

## HB21-1198: HEALTH-CARE BILLING REQUIREMENTS FOR INDIGENT PATIENTS

Concerning health-care billing requirements for indigent patients receiving services not reimbursed through the Colorado Indigent Care Program, and, in connection therewith, establishing procedures before initiating collections proceedings against a patient.

### Details

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<b>Bill Sponsors:</b>	House – Jodeh (D) Senate – Buckner (D) and Kolker (D)
<b>Committee:</b>	House Health & Insurance
<b>Bill History:</b>	3/4/2021- Introduced in House
<b>Next Action:</b>	4/21/2021- Hearing in House Health & Insurance Committee
<b>Fiscal Note:</b>	<u><a href="#">3/30/2021</a></u>

### Bill Summary

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The bill requires hospitals to screen uninsured patients for health coverage options and potential financial assistance for which they may be eligible. Each hospital must use a uniform application developed by the Department of Health Care Policy and Financing (HCPF) when screening a patient. It also limits the amount that low-income patients pay for certain health services by tying what they owe to an established rate while also limiting the size of payments charged on a monthly basis. In addition, it prohibits hospitals from sending a patient to collections unless they have screened the patient for coverage and assistance, offered a fair payment plan, and provided information regarding patient rights.

### Issue Summary

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#### Insurance Coverage

Medical insurance is a contractual relationship between an individual or family and a health care cost administrative company. Medical insurance can either be public, when administered by government entities, or private, as when administered through an employer's relationship with an insurance company.<sup>1</sup> In exchange for monthly payments, or a premium, insurance companies help individuals and/or families finance medical care and access affordable 'in-network' medical providers who have also formed a contractual relationship with the same insurance company.<sup>1</sup> Medical insurance often covers certain medical tests, office visits, treatments, supplies, medications and services.<sup>2</sup> Most, but not all, medical insurance plans require members to pay a copay (e.g. a flat fee for care at the time of service), as well as co-insurance (e.g. a certain percentage of the total cost of medical service covered by the insurance). Such co-insurance is not usually activated until members pay a certain quantity of their own money (e.g. their deductible). Members are expected to pay up to, and no more than, their out-of-pocket maximum - a pre-determined amount for covered services by in-network providers. The insurance company's formulary, or list of drugs it covers, determines the level of member cost sharing requirements for different prescription drugs.<sup>2</sup>

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<sup>1</sup> HealthCare.gov. "Health insurance: How it protects you from health and financial risks", 2021. <https://www.healthcare.gov/why-coverage-is-important/coverage-protects-you/>

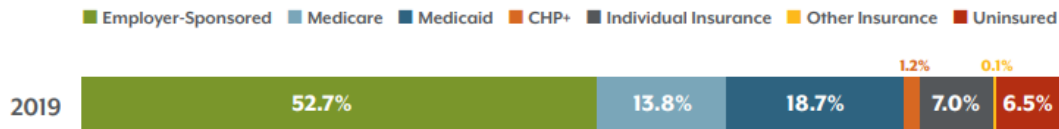
<sup>2</sup> BlueCrossBlueShield Minnesota "How health insurance works", 2021. <https://www.bluecrossmn.com/shop-plans/individual-and-family-plans/how-health-insurance-works>

## Attempts to Cover More Americans; Remaining Need

However, many Americans have been unable to obtain medical insurance, due to cost and/or inability to obtain insurance through employment. The Affordable Care Act (ACA) sought to address this lack of medical insurance coverage by extending Medicaid coverage to those living in households below 133% of federal poverty level (FPL), and by providing subsidies for Marketplace coverage for individuals living in households with incomes below 400% of FPL. More recently, the American Rescue Plan Act, passed in March 2021, has temporarily expanded subsidies for those with incomes above 400% of FPL.<sup>3</sup> Following the ACA, the number of uninsured nonelderly Americans declined by 20 million, dropping to an historic low in 2016. However, beginning in 2017, the number of uninsured nonelderly Americans increased for three straight years, growing by 2.2 million from 26.7 million in 2016 to 28.9 million in 2019, and the uninsured rate increased from 10.0% in 2016 to 10.9% in 2019.<sup>4</sup> Recently, according to data from the U.S. Bureau of Labor Statistics and The Urban Institute, the U.S. uninsured rate rose 21 percent between 2018 and 2020. Each state also saw an increase in their uninsured rates during this period. The COVID-19 pandemic also contributed to an expansion of uninsured rates, as 5.4 million Americans lost health insurance coverage due to job loss between just February and May of 2020.<sup>5</sup>

