INTENT

A. The legislature finds:

1. That the ability to pay for essential health care services is of vital concern to the people of this State;
2. That Hospitals play an important role in providing essential health care services in the communities they serve;
3. That, as Providers of essential health services, the Hospitals of this State have a special obligation to the communities they serve;
4. That notwithstanding public and private efforts to increase access to health care, the people of this State continue to have tremendous unmet health needs;
5. That studies suggest that as many as [number] or [percent] of the State's Residents are uninsured or underinsured; and
6. That certain Residents of this State do not have the economic means to obtain access to quality health care.

B. In light of these findings, the legislature concludes:

1. That licensing privileges conveyed by this State pursuant to [cross reference to state statute(s) that provides for hospital licensure] to Hospitals for the right to conduct business within the State should be accompanied by concomitant obligations to address unmet health care needs;
2. That these obligations should be clearly delineated;
3. That the State has a substantial interest in assuring that the unmet health needs of its Residents are addressed;
4. That Hospitals can help address these needs by providing Free Care to certain uninsured and underinsured members of their communities; and
5. That the provision of Free Care should become a recognized and accepted obligation of all Hospitals in this State; and

II. APPLICATION

A. This Act applies to Hospitals as defined in Section III of this Act.

III. DEFINITIONS

A. Allowable Medical Expenses. Family medical bills from any Provider that, if paid, would qualify as deductible medical expenses for federal income tax purposes.

B. Available Assets. The resources, as distinct from Family Income, that are taken into account in determining eligibility for Medical Hardship Assistance. Available Assets

include cash, bank accounts, retirement funds, securities, life insurance policies, real estate, and motor vehicles.

C. Bad Debt. An account receivable based on services furnished to any patient which: 1) is regarded as uncollectible following reasonable collection efforts; 2) is charged as a credit loss; 3) is not the obligation of any federal or state governmental unit; and 4) is not Free Care.

D. Charge. The uniform price set by a Hospital for a specific service or supply provided by the Hospital.

E. Collection Action. Any activity by which a Hospital, a designated agent or assignee of the Hospital, or a purchaser of the patient account, requests payment for services from a patient or a patient's guarantor. Collection actions include pre-admission or pretreatment deposits, billing statements, letters, electronic mail, telephone and personal contacts related to Hospital bills, court summonses and complaints, and any other activity related to collecting a Hospital bill.

F. Cost. The actual amount of money a Hospital spends to provide each service or supply.

G. Cost-to-Charge Ratio. The ratio of a hospital's total cost of providing patient care to its total charges for patient care, as reported in its most recently settled Medicare Cost Report.

H. Deductible. The patient's liability to the Hospital for Partial Free Care as provided for in Section IV (B) of this Act.

I. The Department. [The state agency responsible for administering and monitoring compliance with this Act.]

J. Effective Date of Eligibility. The date on which the Medically Necessary Services are initiated.

K. Emergency Care. Medically necessary services provided after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity, including severe pain, which a prudent lay person would reasonably believe is an immediate threat to life or has a high risk of serious damage to the individual's health. Conditions include, but are not limited to those which may result in jeopardizing the patient's health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or active labor in women. Examination or treatment for emergency medical conditions or any such other

service rendered to the extent required under 42 USC §1395(DD) qualifies as Emergency Care.

L. Family. The patient, spouse and any dependents living in the patient's household, and any unborn children.

M. Family Income. The sum of annual earnings and cash benefits from all sources before taxes, less payments made for alimony and child support.

N. Federal Poverty Income Guidelines. The Federal Poverty Income Guidelines published annually by the United States Department of Health and Human Services.

O. Free Care. Medically Necessary Services provided without charge to Uninsured Patients and Underinsured Patients who meet the eligibility criteria in Section IV of this Act. Free Care is not recorded by the Hospital as revenue or in its receivables. Categories of Free Care include Full Free Care, Partial Free Care, and Medical Hardship Assistance.

P. Full Free Care. Free Care provided by a Hospital for which the patient incurs no cost in accordance with Section IV(A) of this Act.

