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*Bill Analysis*  
*Legislative Service Commission*

## **S.B. 186**

126th General Assembly  
(As Introduced)

**Sens. Miller, Dann**

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### **BILL SUMMARY**

- Requires that a hospital provide an uninsured or underinsured patient free medically necessary services from a hospital at no cost to the patient if the patient's family income is equal to or less than 200% of the federal poverty guidelines.
- Requires that a hospital provide an uninsured or underinsured patient partial free care if the patient's family income is 201% to 400% of the federal poverty guidelines.
- Provides that a patient eligible for partial free care is eligible to receive free medically necessary services from a hospital after paying an annual deductible.
- Provides that the annual deductible is to equal 20% of the difference between the patient's family income and 200% of the federal poverty guidelines.
- Requires that a hospital provide an uninsured or underinsured patient medical hardship assistance if the patient's allowable medical expenses exceed 25% of the patient's family income and the patient's available assets are insufficient to cover the amount by which the allowable medical expenses exceed 25% of the patient's family income.
- Provides that a patient eligible for medical hardship assistance is eligible to receive free medically necessary services from a hospital once the patient has incurred expenses equaling a contribution equaling the sum of 25% of the patient's family income and the patient's available assets.

- Requires that a hospital bill an uninsured or underinsured individual who is ineligible for medical hardship assistance be at cost if the individual's income does not exceed 500% of the federal poverty guidelines.
- Requires that a hospital publicize the bill's free care program by posting signs conspicuously in certain areas of the hospital, posting a notice on the hospital's internet web site, and quarterly publishing a notice in a newspaper of general circulation and all community health centers in the hospital's service area.
- Authorizes an individual who is eligible for free care under the bill and suffers actual or consequential damages as a result of a hospital's noncompliance with the bill to bring a suit against the hospital in a court of competent jurisdiction to recover the damages.
- Requires that each hospital maintain and offer payment plans to patients who are ineligible for full free care under the bill or are eligible for partial free care or medical hardship assistance.
- Requires that the payment plan be offered on reasonable terms and take into account the patient's family income and financial obligations.
- Prohibits a hospital from charging an interest rate exceeding the lower of the change in the Consumer Price Index for all urban consumers for the proceeding year or 3%.
- Requires that each hospital develop a written credit and collection policy that explains the process and timeframes the hospital uses in its collection actions.
- Prohibits a hospital from taking an action to foreclose on real property, placing a lien on any property, garnishing wages, or attaching or seizing a bank account or any other personal property in connection with unpaid patient bills without the hospital's governing board's express approval.
- Exempts the following from any hospital collection action: patients enrolled in Medicaid, including the Children's Health Insurance Program component of Medicaid, and patients who are eligible for full free care or who are determined to be eligible for partial free care or medical hardship assistance for the portion of the hospital bill that exceeds the deductible or contribution.

- Requires that a hospital, if a patient completes a free care application after a collection action has been initiated, to suspend the collection action until a determination is made regarding the patient's eligibility.
- Requires that the governing board of a hospital annually approve the use of any designated agent, assignee, contractor, or purchaser of accounts receivable.
- Requires that hospitals and the Department of Health prepare annual reports regarding the free care available under the bill.
- Requires that the Department of Health conduct an annual site visit to each hospital to monitor compliance with the bill's requirements.
- Permits the Director of Health to impose a civil penalty of at least \$1,000 on a hospital that the Director determines has violated a provision of the bill.

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## CONTENT AND OPERATION

### Eligibility for free or lower-cost hospital care

(R.C. 3727.36 and 3727.37)

The bill provides that uninsured and underinsured<sup>1</sup> patients who meet financial eligibility requirements are eligible for free medically necessary services from a hospital or to be billed by a hospital at cost (the actual amount of money the hospital spends to provide each service or product). Depending on a patient's family income or other financial circumstances, a patient must incur medical expenses equaling the cost of a deductible or contribution before qualifying for the free care.