## Insurance Coverage in Colorado

According to the 2019 Colorado Health Access Survey (CHAS) administered by the Colorado Health Institute, 93.5% of Coloradans were insured in 2019.<sup>6</sup> The majority of Coloradans (52.7%) are covered through plans provided by employers. Another 33.7% are covered by public programs, including Medicare, Medicaid, and the Child Health Plan Plus (CHP+). And 7% purchase their insurance on the individual market, either through the marketplace run by Connect for Health Colorado (which offers subsidies for those with eligible incomes), or insurance that is offered off the marketplace. The figure below, from the Colorado Health Institute (CHI), demonstrates the proportion of residents in the different types of insurance coverage offered in Colorado.<sup>6</sup>



However, in 2019, 6.5% of respondents in the CHAS survey reported being uninsured. Cost has typically been the biggest barrier to coverage in Colorado. In recent years, more people in Colorado are feeling this financial barrier to medical insurance and care. For those who reported being uninsured, 89.6% cited that the cost of the insurance was a barrier to purchasing coverage, which is much greater than the 78.4% that had the same response in 2017.<sup>1</sup>

The uninsured rate, though, varies significantly throughout the state – ranging from 2.6% in Jefferson County to 14.3% in the I-70 mountain corridor. Additionally, in 2019, despite such a low uninsured rate, 17.3% (or one in six) of Coloradans have switched, lost or gained coverage in the previous year. Such a change in

<sup>3</sup> Kaiser Family Foundation (KFF). “How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured”, March 25, 2021. <https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/>

<sup>4</sup> Kaiser Family Foundation (KFF). “Key Facts About the Uninsured Population”, November 6, 2020. <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=The%20uninsured%20rate%20in%202019%20ticked%20up%20to%2010.9%25%20from,significantly%20below%20pre%20DACA%20levels>

<sup>5</sup> Becker’s Hospital Review. “States Ranked by Uninsured Rates”, July 15, 2020. <https://www.beckershospitalreview.com/rankings-and-ratings/states-ranked-by-uninsured-rates.html>

<sup>6</sup> Colorado Health Institute (CHI) “Progress in Peril: 2019 Colorado Health Access Survey Storybook” (Jan. 2020).

[https://www.coloradohealthinstitute.org/sites/default/files/file\\_attachments/CHAS%20Storybook%202019%20for%20Web.pdf](https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHAS%20Storybook%202019%20for%20Web.pdf)

insurance status can cause disruption in care or strain finances. 53% of the Coloradans who switched insurers or lost coverage said it was due to loss of employer-sponsored coverage.<sup>7</sup>

Each of the 64 counties in Colorado has at least one carrier providing insurance on the Connect for Health Colorado marketplace. For the 2021 plan year, 10 of Colorado's 64 counties had only one carrier offering plans, a decrease from 22 counties for the 2020 plan year.<sup>8</sup>