Q. Hospital. Any institution, licensed by the State, whether operated on a nonprofit or for-profit basis and including any facility that is funded by the State or any subdivision, which is advertised, announced, established or maintained for the purpose of caring for persons admitted thereto for diagnosis or medical, surgical, restorative, psychiatric or rehabilitation treatment which is rendered by the institution.

R. Medical Hardship Assistance. Free Care provided by a Hospital for patients who satisfy the expense and resource qualifications specified in Section IV(C) of this Act and for which the eligible individuals pays a Medical Hardship Assistance Contribution.

S. Medical Hardship Assistance Contribution. The patient's liability to the Hospital for Medical Hardship Assistance as provided for in Section IV (C) of this Act.

T. Medically Necessary Services. Services that are reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity. Medically Necessary Services shall include inpatient and outpatient services as

mandated under Title XIX of the Federal Social Security Act, and Emergency Care as defined in Section III (K) of this Act. They shall also include provision of prescription drugs.

U. Partial Free Care. Free Care provided by a Hospital for which the patient pays a Deductible as provided for in Section IV(B) of this Act.

V. Provider. Any person, corporation, partnership, governmental unit, state institution, or other entity qualified under the laws of the State to perform or provide health care services.

W. State Resident. A person living in the State, regardless of U.S. citizenship status, with the intention of remaining in the State indefinitely. A Resident is not required to maintain a fixed address. Relocation to the State for the sole purpose of receiving health care benefits does not satisfy the residency requirement.

X. Underinsured Patient. A patient who has a policy of health insurance or is a member of a public or private health insurance, health benefit, or other health coverage program but who still has financial liability after that policy or program has paid the amount for which it is responsible.

Y. Uninsured Patient. A patient who does not have a policy of health insurance and is not a member of a public or private health insurance, health benefit, or other health coverage program.

Z. Urgent Care. Medically necessary services provided in a Hospital after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity, including severe pain, that would cause a prudent lay person to believe that the absence of medical attention within 24 hours could result in: placing a patient's health in jeopardy; impairment to bodily function; or dysfunction of any bodily organ or part. Conditions for which Urgent Care services are provided do not need to be life-threatening or pose a high risk of serious damage to an individual's health.

IV. FREE CARE ELIGIBILITY CATEGORIES

A. Full Free Care.

1. Eligibility. Uninsured Patients and Underinsured Patients who meet the following criteria shall be eligible for Full Free Care from the Hospital.

(a) A State Resident whose Family Income is equal to or less than 200% of the Federal Poverty Income Guidelines; and

(b) A person who is not a State Resident who receives Emergency or Urgent Care and whose Family Income is equal to or less than 200% of the Federal Poverty Income Guidelines.

B. Partial Free Care.

1. Eligibility. Uninsured Patients and Underinsured Patients who meet the following criteria shall be eligible for Partial Free Care from the Hospital.

(a) A State Resident whose Family Income is from 201% to 400% of the Federal Poverty Income Guidelines; and
(b) A person who is not a State Resident who receives Emergency or Urgent Care and whose Family Income is from 201% to 400% of the Federal Poverty Income Guidelines.

2. Annual Patient Deductible

(a) The Hospital shall calculate an annual Deductible amount for the patient, and the patient will be eligible for Free Care after he or she has incurred expenses in the amount of the annual Deductible. The Deductible shall equal 20% of the difference between the patient's Family Income and 200% of the Federal Poverty Income Guidelines. The formula for calculating the Deductible is as follows:

[Family Income – (2 x Federal Poverty Income Guidelines)] x 20% = Annual Patient Deductible

(b) There is one Deductible amount per Family per calendar year. Allowable Medical Expenses billed by other Providers during the same calendar year shall be counted toward the Deductible. It is the patient's responsibility to document expenses incurred from other Providers.
(c) Allowable Medical Expenses billed by the Hospital shall be calculated at Cost.
(d) The Hospital shall bill a patient only for the Deductible amount.

C. Medical Hardship Assistance.

1. Eligibility. Uninsured Patients and Underinsured Patients who meet the following criteria shall be eligible for Medical Hardship Assistance from the Hospital.