"Medically necessary services" is defined as services that are reasonably expected to prevent, diagnose, alleviate, correct, or cure conditions that endanger life, aggravate a handicap, result in illness or infirmity, or cause or threaten to cause suffering, pain, or physical deformity or malfunction. This includes inpatient and outpatient services required under federal Medicaid law, emergency room services, and prescription drug services. "Family income" is defined as the sum of annual earnings and cash benefits from all sources before taxes, less payments made for alimony and child support.

The free or at-cost medically necessary services are to be available from a hospital if the hospital is an institution exempt from federal income taxation under section 501 of the Internal Revenue Code that is advertised, announced, established, or maintained for the purpose of caring for persons admitted for diagnosis or medical, surgical, restorative, psychiatric, or rehabilitation treatment rendered by the institution.

### Full free care

(R.C. 3727.36(E) and 3727.37(B))

An uninsured or underinsured patient whose family income is equal to or less than 200% of the federal poverty guidelines is eligible for medically necessary services from a hospital. Under full free care, the patient incurs no cost.

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<sup>1</sup> *The bill does not define the term "underinsured."*

### **Partial free care**

(R.C. 3727.36(C) and (J) and 3727.37(A) and (C))

An uninsured or underinsured patient whose family income is 201% to 400% of the federal poverty guidelines is eligible for partial free care. Under partial free care, the patient must pay an annual deductible calculated by the hospital. The patient is eligible for free care once he or she incurs expenses equaling the deductible. The hospital may bill the patient only for the deductible amount.

The deductible is to equal 20% of the difference between the patient's family income and 200% of the federal poverty guidelines. In determining whether the patient has paid the deductible, allowable medical expenses billed by other providers during the same calendar year are to be counted. The bill defines "allowable medical expenses" as family medical bills from any provider<sup>2</sup> that, if paid, qualify as deductible medical expenses for federal income tax purposes. The hospital may require that the patient document expenses incurred from other providers. Allowable expenses billed by the hospital must be calculated at cost.

A family is responsible for one deductible per calendar year.

### **Medical hardship assistance**

(R.C. 3727.36(G) and (H) and 3727.37(A) and (D))

An uninsured or underinsured patient is eligible for medical hardship assistance if the patient's allowable medical expenses exceed 25% of the patient's family income and the patient's available assets are insufficient to cover the amount by which the allowable medical expenses exceed 25% of the patient's family income. "Available assets" are resources distinct from the family income, including cash, bank accounts, retirement funds, securities, life insurance policies, real estate, and motor vehicles. The value of any asset that has a penalty for early withdrawal is the value of the asset after the penalty has been paid. The following are excluded as available assets: a primary residence, the first motor vehicle, the second motor vehicle if necessary for employment or medical purposes, a pre-paid burial contract, a burial plot or bank account funded for burial, a life insurance policy with a face value of \$10,000 or less, the first \$25,000 of an individual retirement account or other pension assets, and the first \$4,000 of other assets for

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<sup>2</sup> "Provider" is defined as any person, corporation, partnership, governmental entity, or other entity qualified under state law to perform or provide health care services. (R.C. 3727.37(A)(5).)

an individual or \$6,000 of assets for a family of two individuals and \$1,500 of other assets for each additional family member.

Under medical hardship assistance, the patient is eligible for free care once the patient has incurred expenses equaling a contribution calculated by the hospital. The hospital may bill the patient only for the amount of the contribution.

The contribution is to equal the sum of 25% of the patient's family income and the patient's available assets. Allowable medical expenses billed by other providers during the same calendar year count toward the contribution. The hospital is permitted to require the patient to document expenses incurred from other providers. Allowable expenses the hospital bills are to be calculated at cost.

A family is responsible for one contribution per calendar year.

**At-cost hospital care**

(R.C. 3727.37(E))

The bill provides that an uninsured or underinsured individual who is ineligible for medical hardship assistance is to be billed by a hospital at cost if the individual's income does not exceed 500% of the federal poverty guidelines.

**Limitation on free care when otherwise covered**

(R.C. 3727.37(F))

If a patient is enrolled in or otherwise has insurance coverage through another source, public or private, the patient is eligible for free medically necessary hospital care under the bill only to the extent the patient has incurred expenses for medically necessary expenses that are not covered by another source.