The expansion of public health insurance programs impacted the lowest-income Coloradans the most, providing coverage for all those eligible for Medicaid. However, Coloradans with incomes at 201-300% FPL, who are typically not eligible for Medicaid, struggle with affordability, and saw their uninsured rate nearly double in recent years (6.6% in 2015 to 11.8% in 2019).<sup>9</sup> Additionally, just over 10% of Hispanic/Latinx Coloradans are uninsured, a significantly higher percentage than the overall 6.5% uninsured rate for all of Colorado. While this is a marked decrease since 2009 (when it was nearly 27.6%), Hispanic/Latinx Coloradans experience significantly higher uninsured rates than any other racial or ethnic group in the state. Further, Black (non-Hispanic / Latinx) Coloradans are nearly twice as likely to have had problems paying a medical bill than white (non-Hispanic / Latinx) Coloradans (30.2% versus 16.5%).<sup>10</sup>

After falling from 12% to 4% between 2013 and 2016, Larimer County survey respondents aged 18-64 who reported having no health insurance jumped to 8% in 2019. In 2019, 53.8% of Larimer County adults reported being somewhat or very worried about health insurance becoming so expensive that they will not be able to afford it.<sup>11</sup>

### Medical Debt

In 2019, just over 20% of Coloradans cited cost as the reason they did not seek treatment by a doctor or specialist or obtain prescription services. Between 2017 and 2019, the percentage of Coloradans who struggled to pay medical bills rose from 14.0% to 18.1%. Of those who had difficulty paying medical bills in 2019, 70.5% saved less or took funds out of savings, 53.9% took on credit card debt, 32.6% were unable to pay for necessities like rent, food or heat, 28.4% worked extra hours or started another job, 18.6% took out a loan, and 3.7% declared bankruptcy.<sup>12</sup>

### EMTALA

The Emergency Medical Treatment and Labor Act (EMTALA) was passed in 1986<sup>13</sup> to ensure that patients have access to emergency services regardless of their ability to pay.<sup>14</sup> EMTALA imposes specific responsibilities on all Medicare participating hospitals, which apply to all patients. The three central provisions include:

1. The hospital must provide an appropriate medical screening exam to anyone coming to the emergency department (ED) seeking medical care;

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<sup>7</sup> CHI "2019 Colorado Health Access Survey: Health Insurance Coverage", October 9, 2020.

<https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-insurance-coverage>

<sup>8</sup> Division of Insurance "Same eight companies returning to offer individual health insurance plans 2021 while number of plans increases" (July 9, 2020). <https://doi.colorado.gov/press-release/same-eight-companies-returning-to-offer-individual-health-insurance-plans-for-2021>

<sup>9</sup> CHI "2019 Colorado Health Access Survey: Health Insurance Coverage", October 9, 2020.

<https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-insurance-coverage>

<sup>10</sup> CHI "2019 Colorado Health Access Survey: Health Insurance Coverage", October 9, 2020.

<https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-insurance-coverage>

<sup>11</sup> Health District of Northern Larimer County "2019 Community Health Assessment" (2020) <https://www.healthdistrict.org/2019-community-health-assessment>

<sup>12</sup> CHI "2019 Colorado Health Access Survey: Health Insurance Coverage", October 9, 2020.

<https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-insurance-coverage>

<sup>13</sup> 42 U.S.C. §1395dd

<sup>14</sup> CMS. "Emergency Medical Treatment and Labor Act" <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA>

2. For anyone that comes to the hospital and the hospital determines that the individual has an emergency medical condition, the hospital must treat and stabilize the emergency medical condition, or the hospital must transfer the individual; and
3. A hospital must not transfer an individual with an emergency medical condition that has not been stabilized unless several conditions are met that includes effecting an appropriate transfer.

### Colorado Indigent Care Program (CICP)

The Colorado Indigent Care Program (CICP) is a program administered by the Colorado Department of Health Care Policy and Financing (HCPF). Although CICP is not health insurance, the program strives to partially compensate participating providers who care for the uninsured and underinsured who have incomes at or below 250% of FPL<sup>15</sup>. Through provider compensation, CICP delivers discounted health care services to low-income people and families at participating clinics and hospitals throughout the state. Since CICP is not health insurance, medical services discounted under CICP may be different at each participating hospital or clinic. The CICP discount only applies to qualifying services after any health insurance has been applied to the cost. The qualifying individual or family then pays either the balance remaining after insurance or the CICP co-payment, whichever is lower. Potential CICP enrollees must apply to the program with personal identification, household income and resource information for themselves and their family. To be eligible, they must be legal Colorado residents, meet income and resource guidelines, cannot be eligible for Medicaid or the Child Health Plan Plus (CHP+), and may be covered by Medicare or other health insurance.<sup>16</sup>

