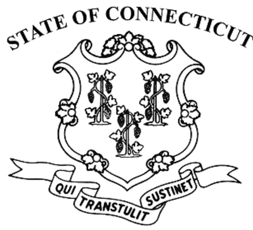

General Assembly **Amendment**

January Session, 2021 LCO No. **9102**

Offered by:
SEN. LOONEY, 11th Dist.

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

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

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

3 "Section 1. Section 19a-673 of the general statutes is repealed and the
4 following is substituted in lieu thereof (*Effective October 1, 2022*):

5 (a) As used in this section:

6 (1) "Affiliated with" means (A) employed by a hospital or health
7 system, (B) under a professional services agreement with a hospital or
8 health system that permits such hospital or health system to bill on
9 behalf of such entity, or (C) a clinical faculty member of a medical
10 school, as defined in section 33-182aa, who is affiliated with a hospital
11 or health system in a manner that permits such hospital or health system
12 to bill on behalf of such clinical faculty member.

13 (2) "Collection agent" has the same meaning as provided in section
14 19a-509b.

15 [(1)] (3) "Cost of providing services" means a hospital's published
16 charges at the time of billing, multiplied by the hospital's most recent
17 relationship of costs to charges as taken from the hospital's most recently
18 available annual financial filing with the unit.

19 [(2)] (4) "Hospital" [means an institution licensed by the Department
20 of Public Health as a short-term general hospital] has the same meaning
21 as provided in section 19a-490.

22 (5) "Owned by" means owned by a hospital or health system when
23 billed under the hospital's tax identification number.

24 [(3)] (6) "Poverty income guidelines" means the poverty income
25 guidelines issued from time to time by the United States Department of
26 Health and Human Services.

27 [(4)] (7) "Uninsured patient" means any person who is liable for one
28 or more hospital charges whose income is at or below two hundred fifty
29 per cent of the poverty income guidelines who (A) has applied and been
30 denied eligibility for any medical or health care coverage provided
31 under the Medicaid program due to failure to satisfy income or other
32 eligibility requirements, and (B) is not eligible for coverage for hospital
33 services under the Medicare or CHAMPUS programs, or under any
34 Medicaid or health insurance program of any other nation, state,
35 territory or commonwealth, or under any other governmental or
36 privately sponsored health or accident insurance or benefit program
37 including, but not limited to, workers' compensation and awards,
38 settlements or judgments arising from claims, suits or proceedings
39 involving motor vehicle accidents or alleged negligence.

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

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

49 Sec. 2. Section 19a-673b of the general statutes is repealed and the
50 following is substituted in lieu thereof (*Effective October 1, 2022*):

51 (a) As used in this section:

52 (1) "Affiliated with" means (A) employed by a hospital or health
53 system, (B) under a professional services agreement with a hospital or
54 health system that permits such hospital or health system to bill on
55 behalf of such entity, or (C) a clinical faculty member of a medical
56 school, as defined in section 33-182aa, who is affiliated with a hospital
57 or health system in a manner that permits such hospital or health system
58 to bill on behalf of such clinical faculty member.

59 (2) "Owned by" means owned by a hospital or health system when
60 billed under the hospital's tax identification number.

61 [(a)] (b) No hospital, as defined in section 19a-490, or entity that is
62 owned by or affiliated with such hospital shall refer to a collection agent,
63 as defined in section 19a-509b, or initiate an action against an individual
64 patient or such patient's estate to collect fees arising from health care
65 provided at a hospital or entity that is owned by or affiliated with such
66 hospital on or after October 1, 2003, unless the hospital [has made a
67 determination whether] or entity that is owned by or affiliated with such
68 hospital has determined that such individual patient is [(1)] an
69 uninsured patient, as defined in section 19a-673, as amended by this act,
70 [and (2) not eligible] who is ineligible for the hospital bed fund.