**Hospitals to encourage enrollment in public health programs**

(R.C. 3727.37(F))

The bill requires that a hospital encourage a patient who is not enrolled in a public program such as Medicaid to apply for coverage from such a program and assist the patient with the application process. However, a hospital is prohibited from denying a patient's application for free care under the bill if the patient refuses to apply for assistance. A hospital is also prohibited from denying or delaying patient care while the patient's application for another source of coverage is pending.

### **Applying for free care**

(R.C. 3727.40(B) and (C) and 3727.46(A)(1) and (2))

A patient or patient's representative is permitted to submit an application for free care available under the bill before, during, or within one year after the patient receives medically necessary services. The Department of Health is required to adopt rules establishing a simple and clear application.<sup>3</sup> The application may request only information that is reasonably necessary to determine eligibility. The Department is also required to adopt rules specifying the types of documentation required to establish family income and available assets. In determining the requirements, the Department must ensure that the lack of official forms of documentation is not a barrier to obtaining free care and provide that an affidavit signed by an applicant is sufficient if no other documentation is reasonably available. The rules may not require an applicant to provide a social security number.

If approved for free care, the patient remains eligible for free care for one year after the patient initially receives medically necessary services unless the patient's family income or insurance status changes to such an extent that the patient is no longer eligible for free care. A hospital is required to give written notice of an eligibility determination to the patient within 14 days after receiving a complete application. A hospital is prohibited from billing a patient while the application is under consideration.

### **Contesting eligibility determinations**

(R.C. 3727.41 and 3727.46(A)(5))

The bill permits a patient or patient's representative who disagrees with a hospital's determination of eligibility for free care to file a written complaint with the Department of Health. The complaint is to include any supporting documentation. The Department is required to send a copy of the complaint to the hospital; the hospital has 30 days to respond. The hospital must include with its response any additional documentation it has regarding the complaint.

The Department must review the complaint and issue a written decision upholding, reversing, or modifying the hospital's determination within 30 days after receiving information from the hospital. The decision must include the basis for the Department's action. The decision constitutes a final administrative

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<sup>3</sup> *The application must be in English and in the five languages other than English that are most frequently spoken in the hospital's service area.*

decision and may be appealed by either party to the Tenth District Court of Appeals.

The Department is required to adopt rules providing procedures the Department is to use to accommodate appeals from a hospital's determination of eligibility for free care under the bill.

**Publicizing free care**

(R.C. 3727.39)

The bill requires that a hospital publicize the bill's free care program in a number of ways. A hospital must post signs conspicuously in the inpatient, outpatient, emergency, admissions, and registration areas of the hospital and the business offices visited by patients that inform them about the free care available under the bill and the location in the hospital where the patient may apply for free care. A hospital must post a notice on the hospital's internet web site informing patients that free care is available. Additionally, a hospital must quarterly publish notice of its free care program in a newspaper of general circulation and all community health centers in the hospital's service area. The internet web posting and quarterly published notices must include a brief description of the free care application process. The posted signs, internet posting, and quarterly published notices must appear in English and in the five languages other than English that are most frequently spoken in the hospital's service area.

A hospital must provide individual notice, in the appropriate language, of the availability of free care to a patient who is identified as uninsured or underinsured. A hospital must also provide notice of the free care as part of any collection action.

All hospital staff and personnel are to receive regular in-service training on the hospital's free care programs. The training must also address the free care programs' procedures.

**Inquiries on need for financial assistance**

(R.C. 3727.40(A))

A hospital is permitted by the bill to ask every patient or the patient's representative whether the patient requires financial assistance. The inquiry is to be made before discharge. The timing of the inquiry must be consistent with the

requirements of federal law that requires hospitals to provide medical screening examinations and treatment without delay under certain circumstances.<sup>4</sup>

### **Civil suit for damages**

(R.C. 3727.42)

An individual who is eligible for free care under the bill and suffers actual or consequential damages as a result of a hospital's noncompliance with the bill is authorized to bring suit against the hospital in a court of competent jurisdiction to recover the damages. The bill provides that any applicable charitable immunity provision does not apply in connection with such a suit.