#### General Income Limits for CICP Eligibility<sup>17</sup>

Family Size	Approximate Annual Income	Approximate Monthly Income
1	up to \$31,900	up to \$2,658
2	up to \$43,100	up to \$3,592
3	up to \$54,300	up to \$4,525
4	up to \$65,500	up to \$5,458

### This Legislation

#### Definitions

**Health-care facility.** A licensed general hospital, University of Colorado hospital authority, Denver Health and Hospital Authority, any freestanding emergency department (FSED), any outpatient facility that is affiliated with or operating under these hospitals or FSEDs.

**Health-care services.** Any services included in furnishing of medical, behavioral, mental health, or substance use disorder care; dental, or optometric care; hospitalization; or nursing home care to an individual, as well as any other services for the purpose of preventing, alleviating, curing, or healing human physical illness or injury, or behavioral, mental health, or substance use disorder. This includes the rendering of the services through the use of telehealth.<sup>18,19</sup>

**Licensed health-care professional.** Any health care professional who is registered, certified, or licensed or a person who provides services under the supervision of a professional, and who provides health care services in a health care facility.

<sup>15</sup> Colorado Department of Health Care Policy & Financing. "Colorado Indigent Care Program (CICP) Health Care Reform Frequently Asked Questions (FAQ) for Providers", September 20, 2013. <https://cchn.org/wp-content/uploads/2013/10/CICP-Provider-FAQ.pdf>

<sup>16</sup>Colorado Department of Health Care Policy & Financing. "Colorado Indigent Care Program", 2019. <https://www.colorado.gov/pacific/hcpf/colorado-indigent-care-program>

<sup>17</sup>Colorado Department of Health Care Policy & Financing. "Colorado Indigent Care Program", 2019. <https://www.colorado.gov/pacific/hcpf/colorado-indigent-care-program>

<sup>18</sup> Definition from C.R.S. §10-16-102(33)

<sup>19</sup> Telehealth defined at: C.R.S. §10-16-123 (4)(e)

**Non-CICP health-care services.** Health care services provided in a health care facility for which reimbursement under the Colorado Indigent Care Program (CICP) is not available.

**Qualified patient.** An individual whose household income is no more than 250% of the federal poverty level (FPL) and who received a health care service at a health care facility.

**Screen/Screening.** A process identified by HCPF rule where health care facilities assess the patient related to eligibility criteria and determine whether the patient is likely to qualify for public health coverage or discounted care, inform the patient of the determination, and provide information to the patient about how the patient can enroll in public coverage.

### **Requirement to Screen Patients for Public Programs & Discounted Care**

Starting June 1, 2022, a health care facility must screen each uninsured patient, unless they decline, for:

- Public health insurance programs, including Medicare, Medicaid, Emergency Medicaid, Children's Health Plan Plus
- Discounted care through CICP, if the service received is eligible for reimbursement through the program
- Discounts on services not eligible for CICP reimbursement, as outlined in the next section

Health facilities must use a single, uniform application developed by HCPF to conduct screening. If a facility determines that the patient is ineligible for discounted care, it must provide the patient with notice of that determination and an opportunity for the patient to appeal, in accordance with HCPF rules. If the patient declines the screening, the facility must document the patient's decision, in accordance with HCPF rules. If screening is requested by an insured patient, the facility must do so to see if they qualify for discounted care.

