

Update on Charity Care Reform



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Scope of the Problem...

- 6.5 million Californians uninsured for all or part of the year (1 out of 5 Californians)
- 4.8 million uninsured at any given time
 - 750,000 children
 - 4.1 million uninsured adult legal residents
 - 1.1 million uninsured persons without green cards (undocumented persons and persons with temporary visas)

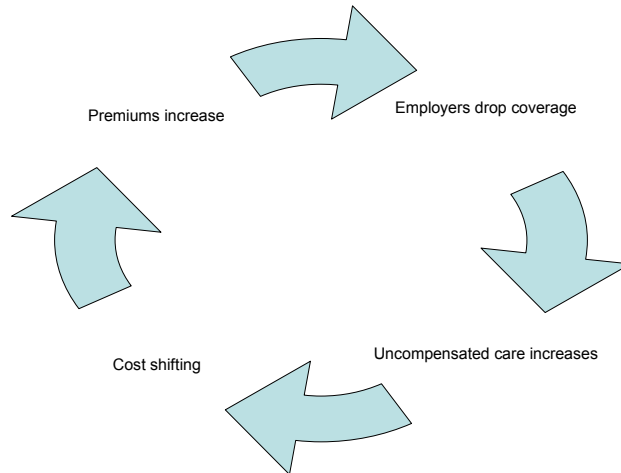
Burden on Providers

- \$6.5 billion in uncompensated care
- Approximately half of hospitals operating in the red
- 65 emergency rooms have closed since 1997

Burden on the Payers

- Cost shifting
- “Hidden Tax” = \$1,186/family, or \$455 for individual
- Result: 10% higher premiums

The Vicious circle



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Attempts to Address the Problem

- Let's try to solve this among ourselves
 - California Hospital Association voluntary guidelines
- Let's let the market solve this problem
 - Health Savings Accounts
 - Chargemaster transparency
- Let's sue 'em!
 - Scruggs lawsuits

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**We're from the Legislature and we're
here to help!**

Assembly Bill 774

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AB 774 from 10,000 feet

- Licensing statute
- Requires charity care policy, discount policy, and collections policy
- Limits **what** you can collect from uninsured and some insured
- Limits **how** you can collect from uninsured

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AB 774: It's gets more complicated on the ground

- Effective January 1, 2007
- What about dates of service prior to January 1, 2007?
- Unclear. Law applies to "patients," but does not specify if "patients" include patients discharged or treated prior to January 1, 2007

Who does AB 774 cover?

- General acute care hospitals
- Acute psychiatric hospitals
- Special hospitals (dentistry & maternity)
- Indirectly, collection agency and assigns working on behalf of hospitals

Who isn't covered

- Facilities operated by State Department of Mental Health
- Facilities operated by Department of Corrections

Is everyone's license at stake?

- Apparently no
- General acute care hospitals must comply with AB 774 as a condition of licensure
- Other affected facilities (psychiatric facilities, specialty hospitals) must follow law, but not as a condition of licensure

Charity Care Policy

- Hospitals must maintain an “understandable written charity care policy”

What is “charity care”?

- Free care?
- OSHPD website: Free care is full charity care, while discounted care is partial charity care

Who qualifies for charity care?

- Not specifically defined when a patient is entitled to free care
- Charity care policy must clearly state eligibility criteria
- When determining eligibility, hospitals only permitted to consider “income and monetary assets”

Determining Income

- Only permitted to review “pay stubs or income tax returns”
- Can hospital require both?
 - Unclear, but likely no
- What if patient has neither?
 - Unclear

Determining Assets – permissible info

- Permitted to review “monetary assets”
 - bank statements
- Are stocks, bonds, real estate holdings “monetary assets”?
 - Unclear

Determining Assets – impermissible info

- Retirement plans or deferred compensation plans (both qualified under Internal revenue code and not qualified)
- First \$10,000 of monetary assets
- 50% of a patient’s assets over \$10,000

Determining Assets - Example

- Hospital charity care policy allows free care for patients with less than \$20,000 in assets
- Patient has \$40,000 in savings account and receives \$10,000 in services

Determining Assets - Example

\$40,000
- \$10,000
= \$30,000
 $\$30,000 \times .50 = \$15,000$ in AB 774 – eligible assets
= FREE CARE

Discount Policy

- Hospitals must maintain an “understandable written policy regarding discount payments for financially qualified patients”

Who is financially qualified for discounts?

Includes both uninsured and insured patients

Financially Qualified Uninsured Patients

1. Self-pay
2. Income does not exceed 350% of the federal poverty level

Note = Assets not considered

Who is self-pay?

- Self-pay = No third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and injuries are not compensable for purposes of workers' compensation, automobile insurance, or "other insurance" as defined by the hospital

Who is less than 350% of the federal poverty level?

- Available on CMS website at http://www.cms.hhs.gov/MedicaidEligibility/07_IncomeandResourceGuidelines.asp
- Recommend putting the most recent guidelines either in policy, or posting on website, or both

Who is less than 350% of the federal poverty level?