71 (c) On or after October 1, 2022, no hospital or entity that is owned by
72 or affiliated with such hospital, as defined in section 19a-490, and no
73 collection agent, as defined in section 19a-509b, that receives a referral
74 from a hospital or entity that is owned by or affiliated with such

75 hospital, shall:

76 (1) Report an individual patient to a credit rating agency, as defined
77 in section 36a-695, for a period of one year beginning on the date that
78 such patient first receives a bill for health care provided by the hospital
79 or entity that is owned by or affiliated with such hospital to such patient
80 on or after October 1, 2022;

81 (2) Initiate an action to foreclose a lien on an individual patient's
82 primary residence if the lien was filed to secure payment for health care
83 provided by the hospital or entity that is owned by or affiliated with
84 such hospital to such patient on or after October 1, 2022; or

85 (3) Apply to a court for an execution against an individual patient's
86 wages pursuant to section 52-361a, or otherwise seek to garnish such
87 patient's wages, to collect payment for health care provided by the
88 hospital or entity that is owned by or affiliated with such hospital to
89 such patient on or after October 1, 2022, if such patient is eligible for the
90 hospital bed fund.

91 **[**(b)**]** (d) Nothing in **[**this**]** subsection (b) or (c) of this section shall
92 affect **[**a hospital's**]** the ability of a hospital or entity that is owned by or
93 affiliated with such hospital to initiate an action against an individual
94 patient or such patient's estate to collect coinsurance, deductibles or fees
95 arising from health care provided at a hospital or entity that is owned
96 by or affiliated with such hospital where such coinsurance, deductibles
97 or fees may be eligible for reimbursement through awards, settlements
98 or judgments arising from claims, suits or proceedings. In addition,
99 nothing in **[**this section**]** said subsections shall affect **[**a hospital's**]** the
100 ability of a hospital or entity that is owned by or affiliated with such
101 hospital to initiate an action against an individual patient or such
102 patient's estate where payment or reimbursement has been made, or
103 likely is to be made, directly to the patient.

104 Sec. 3. Section 19a-673d of the general statutes is repealed and the
105 following is substituted in lieu thereof (*Effective October 1, 2022*):

106 (a) As used in this section:

107 (1) "Affiliated with" means (A) employed by a hospital or health
108 system, (B) under a professional services agreement with a hospital or
109 health system that permits such hospital or health system to bill on
110 behalf of such entity, or (C) a clinical faculty member of a medical
111 school, as defined in section 33-182aa, who is affiliated with a hospital
112 or health system in a manner that permits such hospital or health system
113 to bill on behalf of such clinical faculty member.

114 (2) "Owned by" means owned by a hospital or health system when
115 billed under the hospital's tax identification number.

116 (b) If, at any point in the debt collection process, whether before or
117 after the entry of judgment, a hospital **[**, a consumer collection agency
118 acting on behalf of the hospital, an attorney representing the hospital or
119 any employee or agent of the hospital**]** or entity that is owned by or
120 affiliated with such hospital, as defined in section 19a-490, or a collection
121 agent, as defined in section 19a-509b, becomes aware that a debtor from
122 whom the hospital or entity that is owned by or affiliated with such
123 hospital is seeking payment for **[**services**]** health care rendered receives
124 information that the debtor is eligible for hospital bed funds, free or
125 reduced price hospital services **[**,**]** or any other program which would
126 result in the elimination of liability for the debt or reduction in the
127 amount of such liability, **[**the**]** such hospital **[**, collection agency,
128 attorney, employee or agent**]** or entity that is owned by or affiliated with
129 such hospital or collection agent shall promptly discontinue all
130 collection efforts against such debtor for such health care and refer the
131 collection file for such health care to **[**the**]** such hospital **[**for
132 determination of such eligibility. The**]** or entity that is owned by or
133 affiliated with such hospital until such hospital or entity determines
134 whether such debtor is eligible for such elimination or reduction. Such
135 collection **[**effort**]** efforts shall not resume until such hospital or entity
136 makes such determination. **[**is made.**]**

137 Sec. 4. Section 19a-508c of the general statutes is repealed and the

138 following is substituted in lieu thereof (*Effective October 1, 2022*):

139 (a) As used in this section:

140 (1) "Affiliated provider" means a provider that is: (A) Employed by a
141 hospital or health system, (B) under a professional services agreement
142 with a hospital or health system that permits such hospital or health
143 system to bill on behalf of such provider, or (C) a clinical faculty member
144 of a medical school, as defined in section 33-182aa, that is affiliated with
145 a hospital or health system in a manner that permits such hospital or
146 health system to bill on behalf of such clinical faculty member;