(a) A State Resident at any income level whose Allowable Medical Expenses have depleted Family Income to the extent that he or she is unable to pay for

Medically Necessary Services. In order to qualify for Medical Hardship Assistance, the patient shall meet both the expense and the resource qualifications set out in Sections IV(C)(2)(a) and (b) of this Act.

(b) A person at any income level who is not a State Resident who receives Emergency or Urgent Care whose Allowable Medical Expenses for that care have depleted Family Income to the extent that he or she is unable to pay for Medically Necessary Services. In order to qualify for Medical Hardship Assistance, the patient shall meet both expense and resource qualifications set out in Sections IV(C)(2)(a) and (b) of this Act.

2. Requirements

(a) Expense Qualification. In order to be eligible for Medical Hardship Assistance, the patient's Allowable Medical Expenses must exceed 25% of his or her Family Income.

(i) The Hospital shall multiply the Family Income by 25% and compare that amount to the total amount of the patient's Allowable Medical Expenses.

(ii) If the total amount of Allowable Medical Expenses is greater than 25% of Family Income, the patient meets the expense qualification.

(iii) Allowable Medical Expenses billed by the Hospital shall be calculated at Cost.

(b) Resource Qualification. The patient's Available Assets must be insufficient to cover the amount by which Allowable Medical Expenses exceed 25% of the Family Income.

(i) The Hospital shall calculate total Available Assets, excluding the following: the primary residence; the first motor vehicle; the second motor vehicle if it is necessary for employment or medical purposes; any pre-paid burial contract, burial plot or bank account funded for burial; any life insurance policy with a face value of $10,000 or less; the first $25,000 of IRA, Keogh or other pension assets; the first $ 4,000 of other assets for an individual or $ 6,000 of other assets for a Family of two, and $ 1,500 of other assets for each additional Family member. The value of any asset that has a penalty for early withdrawal shall be the value of the asset after the penalty has been paid.

(ii) If Available Assets exceed the excess Allowable Medical Expenses, the patient is not eligible for Medical Hardship Assistance. If Available Assets are less than the excess Allowable Medical Expenses, the patient is eligible for Medical Hardship Assistance.

3. Medical Hardship Assistance Contribution

(a) The Hospital shall calculate a patient's Medical Hardship Assistance contribution by adding 25% of the patient's Family Income to the patient's Available Assets.
(b) There is one Medical Hardship Assistance contribution per Family per calendar year. Allowable Medical Expenses billed by other Providers during the same calendar year may be counted toward the contribution. It is the patient's responsibility to document expenses incurred from other Providers.
(c) The patient will remain responsible for all Allowable Medical Expenses to the extent of the Medical Hardship Assistance contribution. The patient is eligible for Free Care for all expenses for Medically Necessary Services in excess of the Medical Hardship Assistance contribution for the period of Free Care eligibility pursuant to Section V of this Act.
(d) A Hospital shall bill a patient only for the contribution amount.

D. A State Resident who is an Uninsured Patient or Underinsured Patient who is not eligible for Medical Hardship Assistance but whose income does not exceed 500% of the Federal Poverty Guidelines shall be billed at Cost.

V. ELIGIBILITY PROCESS

A. Initial Screening. Hospitals shall ask every patient, or the patient's representative, prior to discharge, whether the patient requires financial assistance in connection with the hospital bill. The timing of the inquiry shall be consistent with the requirements of 42 USC §1395(DD) et seq. and any regulations promulgated pursuant to those sections.

B. Timing of Free Care Application. A patient, or the patient's representative, may submit an application for Free Care prior to, during, or within one year of the Effective Date of Eligibility.

C. Alternative Coverage. Hospitals shall screen any patient who requests financial assistance or who is otherwise identified as being Uninsured or Underinsured to determine whether he or she is eligible for, or enrolled in, coverage from any other private or public source, including Medicaid and the State Children's Health Insurance Program ("SCHIP"). If the screening determines a patient is enrolled in, or otherwise has, coverage through another source, the patient shall be eligible for Free Care if he or she otherwise meets the eligibility standards contained in Section IV, but only to the extent that the patient has incurred expenses for Medically Necessary Services that are not otherwise covered by the public coverage program. If a Hospital determines a patient meets the eligibility criteria for Medicaid, SCHIP or another government program, it shall encourage the patient to apply for that coverage and shall assist the patient in the application process. Refusal to apply for

another source of coverage shall not disqualify a patient from applying for and, if eligible, being approved for Free Care. A Hospital shall not deny or delay patient care while the patient's application for the other source of coverage is pending.