### **Auditable records of free care**

(R.C. 3727.45(C) and 3727.46(A)(4))

Each hospital is required by the bill to maintain auditable records of free care applications and determinations. The hospitals must retain the records for as long as the Department of Health determines. The Department of Health is required to adopt rules specifying the length of time a hospital must keep records of its free care applications, approvals, and denials.

### **Payment plans for patients**

(R.C. 3727.38)

Under the bill, each hospital must maintain and offer payment plans to patients who are ineligible for free care under the bill or are eligible for partial free care or medical hardship assistance. The payment plan must be offered on reasonable terms and take into account the patient's family income and financial obligations. A hospital is prohibited from charging an interest rate exceeding the

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<sup>4</sup> Federal law requires that a hospital with an emergency department provide an appropriate medical screening examination within the emergency department's capability when any individual comes to the emergency department and requests an examination or treatment for a medical condition. If an individual comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital is required to (1) provide for such further medical examination and treatment as may be required to stabilize the medical condition or (2) transfer the individual in accordance with that law. Hospitals participating in the Medicare program are prohibited from delaying the medical screening examination or further medical examination and treatment to inquire about the individual's method of payment or insurance status. (42 U.S.C. 1395dd.)

lower of 3% or the change in the Consumer Price Index for all urban consumers for the proceeding year.

A hospital must also provide patients with general comparative information on the difference between the interest rate charged on the hospital's payment plan and the typical credit card or consumer bank loan interest rates.

### **Hospitals to develop credit and collection policies**

(R.C. 3727.43(B))

The bill requires that each hospital develop a written credit and collection policy. The policy is due within 180 days after the bill's effective date.<sup>5</sup> The hospital must file the policy with the Department of Health after having its governing board approve it. The policy must explain the process and timeframes the hospital uses in its collection actions, including copies of letters or other notices sent to patients. The bill also requires that the policy be available to the public on request.

### **Restrictions on hospital collection actions**

(R.C. 3727.43 and 3727.44)

Hospitals and designated agents, assignees, contractors, and purchasers of a hospital's accounts receivable are prohibited by the bill from taking certain collection actions in connection with unpaid patient bills without the hospital's governing board's express approval. Specifically, they cannot take an action to foreclose on real property, place a lien on any property, garnish wages, or attach or seize a bank account or any other personal property. A hospital is required by the bill to make all written and verbal communications that relate to a collection action available in English and in the five languages other than English that are most frequently spoken in the hospital's service area.

The bill provides that certain individuals are exempt from any collection action. Because of its context, it may be that it refers to a collection action by a hospital. The following are the exempt individuals: patients enrolled in Medicaid, including the Children's Health Insurance Program component of Medicaid, and patients who are eligible for full free care or who are determined to be eligible for partial free care or medical hardship assistance for the portion of the hospital bill that exceeds the deductible or contribution. If a patient completes a free care application after a collection action has been initiated, the hospital is required to

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<sup>5</sup> Because the credit and collection policy is within 180 days of the bill's effective date, the requirement to develop such a policy may not apply to future hospitals.

suspend the collection action until a determination is made regarding the patient's eligibility. If the patient is determined to be eligible, any money the patient paid on the account is required to be refunded unless the deductible or contribution has not been satisfied. A hospital is required to retract in a timely manner any adverse information reported to any credit reporting agencies as a result of the collection action.

The governing board of a hospital is required by the bill to approve the use of any designated agent, assignee, contractor, or purchaser of accounts receivable. The approval is required annually and cannot be given unless the terms of the agreement expressly include the bill's requirements concerning collection actions.

### **Annual hospital report**

(R.C. 3727.45 and 3727.46(A)(3))

The bill requires that each hospital, not later than three months after the end of its fiscal year, submit an annual report to the Department of Health. The report must be submitted on a form and in a manner the Department specifies. All of the following must be listed in the report:

(1) The number of free care applications, differentiating among applications for full free care, partial free care, and medical hardship assistance, submitted, approved, and denied, including reasons for denials;

(2) The number of appeals to the Department arising from denials of free care applications and disposition of the appeals;

(3) The total and unduplicated number of patients who received free care, differentiating among full free care, partial free care, and medical hardship assistance;

(4) A description of the hospital's free care application process, including the identity of the person or persons responsible for making determinations about free care applications;

(5) The hospital's most recent and complete set of audited financial statements.

