HOUSE BILL REPORT
ESHB 2582

As Passed House:
February 9, 2012

Title: An act relating to billing practices for health care services.

Brief Description: Requiring notice to patients for certain charges at a health care facility.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Johnson, Cody, Ross, Jinkins, Green, Walsh, Hinkle, Clibborn, Liias, Kenney, Klippert, Smith, Alexander, Warnick, Fagan, Bailey, Ahern, Asay, Dahlquist, Kretz, DeBolt, Angel, Kelley, Hunt, Dickerson, Ladenburg, Orcutt, Zeiger, Wilcox, Finn, Wylie, Probst, Darneille, Moscoso, Kagi and Tharinger).

Brief History:
Committee Activity:
Health Care & Wellness: 1/25/12, 1/26/12 [DPS].
Floor Activity:
Passed House: 2/9/12, 81-16.

Brief Summary of Engrossed Substitute Bill

- Requires hospital-owned or operated provider-based clinics that charge a facility fee to notify patients that they may receive a separate billing for a facility fee.
- Requires certain hospitals that own or operate provider-based clinics to report specified information about their facility fees to the Department of Health.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 8 members: Representatives Cody, Chair; Jinkins, Vice Chair; Hinkle, Assistant Ranking Minority Member; Clibborn, Green, Kelley, Moeller and Van De Wege.

Minority Report: Do not pass. Signed by 2 members: Representatives Schmick, Ranking Minority Member; Harris.

Staff: Chris Blake (786-7392).

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Background:

Under the Medicare program, charges for hospital outpatient department visits may be comprised of two components: a professional fee and a facility fee. The facility fee may be charged if the location of the service is considered a provider-based department. Many factors affect the determination of provider-based status, including whether or not the hospital and the outpatient facility operate under the same license, the integration of clinical services of the hospital and the outpatient facility, the financial integration of the outpatient facility and the hospital, and the public's awareness of the relationship of the facility with the hospital.

To maintain provider-based status under the Medicare program, a hospital outpatient department must meet several obligations. One of these requirements is that, if the Medicare patient will be responsible for a coinsurance requirement for the facility fee, the hospital-based entity must provide the Medicare patient with:

- notice of the amount of the potential cost to the patient, prior to the delivery of services; and
- an explanation to the patient that he or she will be responsible for coinsurance costs to the hospital because of the facility's provider-based status.

Summary of Engrossed Substitute Bill:

A "provider-based clinic" is defined as a clinic or provider office that either (1) is 250 yards or more from the main campus of a hospital, or (2) has been determined to be a provider-based clinic by the federal Centers for Medicare and Medicaid Services. In addition, "provider-based clinics" are (1) owned by a hospital or health system that operates hospitals, (2) licensed as part of the hospital, and (3) primarily engaged in providing diagnostic and therapeutic care. The definition excludes clinics that are rural health clinics or that exclusively provide laboratory, x-ray, testing, therapy, pharmacy, or educational services.

A "facility fee" is defined as any separate charge, in addition to professional fees, by a provider-based clinic that is intended to cover building, electronic medical records, billing, and other administrative and operational expenses.

Prior to delivering nonemergency services, provider-based clinics must notify patients that the clinic is licensed as part of the hospital and the patient may receive a separate billing for a facility fee which may result in greater out-of-pocket expenses for the patient. Provider-based clinics must also post a statement, in a place that is accessible and visible to patients, that the clinic is licensed as a part of the hospital and that a separate facility fee may be charged to the patient.

Hospitals that own or operate provider-based clinics which charge facility fees must report specified information to the Department of Health about their facility fees. The report must include: (1) the total number of provider-based clinics owned or operated by the hospital that charge a facility fee, (2) the number of visits at each provider-based clinic for which a facility fee was charged, (3) the total revenue received by the hospital through facility fees at each provider-based clinic, and (4) the range of allowable facility fees charged at each provider-based clinic.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on January 26, 2012.

Effective Date: The bill takes effect on January 1, 2013.

Staff Summary of Public Testimony:

(In support) This bill is about transparency. Some hospital clinics notify patients about facility fees, while others do not. These fees could be better used to lower the cost of health care. If a facility is going to charge a facility fee, it is only fair that it report this to the DOH and notify the patient. The Medicare Payment Advisory Commission recently approved a recommendation to reduce Medicare hospital patients' costs primarily by setting outpatient payment rates equal to those paid by stand-alone physicians. In 2006 there was a class action suit requiring some facilities to post their facility fees. Small businesses end up paying for these additional costs. These fees should either be eliminated or made transparent. This bill should go further and include a service charge, rather than a separate charge.

(In support with amendments) The definitions in the bill should be made consistent with what is already required for Medicare patients. These provisions should be reconciled with the reporting provisions in RCW 70.01.030. The reporting mechanism creates cost to the state and administrative burdens on hospitals. The costs and services for an entity that meets hospital standards are different than for a freestanding entity. Facility-based clinics get less reimbursement for provider services from Medicare than freestanding facilities. Provider-based clinics are more prevalent in places where freestanding physician offices are not able to sustain their practices due to low reimbursements and the hospitals help to keep these services available in the community.

(Opposed) None.

Persons Testifying: (In support) Representative Johnson, prime sponsor; Sue Taylor, Group Health Cooperative; and Sydney Smith Zvarra, Association of Washington Healthcare Plans.

(In support with amendments) Andrew Busz and Lisa Thatcher, Washington State Hospital Association.

Persons Signed In To Testify But Not Testifying: None.