### **Discounted Care for Services Not Eligible for CICP**

If a screened patient is determined to be a qualified patient, a health care facility and a licensed health care professional must, for emergency and other non-CICP services:

- Limit the charged amounts to no more than 80% of Medicare rates
- Collect charged amounts (not including those owed by third-party payers) in monthly installments that are no more than 5% of the patient's monthly household income
- After a total of 36 months of payments, consider the patient's bill to be paid in full and permanently end any and all collections activities on any unpaid balance

A facility cannot deny discounted care on the basis that the patient has not applied for any public benefits program or adopt or maintain policies that result in the denial of admission or treatment of patient because they are uninsured, may qualify for discounted care, require extended or long-term treatment, or has an unpaid medical bill.

### **Notification of Patient's Rights**

A health facility shall make information about patient's rights and the uniform application, both developed by HCPF, available to the public and each patient. At a minimum, the facility shall post that information in all required languages conspicuously on its website, including a link on the main landing page, make the information available in patient waiting areas, make it available to each patient or legal guardian (verbally or in writing) in their primary language before the patient is discharged, and inform each patient on the billing statement of their rights and provide the website, e-mail address, and phone number where information may be obtained in the patient's primary language.

### **Facility Reporting Requirements**

Starting June 1, 2023, and each June 1 thereafter, each health care facility shall collect and report to HCPF data that HCPF deems necessary to evaluate compliance across race, ethnicity, and primary-language-spoken patient groups. If a facility is not capable of disaggregating the required data, then it should report to HCPF the steps the facility is taking to improve data collection and the date by which the facility will be able to disaggregate the reported data.

By April 1, 2022, the Medical Services Board shall promulgate rules necessary for administration and implementation, at a minimum the rules must:

- Outline a process for an insured patient to request a screening
- Outline a process for documenting that a patient has declined a screening
- Establish the process and maximum number of days that a facility has to initiate screening, request information needed for the screening, and to complete the screening
- Outline the requirements for notifying the patient of the results of the screening, including an explanation of the basis for a denial and the process for appeal
- Establish guidelines for patient appeals regarding eligibility for discounted care for services not CICIP eligible
- Establish a methodology that all facilities must use to determine monthly household income, it cannot consider a patient's assets
- Identify the documents that may be required to establish income eligibility for discounted care using the minimum amount of information needed
- Identify the steps a facility and health professional must take before sending patient debt to collections
- Create a single uniform application that a facility shall use when screening

When promulgating rules, HCPF shall align the processes of qualifying for and appealing denials of eligibility for CICIP and discounted care that is not CICIP eligible. Additionally, HCPF shall consider potential limitations relating to EMTALA.

By April 1, 2022, HCPF shall develop a written explanation of patient right's that is written in plain language at a 6<sup>th</sup> grade reading level and translated into all languages spoken by 10% or more of the population in each county of the state. Each facility shall make the explanation available to the public and each patient, as previously outlined. Additionally, HCPF is to establish a process for patients to submit a noncompliance complaint to HCPF by phone, mail, or online. HCPF must conduct a review within 30 days after receiving a complaint. HCPF shall periodically review facilities and professionals to ensure compliance. If HCPF finds noncompliance, HCPF shall notify the facility or professional and they have 90 days to file a corrective action plan with HCPF that must include measures to inform the patient about noncompliance and provide a financial correction. A facility or licensed professional may request up to 120 days to submit a corrective action plan. HCPF may require the facility or professional in noncompliance to develop and operate under a corrective action plan until HCPF determines they are in compliance. If the noncompliance is determined to be knowing or willful or there is a repeated pattern of noncompliance, HCPF may fine the facility or professional no more than \$5,000. If the facility or professional fails to take corrective action or fails to file a corrective action plan, HCPF may fine them no more than \$5,000 a week until they take corrective action. HCPF shall consider the size of the facility and seriousness of the violation in setting the fine amount.

HCPF is to make the reported information and any corrective action plans for which fines were imposed available to the public.