D. Application. Hospitals shall use an application form developed by the Department to determine eligibility for Full Free Care. The Department shall ensure that the application is simple and easy-to-read, and that it requests only the information that is reasonably necessary to determine eligibility. The Department shall translate the application into the five languages most frequently used by the state's population.

E. Documentation. The Department shall specify the forms of documentation an applicant must submit in order to verify residency and Family Income, and, for purposes of an application for Medical Hardship Assistance only, to verify Available Assets. In developing specifications, the Department shall ensure that lack of official forms of documentation is not a barrier to Free Care. An affidavit signed by the applicant shall be sufficient if no other documentation is reasonably available. An applicant for Free Care shall not be required to provide a social security number.

F. Determination of Free Care Eligibility. The Hospital shall give the patient written notice of an eligibility determination within 14 days of receipt of a complete application. The patient will remain eligible for Free Care for one year from the Effective Date of Eligibility determination, unless over the course of that year the patient's Family Income or insurance status changes to such an extent that the patient becomes ineligible.

VI. COLLECTION ACTION

A. Each Hospital shall develop and file with the Department a written credit and collection policy, approved by the Hospital's governing board, within 180 days of the effective date of this Act. The policy shall detail the process and time frames the hospital, or any designated agent, assignee, contractor, or purchaser of its accounts receivable uses in its Collection Actions, including copies of letters or other notices sent to patients. The policy shall be available to the public upon request.

B. No Hospital, or any designated agent, assignee, contractor, or purchaser of its accounts receivable shall undertake any of the following Collection Actions in connection with any unpaid patient bill without the express approval of the Hospital's governing board:

1. Any action to foreclose on real property;
2. Any action to place a lien on any property;
3. Any action to garnish wages; and

4. Any action to attach or seize a bank account or any other personal property.

C. The governing board of the Hospital shall, on an annual basis, approve the use of any designated agent, assignee, contractor, or purchaser of accounts receivable. Approval shall not be given unless the terms of such use expressly include the requirements set out in Section VI(B), (C), (E) and (F) of this Act.

D. All written and verbal communications made by the Hospital or any designated agent, assignee, contractor, or purchaser of its accounts receivable that relate to a Collection Action shall be available in the languages spoken by significant populations within the Hospital's service area.

E. The following are exempt from any Collection Action:

1. Patients enrolled in the Medicaid/SCHIP program;
2. Patients who are determined to be eligible for Full Free Care;
3. Patients who are determined to be eligible for Partial Free Care or Medical Hardship Assistance for the portion of the Hospital bill that exceeds the Deductible or Medical Hardship Assistance Contribution;

F. A Hospital shall not bill a patient who has applied for Free Care while the patient's completed Free Care application is under consideration.

G. If a patient completes a Free Care application after Collection Action has been initiated, the Hospital, or any designated agent, assignee, contractor, or purchaser of the account, shall suspend all Collection Action until a determination is made as to the patient's eligibility for Full Free Care, Partial Free Care or Medical Hardship Assistance. If the patient is determined to be eligible, any money he or she has paid on the account shall be refunded unless the Deductible or Medical Hardship Assistance contribution has not yet been satisfied. The Hospital, or any designated agent, assignee, contractor or purchaser of the account, shall retract any adverse information reported to any credit reporting agencies as a result of any Collection Action in a timely manner.

H. Payment Plans.

1. A payment plan shall be offered only after it has been determined that an Uninsured Patient or Underinsured Patient is not eligible for Free Care.
2. Patients who are eligible for Partial Free Care or Medical Hardship Assistance shall have the option to pay the Deductible or Medical Hardship Assistance contribution in reasonable installments that take into account the patient's income and other financial obligations.