The report must also include a statement that includes (1) the amount of free care, calculated at cost, provided in the reporting year, (2) the amount of bad debt incurred in the reporting year, calculated at cost, identifying how much of the bad debt is attributable to individual patients and how much is attributable to third party payers, (3) the sum of the hospital's net patient service revenue plus its investment income, (4) the amount of any disproportionate share hospital funds

received under the Medicaid or Medicare programs during the reporting year, and (5) the amount of philanthropic funds available to the hospital to subsidize the cost of free care and the amount of those funds that were used during the reporting year.

A hospital is permitted to report the amount of free care provided and bad debt incurred using charges. The bill defines "charges" as the uniform price set by a hospital for a specific service or product provided by the hospital. If a hospital makes its report using charges, the hospital is required to submit its cost-to-charge ratio to the Department of Health. The cost-to-charge ratio is the ratio of the hospital's total cost of providing patient care to its total charges for patient care as reported in its most recently settled Medicare cost report.

The report must include other information the Department of Health deems necessary to ensure the hospital's compliance with the bill's requirements. This is to include income information related to applicants for free care and any disease or diagnostic code information related to services provided to patients who receive free care.

The Department of Health is required to adopt rules specifying the documents or data a hospital must submit to ensure compliance with the bill's requirements. This is to include information related to applicants for free care and any disease or diagnostic code information related to services provided to free care patients.

### **Department of Health's annual report**

(R.C. 3727.46(C))

The bill requires that the Department of Health issue an annual public report containing information about all of the following for the preceding year:

(1) The number of free care applications submitted to, and the number of such applications approved or denied by, each hospital, differentiating among applications for full free care, partial free care, and medical hardship assistance;<sup>6</sup>

(2) The number of appeals to the Department of the denials and the disposition of the appeals;

(3) The amount of free care, calculated at cost, provided by each hospital;

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<sup>6</sup> *The report must include the reasons for denials.*

(4) The amount of bad debt, calculated at cost, incurred by each hospital, identifying how much of the bad debt is attributable to individual patients and how much is attributable to private third party payers;

(5) The amount of free care provided by each hospital relative to the sum of the hospital's net patient service revenue and investment income.

**Annual site visit to hospitals**

(R.C. 3727.46(B))

The Department of Health is required by the bill to conduct an annual site visit to each hospital to monitor compliance with the bill's requirements.

**Civil penalty for violations**

(R.C. 3727.47)

The bill provides that the Director of Health may impose a civil penalty on a hospital that the Director determines has violated the bill. The penalty must be at least \$1,000.

**Rules**

(R.C. 3727.46(A)(6))

In addition to the other rules authorized by the bill as discussed above, the bill requires that the Department of Health adopt any other rules the Department determines necessary to implement the bill.

All of the rules adopted under the bill are to be adopted in accordance with the Administrative Procedure Act (Revised Code Chapter 119.).

**Bill's provisions are in addition to HCAP requirements**

(R.C. 3727.35)

The bill provides that its requirements are in addition to the requirements of current law governing the Hospital Care Assurance Program (HCAP). Under HCAP, hospitals are annually assessed an amount based on their total facility costs and government hospitals make annual intergovernmental transfers to the Department of Job and Family Services. The Department distributes to hospitals money generated by assessments, intergovernmental transfers, and federal matching funds generated by the assessments and transfers. A hospital compensated under HCAP must provide, without charge, basic, medically necessary, hospital-level services to Ohio residents who are not recipients of

Medicare or Medicaid and whose income does not exceed the federal poverty guidelines.<sup>7</sup>

The bill also provides that its provisions apply notwithstanding any other provision of state law codified in the Revised Code.

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## **HISTORY**

ACTION	DATE
Introduced	09-27-05

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<sup>7</sup> R.C. 5112.01 to 5112.21.