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SENATE . . . . . No.

The Commonwealth of Massachusetts

PRESENTED BY:

Richard T. Moore

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act to Contain Health Care Costs.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Richard T. Moore	Worcester and Norfolk

The Commonwealth of Massachusetts

In the Year Two Thousand and Nine

AN ACT TO CONTAIN HEALTH CARE COSTS.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 118G of the General Laws, as so appearing in the 2008 Official Edition, is hereby amended by adding at the end thereof the following two new sections-

Section 23. Self-Pay Patient Health Care Costs

(a) Definitions. For purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings: –

“Alternative payment arrangement,” a method of compensation that allows payment of billed charges on other than a lump sum or a delayed basis.

“Division," the division of Health Care Finance and Policy

"Health facility," any hospital or ambulatory surgical center as defined in section 1 of Chapter 118G of the General Laws.

“Self-pay patient,” a patient who is a resident of the commonwealth and who does not have coverage under a health insurance plan, Medicare, Medicaid, or other government program, and is not eligible for free care or partial free care in the Uncompensated Care Pool under Chapter 118G. For the purpose of this section, “Self-pay patient” hereon will be referred to as “patient”.

“Reduced charges,” a charge established by the division of Health Care Finance and Policy which is no more than the maximum allowable charge for a particular health care service for the category of self-pay patients.

“Self-pay program,” a program administered by a health facility which at minimum includes, reduced charges for self-pay patients and alternative payment arrangements for self-pay individuals.

(b) Self-pay patient program. (1) Each health facility shall develop a self-pay program and shall provide each patient with information on its self-pay patient program as a condition of admission for the provision of non-emergency health care services and as soon as reasonably practicable for the provision of emergency health care services.

(2) A health facility shall develop and implement procedures for self-pay patients to apply for reduced charges or an alternative payment arrangement. The healthcare facility shall design the application form and procedures in a manner calculated to encourage participation in the program by eligible self-pay patients.

(c) Publication of self-pay program; reports (1) A health facility shall make available to the public on its Internet website, in a format that can be downloaded, a copy of its self-pay program. It shall post a clear and conspicuous notice in its (a) reception areas open to the public, in its

admissions office, if applicable, and (b) in its billing office informing patients of the health facility's self-pay program and the ability to obtain a copy of educational materials regarding the program upon request.

(2) Each health facility shall, on a quarterly basis, report to the division the number of patients applying for the self-pay program and the number of patients accepted for reduced charges under the self-pay program.

(d) Charges for Service. (1) A health facility shall not, as a condition of admission or the provision of non-emergency services, require a patient or a patient’s representative to sign any form that requires or binds the patient or the patient's representative to make an unspecified or unlimited financial payment to the health facility or to waive the patient's right to appeal charges billed.

(2) A health facility may require a financial commitment from a patient or a patient’s representative for non-emergency services only if it provides a prior written estimate of charges for the health facility, its contractors, and facility-based physicians for the items and services generally required to treat the patient's condition. The health facility shall notify the patient or the ay patient’s representative of any revision to the estimate in a timely manner. If the health facility makes a revision to the estimate that exceeds the lesser of either 20% of the original estimate or $1,000.00, any financial commitment made by the self-pay patient or the self-pay patient’s representative shall be null and void.

(3) In the event of any unanticipated complications or unforeseen circumstances in providing non-emergency services to a self-pay patient, the health facility may charge the patient for

additional treatment, services, or supplies rendered in connection with the complication or unforeseen circumstance, if such charges are itemized on the patient's billing statement.

(4) Each health facility shall provide a patient with an itemized bill for the medical service or item rendered to the patient detailing the following:

(i) the original full charge for each medical service or item rendered

(ii) the reduced charge to be paid by the patient for each medical service or item rendered; and

(iii) the expected amount that would be paid under the Medicare program for that item or service, including the amount of any required cost-sharing, and excluding the amount of any add-on or supplemental Medicare payments, such as for graduate medical education or the disproportionate share or critical access hospital adjustment.

(5) A health facility shall not condition the provision of health care services to a self-pay patient based upon the patient waiving any provision of this Act.

(e) Right to contest billings. (1) A patient or a patient's representative shall have the right to appeal any charges in their health facility bill, including charges for any of the health facility's contractors or facility-based medical providers. All health facility bills shall conspicuously display at the bottom of each bill in at least twelve-point boldface capital letters a prominent notice of the patient or patient's representative right to appeal any of the charges in the bill.