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

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

158 (4) "Health system" means: (A) A parent corporation of one or more
159 hospitals and any entity affiliated with such parent corporation through
160 ownership, governance, membership or other means, or (B) a hospital
161 and any entity affiliated with such hospital through ownership,
162 governance, membership or other means;

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

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

167 (7) "Payer mix" means the proportion of different sources of payment

168 received by a hospital or health system, including, but not limited to,
169 Medicare, Medicaid, other government-provided insurance, private
170 insurance and self-pay patients;

171 [(7)] (8) "Professional fee" means any fee charged or billed by a
172 provider for professional medical services provided in a hospital-based
173 facility; [and]

174 [(8)] (9) "Provider" means an individual, entity, corporation or health
175 care provider, whether for profit or nonprofit, whose primary purpose
176 is to provide professional medical services; and

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

180 (b) If a hospital or health system charges a facility fee utilizing a
181 current procedural terminology evaluation and management (CPT
182 E/M) code or assessment and management (CPT A/M) code for
183 outpatient services provided at a hospital-based facility where a
184 professional fee is also expected to be charged, the hospital or health
185 system shall provide the patient with a written notice that includes the
186 following information:

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

191 (2) (A) The amount of the patient's potential financial liability,
192 including any facility fee likely to be charged, and, where professional
193 medical services are provided by an affiliated provider, any professional
194 fee likely to be charged, or, if the exact type and extent of the
195 professional medical services needed are not known or the terms of a
196 patient's health insurance coverage are not known with reasonable
197 certainty, an estimate of the patient's financial liability based on typical
198 or average charges for visits to the hospital-based facility, including the

199 facility fee, (B) a statement that the patient's actual financial liability will
200 depend on the professional medical services actually provided to the
201 patient, (C) an explanation that the patient may incur financial liability
202 that is greater than the patient would incur if the professional medical
203 services were not provided by a hospital-based facility, and (D) a
204 telephone number the patient may call for additional information
205 regarding such patient's potential financial liability, including an
206 estimate of the facility fee likely to be charged based on the scheduled
207 professional medical services; and

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

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

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

222 (2) (A) A statement that the patient's actual financial liability will
223 depend on the professional medical services actually provided to the
224 patient, (B) an explanation that the patient may incur financial liability
225 that is greater than the patient would incur if the hospital-based facility
226 was not hospital-based, and (C) a telephone number the patient may call
227 for additional information regarding such patient's potential financial
228 liability, including an estimate of the facility fee likely to be charged
229 based on the scheduled professional medical services; and

230 (3) That a patient covered by a health insurance policy should contact

231 the health insurer for additional information regarding the hospital's or
232 health system's charges and fees, including the patient's potential
233 financial liability, if any, for such charges and fees.

234 (d) **[**On and after January 1, 2016, each**]** Each initial billing statement
235 that includes a facility fee shall: (1) Clearly identify the fee as a facility
236 fee that is billed in addition to, or separately from, any professional fee
237 billed by the provider; (2) provide the corresponding Medicare facility
238 fee reimbursement rate for the same service as a comparison or, if there
239 is no corresponding Medicare facility fee for such service, (A) the
240 approximate amount Medicare would have paid the hospital for the
241 facility fee on the billing statement, or (B) the percentage of the hospital's
242 charges that Medicare would have paid the hospital for the facility fee;
243 (3) include a statement that the facility fee is intended to cover the
244 hospital's or health system's operational expenses; (4) inform the patient
245 that the patient's financial liability may have been less if the services had
246 been provided at a facility not owned or operated by the hospital or
247 health system; and (5) include written notice of the patient's right to
248 request a reduction in the facility fee or any other portion of the bill and
249 a telephone number that the patient may use to request such a reduction
250 without regard to whether such patient qualifies for, or is likely to be
251 granted, any reduction. Not later than October 15, 2022, and annually
252 thereafter, each hospital, health system and hospital-based facility shall
253 submit to the Health Planning Unit of the Office of Health Strategy a
254 sample of a billing statement issued by such hospital, health system or
255 hospital-based facility that complies with the provisions of this
256 subsection and which represents the format of billing statements
257 received by patients. Such billing statement shall not contain patient
258 identifying information.