3. Hospitals shall offer payment plans to Uninsured Patients and Underinsured Patients who are not eligible for Partial Free Care or Medical Hardship Assistance. Such plans shall be reasonable in light of the patient's income and other financial obligations.
4. Interest rates for payment plans shall not exceed the Consumer Price Index or 5% per annum, whichever is lower. Hospitals shall provide general comparative information on the difference between the interest rate it will charge and the typical credit card or consumer bank loan interest rates.

VII. Patient Rights and Responsibilities

A. Patient Rights. Hospitals shall advise patients of the following rights to:

1. Apply for Free Care within one year of their initial visit to the Hospital;
2. Enter into a payment plan if determined ineligible fore Free Care;
3. Receive a determination, in writing, on the Free Care application within 14 days of submitting a completed application, including verification of Family Income.
4. File a grievance pursuant to Section VIII of this Act.

B. Patient Responsibilities. Patients shall:

1. Provide all required residency, Family Income, and Available Assets verification;
2. Provide all necessary documentation relating to Medicaid enrollment or the denial of Medicaid enrollment;
3. Inform the Hospital of changes in Family Income and insurance status; and
4. Provide documentation of expenses for Medically Necessary Services incurred from other Providers for purposes of determining eligibility for Partial Free Care or Medical Hardship Assistance.

VIII. Grievance and Appeal

A person who is aggrieved by a Hospital's determination on his or her application for Free Care may initiate the following process:

A. The patient shall send a written complaint to the Department, including any supporting documentation.

B. The Department shall send a copy of the complaint to the Hospital and ask for the Hospital's written response, including any additional documentation the hospital may have. The Hospital shall have 30 days to provide the response.

C. The Department shall have 30 days from receipt of the information to review it and issue a written decision upholding, reversing, or modifying the hospital's determination. The decision will explain the basis for the Department's action.

D. The Department's determination shall constitute a final administrative decision and may be appealed by either party to a court of competent jurisdiction.

IX. NOTIFICATION

Every Hospital shall provide notification of the availability of Free Care as follows:

A. The Hospital shall post signs in the inpatient, outpatient, emergency, admissions, and registration areas of the facility, and in business office areas that are customarily used by patients, that conspicuously inform patients of the availability of Free Care and the location within the Hospital at which to apply for Free Care. Signs shall be in English and also in the five language(s) other than English that are most frequently spoken by the Hospital's service area.

B. The Hospital shall post a notice in a prominent place on its website that Free Care is available. The notice shall include a brief description of the Free Care application process. The notice shall be in the same languages as the signs that are required pursuant to Section IX (A)

C. The Hospital shall provide individual notice, in the appropriate language, of the availability of Free Care to a patient who is identified as an Uninsured Patient or an Underinsured Patient.

D. The Hospital, and any collection agent, assignee or purchaser of a hospital account, shall provide notice of the availability of Free Care, in the appropriate language, in any Collection Action.

E. The Hospital shall provide regular in-service training to all Hospital staff and personnel on Hospital Free Care policies and procedures.

F. The Hospital shall, on a quarterly basis, publish notice in a newspaper of general circulation in the Hospital's service area, that Free Care is available. The notice shall include a brief description of the Free Care application process. The Hospital shall provide a similar notice to all community health centers located in the Hospital's service area. The notices shall be in the same languages as the signs required pursuant to Section IX (A).

X. REPORTING

A. Within three months of the end of its fiscal year, each Hospital shall submit an annual report to the Department in a format specified by the Department.

B. The report shall, at a minimum, include the following information for the fiscal year:

1. The number of Free Care applications submitted, differentiating among applications for Full Free Care, Partial Free Care, and Medical Hardship Assistance;
2. The number of Free Care applications approved, differentiating among applications for Full Free Care, Partial Free Care, and Medical Hardship Assistance;
3. The number of Free Care applications denied and the reason for denial, differentiating among applications for Full Free Care, Partial Free Care, and Medical Hardship Assistance;
4. The number of appeals to the Department arising from denial of a Free Care application and the disposition of those appeals; and
5. The total and unduplicated number of patients who received Free Care, differentiating among applications for Full Free Care, Partial Free Care, and Medical Hardship Assistance;

C. The Department may require a Hospital to submit other data sufficient for the Department to ensure that the Hospital is not discriminating against patients who request, or are eligible for, Free Care.