(2) A patient or a patient's representative with appropriate authorization shall have unlimited access to the patient's complete medical record and all health facility billing records relating to the patient's bill to enable the patient or the patient's representative to determine the

appropriateness and correctness of all charges. A health facility may not charge any fee for this access, but may charge reasonable fee for copies of these records.

(3) A health facility shall establish an impartial method for reviewing billing complains that includes, at a minimum: (a) review by an individual who was not involved in the initial billing; and (b) the provision of a written decision with a clear explanation of the grounds for the decision to (i) the patient or patient's representative making the appeal and (ii) the division within thirty (30) days of the receipt of the appeal.

(4) A health facility shall maintain a complete and accurate log of all appeals that includes, at a minimum, the name of the patient or patient's representative making the appeal, the basis for the appeal, the charges and the amount of the charges under appeal, and the disposition of the appeal.

(5) A health facility shall annually report to the division the number of appeals, the total of the charges subject to appeal, and a summary of the dispositions of the appeals.

(f) Investigations and penalties. (1) The division may fine a health facility up to five thousand dollars ($5,000) per violation of this section. (2) Actions taken by the division pursuant to this section shall not preclude any other remedy by an individual, a health insurance plan, or other party that is available under contract or any other provision of law. (3) Any person may file a claim with the division alleging a violation of Act. The division shall investigate and inform the complaining person of its determination of whether a violation has occurred and what action it will take.

(g) Division reports. (1) The division shall make public and post on its Internet website, information regarding the reports submitted by each health facility under sections (c) and (d).

(2) Upon enactment, on or before March 1 of each year, the division shall issue a report to the general court and the governor that includes all of the following:

(i) the total number of patients applying for reduced charges under a health facility's self-pay program;

(ii) the total number receiving reduced charges under a health facility's self-pay program;

(iii) the number of investigations it has conducted for alleged violations of this Act;

(iv) the number of violations the division determined occurred; and

(v) the name of each health facility that has violated this article and

(vi) the actions it has taken against these facilities.

(3) Copies of reports prepared pursuant to this section shall be made available free of charge to the public upon request.

(h) Privacy. Any patient data collected or reported pursuant to this Act must be consistent with state and federal law, including, but not limited to, the Gramm-Leach-Bliley Act (12 U.S.C. §1811 et. seq.) and the Health Insurance Portability and Accountability Act privacy regulations (45 C.F.R. Part 164).

Section 24. The division, in consultation with other relevant state agencies, shall conduct a review and evaluation of all existing mandated health benefits and shall report its findings to the joint committees on health care and insurance on or before December 1, 2010. For the purpose of this section, "existing mandated health benefits" shall have the same meaning as a "mandated health benefit proposal" in paragraph (a) of section 38C of chapter 3 of the General Laws.

The division shall enter into interagency agreements as necessary with the division of medical assistance, the group insurance commission, the department of public health, the division of insurance, and other state agencies holding utilization and cost data relevant to the division's review. Such interagency agreements shall require that the data shared under the agreements is used solely in connection with the division's review under this section, and that the confidentiality of any personal data is protected. The division may also require data from insurers licensed or otherwise authorized to transact accident or health insurance under chapter 175, nonprofit hospital service organizations organized under chapter 176A, nonprofit medical service corporations organized under chapter 176B, health maintenance organizations organized under chapter 176G and their industry organizations to complete its analysis. The division may contract with an actuary, or economist as necessary to complete its analysis. The division shall reference all information pertaining to cost, utilization and outcomes that it examines in conducting its review and make it available upon request.

The report shall include an evaluation of the medical efficacy of mandating the benefit, including the impact of the benefit to the quality of the patient care and health status of the population and the results of any research demonstrating the medical efficacy of the treatment or service compared to alternative treatments or services, or not providing the service or treatment; and the increase in insurance premiums, if any, resulting from mandating the coverage of this service or treatment and any other relevant information that would be useful in evaluating the mandated health benefit. Costs associated with the mandate shall be evaluated based on the experience of the prior five years, or from the date the mandate is passed, if in existence less than five years. The report may include a recommendation to repeal any mandate that is no longer

justified as to cost effectiveness, medical efficacy or safety. This process shall be repeated every five (5) years.