- For family of 3, poverty level is \$17,170
- 350% of poverty level for this family is **\$60,095**
- For family of 5, poverty level is \$24,130
- 350% of poverty level for this family is **\$84,455**

Insured patients who qualify for discount

“High medical costs” =

- 1. Income less than 350% of FPL**
- 2. Does not receive discounted rate from hospital as a result of third-party coverage**
- 3. Out-of-pocket costs exceed 10% of annual income**

Qualified insured patients

Example 1: Patient with 20% co-insurance who has already met income and 10% out-of-pocket threshold

\$20,000 in billed charges

40% contractual discount

Bill re-priced by plan to 12,000 (60% of \$20,000, of which plan pays \$9,600 (80% of \$12,000))

Qualified insured patients

Example 1 Result: Not eligible for high medical cost discount. The plan re-priced the bill so the patient is paying discounted charges

Qualified insured patients

Example 2: Patient with 20% co-insurance who has already met income and 10% out-of-pocket threshold

\$20,000 in billed charges

No contractual discount – plan pays 80% of charges (PPO W/ OON Benefit)

Patient pays 20% of billed charges

Qualified insured patients

Example 2 Result: Patient did not receive a discount from full billed charges for his/her portion of the bill, so he/she is entitled to a discount

What is the discount?

Hospital must limit expected payment to eligible patients to the amount the hospital would expect to receive, in good faith, from Medicare, Medi-Cal, Healthy Families, or any other gov't-sponsored health program of health benefits in which the hospital participates, whichever is greater

What is the discount?

- **If no government program payment for the services in question, hospital must establish an appropriate discount**

Limitations?

- **Elective services (e.g. cosmetic)**
If they receive the service, they are eligible, so consider whether a screening process is appropriate
- **Scheduled non-elective services (e.g. transplants)**
- **If they receive the service, they are eligible, so consider whether a screening process is appropriate**

Limitations?

- **Out-of-service-area patients**
- **Foreign citizens**
Same answer = They are eligible if they receive services

Nothing in AB 774 requires hospitals to provide services, but when they do, eligible patients must be given a discount

Getting the word out about charity/discounted care

- **Intake process extraordinarily important**
- **All patients (not just uninsured) must receive information about charity/discounted care policies**
- **Hospital must provide uninsured patients with government program applications**

Getting the word out about charity/discounted care

- Posting requirements: Information about charity/discounted care must be posted in ER, billing office, admissions office, and other outpatient settings

Getting the word out about charity/discounted care

- Language requirements: All information must be printed in any language spoken by at least 5% of the population

5% languages

- Healthy Families approach: Applications printed in following languages:

English
Spanish
Armenian
Cambodian
Chinese
Farsi
Hmong
Korean
Lao
Russian
Vietnamese

Bills to the uninsured

- Must include information about charity/discounted care
- Must include information about government programs
- Contact information for hospital employee
- Must be in language spoken by patient

Appeals

- In the event of dispute, patient may appeal to CFO, business manager, or other appropriate manager
- Policy must describe the appeal process

Collection Practices

- Hospital must have written policy about when and under whose authority patient debt advanced to collection
- Collection agencies adhere to the same rules

A few tools no longer in the shed...

- Negative Credit reports – Not permitted until 150 days from initial billing has passed. Applies to all uninsured (not just those below 350% of FPL) Extended if patient appealing coverage decision.
- Interest on payment plans – Not permitted. Patient must be given opportunity to negotiate a payment plan.

A few tools no longer in the shed...

- Wage garnishments – Not permitted if you are a hospital. Permitted if you are a collection agency, but only if you receive court order after noticed motion and hearing.
- Notice or conduct of sale of residence – Not permitted except under very limited circumstances.

Put the blinders on again...

- Assets considered in charity care application cannot be used in collection activities, but information obtained independently can
- Assets exempt from charity care consideration also exempt from collection activities

Here come the penalties!

- Hospitals must reimburse patients for amounts actually paid in excess of amount due under this article, including interest
- SB 1312: \$17,500 penalty/violation for “financial harm” to patients

Posting the policies

- By January 1, 2008, all hospitals must post their charity care/discount policies with OSHPD, and biennially thereafter, unless no “significant” changes made
- Significant = patient’s perspective
- Need help?
<http://www.oshpd.state.ca.us/HID/AboutHID/AB774/AB774.htm>

Posting the policies

- Must be submitted electronically (paper copies not permitted)
- Two separate documents – Policies and Application
- Policies must be in MS Word
Application can be MS Word or PDF
- Technical requirements – Title 22, section 96046

Posting the policies

- Technical requirements – Title 22, section 96046:

“Hospitals shall use a Microsoft Internet Explorer web browser that supports a secure internet connection utilizing the Secure Hypertext Transfer Protocol (HTTPS or https) and 128-bit cypher strength Secure Socket Layer (SSL) to utilize the Office's internet System for Fair Price Hospital Reporting.”

In the Future...



Cleanup Legislation

- SB 350 – Chaptered October 8, 2007
- Effective January 1, 2008

SB 350

- Mitigates one unintended consequence of AB 774 – Inability of hospital to submit patient account to collection for patient who agreed to a payment plan but has defaulted on the agreement
- Hospital may declare the payment plan “no longer operative” after patient fails to make all consecutive payments due in a 90-day period

SB 350

- Cannot be “declared inoperative” until hospital or collection agency makes a reasonable attempt to contact the patient – both by phone and by mail – to inform patient that the plan may become inoperative
- Phone call to last known number, and notice to last known address
- If contact made, patient must be given opportunity to renegotiate the extended payment plan

SB 350

- Missed payments must be consecutive
→ If a patient misses a payment or two and then makes a subsequent payment, all within the 90-day period, the clock starts over
- Can a hospital make full payment of the arrears a condition for the renegotiation?
→ Unclear

SB 350

- Clarifies amount of interest that must be paid if hospital charges in excess of amounts permitted
- Tied to Code of Civil Procedure section 685.010
- 10% per annum (simple interest) from the date payment received by the hospital
- Interest Amounts < \$5 are not payable

In the future...

- SCHIP expansion is only a part of the puzzle
- Medi-Cal changes?
- Competing referenda?
- Federal action?

Charity Care Update



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