#### **Limitations on Collection Actions**

Before assigning or selling patient debt to a collection agency or a debt collection buyer or pursuing any permissible extraordinary collection action:

- A facility must meet the screening requirements
- A facility and professional shall provide discounted care, or if the patient is not determined to be a "qualified patient", offer them a payment plan that does not exceed 5% of the patient's monthly household income

- Provide a plain language explanation of services and fees being billed and notify the patient of potential collection actions

A facility or professional that does not comply with the requirements of this section is liable to the patient in an amount equal to the sum of:

- Any actual damages sustained by the patient as a result of such failure to comply
- In the case of action brought by an individual, any additional damages that the court may allow, not exceeding \$1,000
- In the case of class action, such amount that the court may allow for class members without regard to a minimum individual recovery not to exceed the lesser of \$500,000 or 1% of the net worth of the facility or professional
- In the case of successful action to enforce liability, the costs of the action together with reasonable attorney fees, as determined by the court. On a finding by the court that the action was brought in bad faith, the court may award reasonable attorney fees to the defendant that are related to the work expended and costs

In determining the amount of liability in any individual action brought, the court shall consider, among other relevant factors, the frequency and persistence of noncompliance by the facility or professional, the nature of noncompliance, and the extent to which noncompliance was intentional.

#### **Notification of Debt by a Health Care Provider**

The bill adds the following definitions to existing statute regarding health care debt and notification.

***Impermissible extraordinary collection action.*** Causing an individual's arrest, causing an individual to be subject to a writ of body attachment<sup>20</sup> or similar process, foreclosing on an individual's real property, or garnishing an individual's state income tax refund.

***Medical creditor.*** A health care provider taking any collection activities or permissible extraordinary collection actions on an unpaid medical account on its own behalf. Any entity assigned an unpaid medical account by a provider in order to take collection action, which includes the provider's billing department, a business entity owned by the provider or a contracted collection business. It also includes any entity that has purchased an unpaid account and is taking collection actions on its own behalf.

***Permissible extraordinary collection action.*** An action other than an impermissible extraordinary collection action that requires a legal or judicial process, including but not limited to placing a lien on an individual's real property, attaching or seizing a bank account or any other personal property, commencing civil action, or garnishing wages.

#### **Limitations of Collections**

Impermissible collection actions cannot be used by any creditor to collect debts owed for health services.

Permissible collection actions cannot occur until 180 days after the first bill for a medical debt is sent to the patient. At least 30 days before taking any permissible collection action, a creditor shall provide the patient with a notice, to be developed by HCPF that contains the following:

- Statement that discounted care is available for qualified individuals and a plain-language summary of the discounted care policy and how to apply
- Statement of the permissible collection actions that will be initiated to obtain payment, and
- A deadline after which those collection actions will be initiated

If a creditor is collecting on a medical debt and it is later determined that the patient should have been screened for discounted care and is determined to be a qualified patient the creditor must reverse any collection actions including:

- Deleting any negative reports to consumer reporting agencies
- Dismissing any collection lawsuits over the medical debt and vacating any judgment

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<sup>20</sup> A process issued by a court directing a law enforcement official to bring a person who has been found in civil contempt before the court.

- Removing any wage garnishment orders- if the patient has paid any part of the debt, or any of the patient's money has been seized/levied above the amount that they owe after applying the financial assistance must be refunded

A creditor collection on a medical debt shall not sell that debt to another entity unless the creditor has entered into a legally binding written agreement with the buyer that includes:

- The debt buyer or collector agrees not to pursue impermissible extraordinary collection actions
- The debt buyer cannot charge interest on the debt in excess of 8% per year<sup>21</sup>
- The debt is returnable to the creditor upon a determination that the patient is eligible for discounted care
- If the patient is determined to be eligible for discounted care and the debt is not returned, the debt buyer must adhere to procedures that ensure that the patient will not pay and has no obligation to pay more than what the patient is responsible for paying

This does not limit or affect the provider's right to pursue the collection of personal injury, liability, uninsured, underinsured, medical payment rehabilitation, disability, homeowner's, business owner's, worker's compensation, or fault-based insurance.