259 (e) The written notice described in subsections (b) to (d), inclusive,
260 and (h) to (j), inclusive, of this section shall be in plain language and in
261 a form that may be reasonably understood by a patient who does not
262 possess special knowledge regarding hospital or health system facility
263 fee charges. On and after October 1, 2022, such notices shall include tag
264 lines in at least the top fifteen languages spoken in the state indicating

265 that the notice is available in each of those top fifteen languages. The
266 fifteen languages shall be either the languages in the list published by
267 the Department of Health and Human Services in connection with
268 section 1557 of the Patient Protection and Affordable Care Act, P.L. 111-
269 148, or, as determined by the hospital or health system, the top fifteen
270 languages in the geographic area of the hospital-based facility.

271 (f) (1) For nonemergency care, if a patient's appointment is scheduled
272 to occur ten or more days after the appointment is made, such written
273 notice shall be sent to the patient by first class mail, encrypted electronic
274 mail or a secure patient Internet portal not less than three days after the
275 appointment is made. If an appointment is scheduled to occur less than
276 ten days after the appointment is made or if the patient arrives without
277 an appointment, such notice shall be hand-delivered to the patient when
278 the patient arrives at the hospital-based facility.

279 (2) For emergency care, such written notice shall be provided to the
280 patient as soon as practicable after the patient is stabilized in accordance
281 with the federal Emergency Medical Treatment and Active Labor Act,
282 42 USC 1395dd, as amended from time to time, or is determined not to
283 have an emergency medical condition and before the patient leaves the
284 hospital-based facility. If the patient is unconscious, under great duress
285 or for any other reason unable to read the notice and understand and
286 act on his or her rights, the notice shall be provided to the patient's
287 representative as soon as practicable.

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

292 (h) A hospital-based facility shall prominently display written notice
293 in locations that are readily accessible to and visible by patients,
294 including patient waiting or appointment check-in areas, stating: (1)
295 That the hospital-based facility is part of a hospital or health system, (2)
296 the name of the hospital or health system, and (3) that if the hospital-

297 based facility charges a facility fee, the patient may incur a financial
298 liability greater than the patient would incur if the hospital-based
299 facility was not hospital-based. On and after October 1, 2022, such
300 notices shall include tag lines in at least the top fifteen languages spoken
301 in the state indicating that the notice is available in each of those top
302 fifteen languages. The fifteen languages shall be either the languages in
303 the list published by the Department of Health and Human Services in
304 connection with section 1557 of the Patient Protection and Affordable
305 Care Act, P.L. 111-148, or, as determined by the hospital or health
306 system, the top fifteen languages in the geographic area of the hospital-
307 based facility. Not later than October 1, 2022, and annually thereafter,
308 each hospital-based facility shall submit a copy of the written notice
309 required by this subsection to the Health Systems Planning Unit of the
310 Office of Health Strategy.

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

315 (j) A hospital-based facility shall, when scheduling services for which
316 a facility fee may be charged, inform the patient (1) that the hospital-
317 based facility is part of a hospital or health system, (2) of the name of the
318 hospital or health system, (3) that the hospital or health system may
319 charge a facility fee in addition to and separate from the professional fee
320 charged by the provider, and (4) of the telephone number the patient
321 may call for additional information regarding such patient's potential
322 financial liability.

323 (k) (1) [On and after January 1, 2016, if any transaction, as] If any
324 transaction described in subsection (c) of section 19a-486i, results in the
325 establishment of a hospital-based facility at which facility fees [will
326 likely] may be billed, the hospital or health system, that is the purchaser
327 in such transaction shall, not later than thirty days after such transaction,
328 provide written notice, by first class mail, of the transaction to each
329 patient served within the [previous] three years preceding the date of

330 the transaction by the health care facility that has been purchased as part
331 of such transaction.

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

333 (A) A statement that the health care facility is now a hospital-based
334 facility and is part of a hospital or health system, the health care facility's
335 full legal and business name and the date of such facility's acquisition
336 by a hospital or health system;

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

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

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

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

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

357 (3) A copy of the written notice provided to patients in accordance
358 with this subsection shall be filed with the Health Systems Planning
359 Unit of the Office of Health Strategy, established under section 19a-612.

