SENATE BILL REPORT
ESHB 2582

As Reported by Senate Committee On:
Health & Long-Term Care, February 22, 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: Passed House: 2/09/12, 81-16.
Committee Activity: Health & Long-Term Care: 2/20/12, 2/22/12 [DP].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass.
Signed by Senators Keiser, Chair; Conway, Vice Chair; Becker, Ranking Minority Member; Carrell, Frockt, Kline, Parlette, Pflug and Pridemore.

Staff: Mich'l Needham (786-7442)

Background: Under the Medicare program, charges for hospital outpatient department visits may comprise 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:

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

Summary of Bill: 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.

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.

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 in their annual financial reports. 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.

Committee/Commission/Task Force Created: No.

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

Staff Summary of Public Testimony: PRO: The people of Washington deserve transparency in the billing. If they are getting billed for an additional facility fee, they should be notified up front. This first came to my attention in Yakima when the clinic started added facility fees onto their bills. There is also some discussion in Congress to end the facility fees for providers. It is helpful to post a notification of the facility charges for patients, but we wish this language went further to stop the facility fees or require them in the existing charges. This is a good first step though. Provider-based clinics include facility fees now, but they are broken out separately if the facility is hospital-owned. The payment is

negotiated with the insurers. We would like an amendment that clarifies that hospitals report net revenue, but not all revenue. and focuses the reporting on some of the most commonly charged facility fees, but not all facility fees.

Persons Testifying: PRO: Representative Johnson, prime sponsor; Sydney Zvara, Assn. of WA Healthcare Plans; Lisa Thatcher, WA State Hospital Assn.