### **CICP Rules**

HCPF is to promulgate rules for hospital providers under current CICP rules,<sup>22</sup> which are approved by HCPF to participate in CICP and is a general hospital licensed by CDPHE and operates inpatient facilities. The rules are to prohibit hospitals from considering assets when determining whether a patient meets the program's specified percentage of the FPL and ensures the method for determining whether a patient meets the specified FPL is uniform across hospitals and aligned with the method for counting income to determine eligibility for discounted care.

### **Effective Date**

The bill, subject to a petition, takes effect at 12:01am on the day following the expiration of the 90 day period after the final adjournment of the General Assembly.

### **Fiscal Note**

The bill requires appropriation adjustments totaling \$181,182 to the Department of Health Care Policy and Financing and the Colorado Department of Public Health and Environment.

The bill will increase expenditures in HCPF by \$230,625 and 1.0 FTE in FY 2021-22 and \$565,331 and 3.0 FTE in FY 2022-23. Staff is needed in FY 2021-22 to assist in rulemaking, develop an official statement of patient rights, develop a uniform screening application, and to begin compliance reviews on April 1, 2022.

The bill will decrease expenditures in the CDPHE by \$44,204 and 0.4 FTE beginning in FY 2021-22. In addition to a reduction in personal services, CDPHE will have a reduction of \$5,000 for a financial services consultant and \$10,000 to investigate hospital compliance.

Expenditures in the University of Colorado may increase to comply with the bill. If additional FTE are needed, the fiscal note assumes the health system will adjust current revenue sources to cover any additional expenditures affected by the bill. The bill may also affect revenue to these facilities in two main ways. First, it may limit revenue and debt collections from certain patients. Second, additional screening for public health insurance or the indigent care program may increase reimbursement for care provided.

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<sup>21</sup> C.R.S. § 5-12-101

<sup>22</sup> 10 CCR 2505-10, SEC. 8.901.J



To the extent more civil cases are filed with the trial courts, workload in the Judicial Department will increase. The fiscal note assumes that the bill will not increase the number of cases to require additional FTE; therefore, no change in appropriation is required.

### Reasons to Support

The bill would improve patient experience by establishing clear and consistent billing and collection practices across providers. It would assure that those with lower incomes gain access to programs providing discounted care. For services not covered by CICIP, it would provide those with lower incomes discounts, limits on monthly billing, and write-offs after 3 years. It would likely reduce the number of patients sent to collections for receiving necessary health care, and may reduce medical bankruptcies. People who have put off care due to cost would be more likely to seek care, increasing their health status.

High medical debt can have long-term consequences, ruining credit, and fostering poverty. It also causes disproportionate harm to communities of color, further concentrating financial distress and higher uninsured rates in BIPOC communities.

Further, the state's COVID-19 recovery may be jeopardized if Coloradans are forced to avoid care or take on debt due to the cost of health care.

### Supporters

- 9to5 Colorado
- AARP Colorado
- Bell Policy Center
- Center for Health Progress
- Chronic Care Collaborative
- Clayton Early Learning
- Colorado Center on Law and Policy
- Colorado Children's Campaign
- Colorado Coalition for the Homeless
- Colorado Consumer Health Initiative
- Colorado Cross-Disability Coalition
- Colorado Fiscal Institute
- Colorado Social Legislation Committee
- El Grupo Vida
- Family Voices Colorado
- League of Women Voters of Colorado
- Raise Coalition
- Spring Institute for Intercultural Learning
- Summit Family & Intercultural Resource Center
- The Consortium
- Towards Justice
- Women's Lobby of Colorado

### Reasons to Oppose

This bill will create significant new administrative burdens for HCPF, and additional time and resources are likely to be needed. HCPF would need to develop, administer, and monitor new rules and regulations. They would need to develop and implement a complaint system, as well as the system to review facilities and professionals across the entire state. Writing patient rights in several different languages will be time-intensive and may cause HCPF to incur the cost of translation services. Additionally, the languages that are spoken by 10% or more of the population may change over time, so HCPF may also need to (1) periodically complete or obtain statewide surveys to determine which languages are fall under the required category and (2) create and disseminate completely updated patient rights resources as these linguistic/demographic changes occur.

