Approved: 04/09/10
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:30 p.m. on February 15, 2010, in Room 546-S of the Capitol.

All members were present.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Renae Jefferies, Office of the Revisor of Statutes
Iraida Orr, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Amanda Nguyen, Intern, Kansas Legislative Research Department
Jan Lunn, Committee Assistant

2/15

Conferees appearing before the Committee:
Kelly Hedlund, Officer, Kansas Practicing Perfusionists Society
Marla Rhoden, Director, Kansas Department of Health and Environment (KDHE)
Corrie Edwards, Kansas Health Consumer Coalition
DonnTeske, Kansas Farmers Union
Meg Braun, consumer
Rev. Doctor Matthew Cobb, Kansas Faith Alliance for Health Reform
Deb Kiker, Community Health Ministries
Margaret Pender, consumer
Fred Lucky, Kansas Hospital Association
Shannon Flach, Wamego City Hospital
Cynthia Smith, JD, Advocacy Council, Sisters of Charity of Leavenworth
Peter Bath, Shawnee Mission Medical Center

See the attached list for others attending.

SB 501 - Kansas board of healing arts; licensure and education of perfusionists

Nobuko Folmsbee, Office of the Revisor of Statutes Office, described **SB 501** as legislation creating the perfusion practice act, establishing a perfusion council under the authority of the Kansas State Board of Healing Arts, and developing the educational and licensure requirements for perfusionists in Kansas.

Kelly Hedlund, Kansas Practicing Perfusionists Society, spoke in support of **SB 501** (Attachment 1). Mr. Hedlund described the role of a perfusionist in coronary artery bypass surgery (CABG). He emphasized at the current time, there is no licensure or regulatory oversight for practicing perfusionists in Kansas. Currently, there are 17 states with licensure requirements in place; nine other states have licensure initiatives in process.

Senator Kelly inquired concerning the language in Section 4 of the bill, which exempts other health care specialties from the requirement of licensure. Mr. Hedlund responded that respiratory therapists (who are licensed under the KBOHA) are trained to operate an extracorporeal membrane oxygenation circuit under the supervision of a licensed physician. These are the health care providers who can operate a heart/lung machine for long-term management of a patient requiring this technology and would be exempted from the perfusionist licensure act.

Marla Rhoden, Health Occupations Credentialing, KDHE, described the purpose of her office is to review the public's need for credentialing a new health occupation in the State. She provided a review of the perfusionists credentialing process. (Attachment 2)

Senators asked many questions concerning the proposed legislation.
- are most perfusion practitioners licensed in another field of practice?
- what are term limits for individuals serving on the perfusion board?
- if someone is not attending board meetings regularly, will he/she be removed from the board?
- how do license fees compare to others?

- the fiscal note appears not to cover expenses of licenses, is that typical of how licensure is implemented?
- the bill excludes any liability coverage, is malpractice insurance required for licensure?
- many perfusionists are registered nurses or physician assistants, how is oversight or jurisdiction over these providers delineated?
- what is the experience in outcomes or quality of care related to perfusionists?

Steve Irwin, Health Program Analyst, KDHE, was in the audience. He indicated the purpose of the credentialing board is to review the public's need for credentialing a new health occupation, not to determine how oversight or jurisdiction is delineated, assess outcomes, or develop consequences for board meeting attendance. He responded the license fees are comparable to others.

Insofar as the question related to the fiscal note, Kathleen Lippert, Acting Director of the Kansas Board of Healing Arts (KBOHA) responded the Perfusionists Society drafted the language, and the KBOHA would assist in further reviewing the fee structure if desired.

Senator Barnett suggested that Mr. Hedlund and other parties work together to craft amendments that further enhance the proposed legislation. He announced **SB 501** would be returned to committee members at a later date for possible final action. Chairperson Barnett closed the hearing on **SB 501**.

SB 525 - Hospitals; charges for health care goods and services

Terri Weber, Legislative Research Department briefed those attending on **SB 525** which enacts new law by establishing the Fair Hospital Charges Act. Ms. Weber described the definitions (eligible self-pay patient, etc.) contained in the bill and reported the key component is that no hospital shall seek to collect monies for health care goods or services provided to an eligible self-pay patient exceeding the amount the individual hospital's highest volume private payer would pay for the same goods/services by more than 25%. Additional requirements relate to hospital disclosure and notice of financial assistance policies to patients.

Corrie Edwards, Executive Director, Kansas Health Consumer Coalition, spoke in support of **SB 525**. She explained the legislation addresses the medical debt continuum and provides financial parity with what insurance companies pay for like healthcare goods and services. It also provides language related to hospital policies in existence concerning charity care and/or available financial assistance (Attachment 3). Ms. Edwards also reported the legislation is modeled after the American Hospital Association guidelines on billing, collections, and community health.

Donn Teske, President, Kansas Farmers Union, encouraged favorable passage of this legislation. He described the correlation between farmers and pricing parity for healthcare costs. He indicated that often farmers pay higher insurance premium costs due to the inability to participate in group healthcare plans (Attachment 4).

Meg Braun shared her story as it related to issues of medical debt and charity care. She indicated that by sharing her personal experience policy changes would be forthcoming to assist fellow Kansans with the issue of medical debt. (Attachment 5) She asked Senators to pass **SB 525**.

Margaret Pender, private citizen and consumer, also spoke concerning her experience with medical debt and her support of appropriate policies related to discounted healthcare services and/or charity care (Attachment 6).