360 Said unit shall post a link to such notice on its Internet web site.

361 (4) A hospital, health system or hospital-based facility shall not collect
362 a facility fee for services provided at a hospital-based facility that is
363 subject to the provisions of this subsection from the date of the
364 transaction until at least thirty days after the written notice required
365 pursuant to this subsection is mailed to the patient or a copy of such
366 notice is filed with the Health Systems Planning Unit, whichever is later.
367 A violation of this subsection shall be considered an unfair trade
368 practice pursuant to section 42-110b.

369 (5) Not later than July 1, 2023, and annually thereafter, each hospital-
370 based facility that was the subject of a transaction, as described in
371 subsection (c) of section 19a-486i, during the preceding calendar year
372 shall report to the Health Systems Planning Unit the number of patients
373 served by such hospital-based facility in the preceding three years.

374 (l) Notwithstanding the provisions of this section, no hospital, health
375 system or hospital-based facility shall collect a facility fee for (1)
376 outpatient health care services that use a current procedural
377 terminology evaluation and management (CPT E/M) code or
378 assessment and management (CPT A/M) code and are provided at a
379 hospital-based facility located off-site from a hospital campus, or (2)
380 outpatient health care services provided at a hospital-based facility
381 located off-site from a hospital campus, received by a patient who is
382 uninsured of more than the Medicare rate. Notwithstanding the
383 provisions of this subsection, in circumstances when an insurance
384 contract that is in effect on July 1, 2016, provides reimbursement for
385 facility fees prohibited under the provisions of this section, a hospital or
386 health system may continue to collect reimbursement from the health
387 insurer for such facility fees until the date of expiration, renewal or
388 amendment of such contract, whichever such date is the earliest. A
389 violation of this subsection shall be considered an unfair trade practice
390 pursuant to chapter 735a. The provisions of this subsection shall not
391 apply to a freestanding emergency department. As used in this
392 subsection, "freestanding emergency department" means a freestanding

facility that (A) is structurally separate and distinct from a hospital, (B) provides emergency care, (C) is a department of a hospital licensed under chapter 368v, and (D) has been issued a certificate of need to operate as a freestanding emergency department pursuant to chapter 368z.

(m) (1) Each hospital and health system shall report not later than July 1, **[**2016**]** 2023, and annually thereafter to the executive director of the Office of Health Strategy, on a form prescribed by the executive director, concerning facility fees charged or billed during the preceding calendar year. Such report shall include (A) the name and **[**location**]** address of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or billed, (B) the number of patient visits at each such facility for which a facility fee was charged or billed, (C) the number, total amount and range of allowable facility fees paid at each such facility **[**by Medicare, Medicaid or under private insurance policies**]** disaggregated by payer mix, (D) for each facility, the total amount of facility fees charged and the total amount of revenue received by the hospital or health system derived from facility fees, (E) the total amount of facility fees charged and the total amount of revenue received by the hospital or health system from all facilities derived from facility fees, (F) a description of the ten procedures or services that generated the greatest amount of facility fee gross revenue, disaggregated by current procedural terminology category (CPT) code for each such procedure or service and, for each such procedure or service, patient volume and the total amount of gross and net revenue received by the hospital or health system derived from facility fees, and (G) the top ten procedures or services for which facility fees are charged based on patient volume and the gross and net revenue received by the hospital or health system for each such procedure or service. For purposes of this subsection, "facility" means a hospital-based facility that is located outside a hospital campus.

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

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

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

433 (2) Study methods to ensure the viability of physician practices; and

434 (3) Develop legislative recommendations to improve reporting and
435 oversight of physician practice mergers and acquisitions, including, but
436 not limited to, the necessity for any amendments to section 19a-486i,
437 19a-639 or 19a-630 of the general statutes.

438 (b) Not later than February 1, 2023, the executive director of the Office
439 of Health Strategy shall report, in accordance with the provisions of
440 section 11-4a of the general statutes, to the joint standing committee of
441 the General Assembly having cognizance of matters relating to public
442 health regarding the outcome of the study and any recommendations
443 for legislative action as a result of such study."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2022*	19a-673
Sec. 2	*October 1, 2022*	19a-673b
Sec. 3	*October 1, 2022*	19a-673d
Sec. 4	*October 1, 2022*	19a-508c
Sec. 5	*from passage*	New section