The bill could create significant burdens on hospitals, outpatient facilities, and professionals in terms of increased administrative responsibilities and possibly lowered income. Administrative burdens on hospitals across Colorado would include (1) screening uninsured patients for health coverage options and potential financial assistance for which they may be eligible; (2) screening patients for coverage and assistance, offering them a fair payment plan and provide information regarding patient rights, before they can send a patient to collections; and (3) increasing state reporting requirements. Further, there is concern that the

determination of income for eligibility purposes would be very complicated for all types of facilities to accomplish and the process may not be uniform across facilities and systems, which would be unfair for consumers.

There may be financial burdens for facilities as services not included in CICIP for those determined to be “qualified patients” would be reimbursed at 80% of Medicare rates, they would not be able to bill more than 5% of a household’s monthly income (which may be variable by month), and are required to write off all payments after 36 months, no matter how much of the bill has been paid. The financial burden is initially born by facilities and providers, and may be spread to those who are insured through higher charged rates. Rural hospitals are already struggling to stay afloat financially and to obtain/retain enough staff & providers - the burdens of this bill may push some rural facilities to close, exacerbating the shortage of health providers and facilities in rural areas of the state.

The requirement of ‘if the patient is not determined to be a “qualified patient”, they must be offered a payment plan that does not exceed 5% of the patient’s monthly household income’ before they are sent to collections seems to indicate that even those with incomes above 250% of FPL could be offered a payment plan that could last for years and may significantly impact the bottom lines of the providers.

The scope of facilities covered by this proposal is beyond just hospitals; including any outpatient facility that is affiliated with or operating under these hospitals or FSEDs, which could include all primary care and specialty clinics with any affiliation with a hospital, which may be the majority of clinics in any community. Most outpatient clinics likely do not have the current staff capacity to follow the requirements of the law and many not be able to accept 80% of Medicare rates and remain financially viable.

The write-off of all payments after 36 months could be a disincentive for people with income below 250% of FPL to acquire health insurance, if they knew that all financial obligations to pay an outstanding medical debt may eventually disappear.

Medicare does not cover all services (for example, dental or maternity care), so limiting charges to 80% of Medicare rates would sometimes prohibit providers from charging anything at all with the current proposed language.

Not taking any assets into consideration in determining income could mean that people who have very significant investments and bank accounts, but live off the interest, could remain uninsured, have very low payments to facilities and providers, and have their debt written off in 3 years, which likely shifts the financial burden to providers and insured patients.

The bill includes strong protections for consumers, but no protections for health services providers should a consumer commit fraud by not fully or accurately reporting income.

### **Opponents**

- Colorado Chamber of Commerce
- Denver Metro Chamber of Commerce

### **Other Considerations**

Would income be self-reported and verified by the hospital or outpatient facility or would health facilities be able to take advantage of the systems currently used by HCPF and the state government to verify income? Or would it just utilize the current system under CICIP?

Should the provision requiring remaining debt to be cancelled after 36 months be removed from the bill?

Should the provision requiring facilities to provide a payment plan that does not exceed 5% of monthly income only be reserved for those deemed qualified patients by the screening process?

Suggest the use of language for what rate should be referenced and utilized when Medicare does not cover that service. Should that inclusion be in statute or done through rulemaking?

**Groups Amending the Bill**

- Associated Collection Agencies
- Colorado Hospital Association
- Denver Health
- HCA- The Healthcare Company
- SCL Health

**About this Analysis**

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. This analysis is accurate to staff knowledge as of date printed. For more information about this analysis or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at [awilliams@healthdistrict.org](mailto:awilliams@healthdistrict.org).