F I S C A L I M P A C T R E P O R T

SPONSOR Chavez, E. **ORIGINAL DATE** 02/08/11 **LAST UPDATED** **HB** 223

SHORT TITLE Limit Hospital Charges for Uninsured **SB**

ANALYST Esquibel

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY11	**FY12**		
	None		

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files
Responses Received From
Human Services Department
Department of Health
NM Hospital Association
Aging and Long-Term Services Department

SUMMARY

Synopsis of Bill

House Bill 223 would amend section 24.1.5.8 "Legislative Findings; Licensing Requirements for Certain Hospitals" of the Public Health Act by adding language requiring hospitals to limit charges to uninsured residents of the state to no greater than 115% of the applicable payment rate under the federal Medicare program.

The amount charged to uninsured residents of the state whose gross family income is less than 500% of the federal poverty level (FPL) income would be restricted to a sliding scale amount established by the Department of Health and based on income.

The bill adds language that the legislature finds that "when an uninsured patient feels a fair price is being charged for emergency and general health care services, the uninsured patient is more likely to pay for those services, which can reduce the financial losses of these hospitals."

FISCAL IMPLICATIONS

The bill contains no appropriation or direct affect on state agencies.

SIGNIFICANT ISSUES

The Human Services Department indicates hospitals are required by most payers to maintain a "charge master" which states the amount that will be charged for services. Hospitals are typically required to bill insurance programs, including Medicare and Medicaid, at the amount stated in the charge master, even though these payers do not pay the hospital the full amount of the billed charge. Because of contracts, provider agreements, and Medicare and Medicaid payment levels, hospitals often "write-off" some portions of the charges as exceeding the contractual allowance. This charge master is also used to bill a non-insured patient at that same charge master rate. Since there is not an agreement between the non-insured patient and the hospital to be paid at a lower rate, the amount a hospital charges a non-insured patient is much more than the hospital would receive from almost every other payer.

For uninsured patients, there is no immediate "write-off", so the patient is billed the entire amount. Most hospitals, after carrying the unpaid bill in their accounts receivable, will negotiate with a patient over lower interest rates and even reduced charges, but this is dependent on the astuteness of the patient and the flexibility of the hospital. Often, the account is turned over to a collection agency.

On an inpatient hospital claim, Medicare pays approximately 34% of the billed charges when averaged across all hospitals and all claims. On average then, a hospital would reduce their charges to an uninsured patient to approximately 39% of the patient's total current charges.

Overall, HB223 would reduce the amount billed to an uninsured patient by about 61%, and the patient would be charged an amount much closer to what insurance companies, Medicare, and Medicaid, would pay the hospital.

Implementation of HB223 would almost certainly mean a drop in a hospital's revenue. However, HSD does not have access to any information on the amount of charges to uninsured patients that is collected, either wholly or partially, or the amount that is sold to collection agencies at a percentage of the value.

There are two states that have given rate setting authority to a state agency. West Virginia, for example, does not allow a hospital to agree to a reduced or discounted payment rate from private insurers without state agency approval. (This does not apply to government payers such as Medicare and Medicaid). So the insurance company pays a higher portion on a hospital's bill. West Virginia maintains this has allowed the hospital to keep charges lower, which would mean a non-insured patient would be charged less. The hospitals would not be expecting their non-insured patients to essentially make up for the lower payment levels of insurance companies.

The Department of Health indicates sliding fee scales are commonly set locally, reflecting community specific conditions and norms.

Uninsured patients are usually referred to as self-pay patients for the purposes of billing. Many New Mexico hospitals utilize a sliding fee scale for self-pay patients. For example, St Vincent Regional Medical Center, Los Alamos Medical Center, and Espanola Hospital provide sliding fee scale services for those without any insurance, through Santa Fe County's Healthcare Assistance Program.

(http://www.santafecounty.org/community_services/hhsd/hap)

The six Critical Access Hospitals in New Mexico currently utilize sliding fee scales to meet requirements of federal Public Health Law 2807-k(9-a) which states that self-pay discounts should be equal to the discount taken by the hospital's largest volume payer. For Critical Access Hospitals, Medicare is normally the largest volume payer. *(Source: DOH Office of Primary Care and Rural Health*)

Many hospitals also offer a variety of payment plans to assist uninsured patients, including county indigent funding, reduced prescription drugs and related programs. For some hospitals, working with uninsured patients is a major component of care. *(Source: Discussion with Dee Rush, CEO Sierra Vista Hospital, 1/28/11).*

The New Mexico Hospital Association also provides guidance to hospitals in assisting patients that have financial difficulties for a variety of reasons, not just being uninsured (*Source: Discussion with Jeff Dye, President & CEO, NM Hospital Association, 1/28/11*).

TECHNICAL ISSUES

The New Mexico Hospital Association (NMHA) notes the following difficulties with HB223:

- The use of the term "uninsured" is problematic. Hospitals interact with patients who have a broad range of personal circumstances and may have multiple levels of insurance coverage or partial insurance from different sources. Flexible local policies allow hospitals to tailor payment options to all patients that need financial assistance.
- 500% of FPL is too high. Kaiser Family Foundation estimates there are 334,800 non-elderly, uninsured New Mexicans below 250% of FPL. A 500% FPL threshold would add a mandatory requirement on hospitals to reduce collections from a pool of an additional 100,000 people with fairly high income levels.
- The terminology "charge" should be replaced with "collect". Hospitals generally charge all patients equally but then collect reduced amounts in keeping with their billing and collection policies.
- The bill has a compounding effect. It limits charges to ALL uninsured to 115% of Medicare. Patients under 500% of FPL are eligible for a sliding scale that would result in even lower charges.
- HB223 would discourage, rather than encourage, people to buy insurance and would end up shifting more costs to commercial coverage and increasing the burden on business.

OTHER SUBSTANTIVE ISSUES

The New Mexico Hospital Association (NMHA) respectfully opposes the bill on the following grounds:

- New Mexico hospitals are already actively providing financial assistance to patients in need.
- The members of NMHA are committed to billing and collection practices that treat patients equitably, with dignity, respect and compassion.

- NMHA has published a guidance document to its members which already addresses the intent of HB223.
- Hospitals are already advised to limit charges to financial assistance patients at 100% of government-sponsored health programs, such as Medicare.
- In practice, most hospitals already tie their financial assistance programs to FPL levels of 200% or more.
- The policy at one large system provides for free care up to 200% and sliding scale up to 300% of FPL and would cover 1/3 of the state.

RAE/bym