D. Each Hospital shall submit with its annual report a description of its Free Care application process, including the identity of the person or persons responsible for making determinations on Free Care applications.

E. Each Hospital shall submit with its annual report its most recent and complete set of audited financial statements.

F. Each Hospital shall submit with its annual report a statement that details the following:

(a) The amount of Free Care, calculated at Cost, provided in the reporting year;
(b) The amount of Bad Debt incurred in the reporting year calculated at Cost, and identifying how much of the Bad Debt is attributable to individual patients, and how much is attributable to private third party payers;
(c) The sum of the Hospital's net patient service revenue plus its investment income;

(d) The amount of any "disproportionate share hospital" funds received from the Medicaid or Medicare program during the reporting year; and
(e) The amount of philanthropic funds available to the hospital to subsidize the cost of Free Care, and the amount of those philanthropic funds that were used during the reporting year to subsidize free care.

G. A Hospital may report the amount of Free Care provided and Bad Debt incurred using Charges, but it must also submit to the Department its Cost-to-Charge ratio as calculated in its most recently settled Medicare Cost Report.

H. Each Hospital shall, at the request of the Department, provide income information related to applicants for Free Care, and any disease or diagnostic code information related to services provided to patient who receive Free Care, to enable the Department to develop and implement strategies to address health access and other public health issues.

I. Hospitals shall maintain auditable records of Free Care applications and determinations.

J. Hospitals shall report any other information that the Department deems necessary to ensure compliance with the provisions of this Act.

XI. REGULATORY OVERSIGHT

A. The Department shall be responsible for administering and ensuring compliance with this Act, including development of a uniform Free Care application and specifications for documentation of residency, Family Income, and Available Assets as provided for in Section V of this Act.

B. If a Hospital has reported its Free Care and Bad Debt data using Charges, the Department shall deflate those amounts using the Cost-to-Charge ratio submitted by the Hospital pursuant to Section X (G) of this Act.

C. The Department shall issue a report to the public on an annual basis which shall contain the following:

1. The number of Free Care applications submitted to each hospital during the applicable year, differentiating among applications for Full Free Care, Partial Free Care, and Medical Hardship Assistance;
2. The number of Free Care applications approved by each hospital during the applicable year, differentiating among applications for Full Free Care, Partial Free Care, and Medical Hardship Assistance;

3. The number of Free Care applications denied and the reason for denial, differentiating among applications for Full Free Care, Partial Free Care, and Medical Hardship Assistance;
4. The number of appeals to the Department arising from denial of a Free Care application and the disposition of those appeals;
5. The amount of Free Care, calculated at Cost, provided by each Hospital during the applicable year,
6. The amount of Bad Debt, calculated at Cost, incurred by each Hospital during the applicable year, identifying how much of the Bad Debt is attributable to individual patients and how much is attributable to private third party payers;
7. The amount of Free Care provided by each Hospital during the applicable year relative to the sum of the Hospital's net patient service revenue and investment income for the applicable year.

D. The Department shall conduct a site visit to each Hospital, at least annually, to monitor compliance with the provisions of this Act.

E. The Department may promulgate any rules and regulations that are necessary to carry out the provisions of this Act.

XII. PENALTIES

A. The Department may, after notice and opportunity for hearing, impose a civil penalty on any Hospital that fails to comply with any provision of this Act in an amount of not less than $1,000 for each failure to comply.

B. Any decision by the Department shall be considered a final administrative decision for purposes of appeal.

XIII. PRIVATE RIGHT OF ACTION

Any individual who is otherwise eligible for Free Care and who suffers actual or consequential damages as a result of Hospital non-compliance with any provision of this Act may bring suit against the Hospital in a court of competent jurisdiction to recover those damages. Any applicable charitable immunity provision shall not apply in connection with any suit brought pursuant to this section.

XIV. SEVERABILITY

The provisions of this Act are declared to be severable. If any of its provisions or the application of its provisions are held to be invalid or unconstitutional, that invalidity shall not be construed to affect the validity or constitutionality of the remaining provisions of this Act.