Fred Lucky, Senior Vice President Kansas Hospital Association (KHA), spoke in opposition to **SB 525**, pointing out that with the growing number of uninsured and underinsured in the state, it is becoming more difficult and a greater financial challenge to assist patients with limited financial resources. He indicated the Kansas Hospital Association encourages hospitals to use current KHA policies related to recommended billing, financial assistance and collection

practices (Attachment 7).

Shannon Flach from Wamego City Hospital, spoke in opposition to **SB 525**. She described the Wamego City hospital as a not-for-profit, critical-access hospital seeing an increasing amount of patients requiring financial assistance (Attachment 8). She outlined some of the current policies utilized by this facilities. Ms. Flach indicated that passage of this legislation could violate some managed care contracts and jeopardize effectiveness of healthcare reform.

Cynthia Smith, Our Sisters of Charity of Leavenworth Health System, distributed information describing the policies and forms used at the hospitals in this system related to financial assistance. In addition, Ms. Smith, addressed several issues concerning the bill's language and definitions deemed to be overly broad, confusing, or lacking clarity (Attachment 9). Ms. Smith opposed the proposed legislation

Peter Bath, D Min., Shawnee Mission Medical Center, spoke in opposition to **SB 525**. He indicated that although the bill is well intended, Shawnee Mission Medical Center has compassionate and supportive policies in place that support the self-pay patients. (Attachment 10)

Written testimony in support of **SB 525** was received from:

Deb Kiker, RN, MSN, Community Health Ministry, Wamego, Kansas (Attachment 11)
Roberta Lindbeck, Executive Director Cross-Lines Community Outreach, Kansas City, KS (Attachment 12)
Linda DeCoursey, Advocacy Director, Kansas American Heart Association (Attachment 13)
Rick Cagan, Executive Director, Kansas National Alliance on Mental Illness (Attachment 14)
Sarah Tidwell, RN, MS, Kanss State Nurses Association (Attachment 15)
Shane Hessman, Hampton Consulting Group (Attachment 16)
Christopher J. Masoner, American Cancer Society (Attachment 17)
Rev. Doctor Matthew Cobb, Kansas Faith Alliance for Health Reform (Attachment 18)

Written testimony from a neutral perspective was submitted by:

Suzanne Cleveland, JD, Senior Analyst, Kansas Health Institute (Attachment 19)

Chairperson Barnett thanked all conferees and adjourned the meeting at 2:37 p.m.

PUBLIC HEALTH AND WELFARE
GUEST LIST
February 15, 2010

NAME	AFFILIATION
Kyri Presley	Kearney & Associates
Linda McCoursey	~~American Cancer Society~~
Donn Teske	Ks Farmers Union
Matthew Cobb	KS Faith Alliance for Health Reform
Barbara Gibson	Episcopal Diocese of Kansas
Meg Braun	KHCC - consumer
Margaret Pender	KHCC - consumer
Connie Edwards	KHCC
Deb Kuka	Community Health Ministry
Carrie Kiker	Student
Samantha Green	Student
Russ Hazlewood	self
ANNA LAMBERTSON	KS HEALTH CONSUMER COALITION
Sonia Olmos	KS Health Consumer Coalition
Hallie Silber	KHCC - student
Melissa Ness	Shawnee Mission Medical Ctr.
Fred Lucky	Kansas Hosp. Assn.
PETER BATH	SHAWNEE MISSION MEDICAL CENTER
Shannan Roach	Wamego City Hospital
Tish Hollingsworth	Kansas Hospital Assn
Steve Smith	KDHE
DEBRA HERNANDEZ	KHCC - CONSUMER
Tonisha Hernandez	" "
Ludelia Black Cowan	CCO
Emily Meisser-Sebastus	KHI
Rev. Shirley Fletcher	St. Peter CME Church - Communities Creating Opportunity (CCO) Kansas City
Christine Brown	St Peter CME church community creating
Brenda Pitchlyn	St Peter CME CCO opportunity/CCO

Agatha Smith	SCA Health Systems
Linda Kaaree	KDHE
Lowell Nunley	CCO
Tim VanZandt	Saint Luke's Health System
Bruce Auld	Via Christi Health
Tracy Russell	KHCC
Robert Stiles	KDHE

KANSAS PRACTICING PERFUSIONIST SOCIETY

TO: Senate Public Health & Welfare Committee -
Senator Jim Barnett, Chairperson; Senator Vicki Schmidt, Vice Chairperson; Senator Pete Brungardt; Senator Jeff Colyer; Senator Terrie Huntington; Senator Dick Kelsey; Senator Mary Pilcher-Cook; Senator Laura Kelly; Senator David Haley, Ranking Minority Member

FROM: Kelly Hedlund, Secretary/Treasurer, Kansas Practicing Perfusionist Society

DATE: Monday, February 15th, 2010

RE: Testimony regarding Senate Bill No. 501 -
An act concerning the Kansas Board of Healing Arts; relating to licensure and education of perfusionists; establishing perfusion council

To all distinguished members of this committee,

I stand before you this afternoon in full support of Senate Bill No. 501. With your kind indulgence, I would like to outline a few of the reasons why the state of Kansas should regulate and license practicing perfusionists. To begin, I am a practicing perfusionist myself, with over 25 years of experience. Compared to other allied healthcare workers, our profession is fairly young. In 1977, the American Medical Association recognized perfusionists as bonifide allied healthcare professionals. As a young and rapidly growing specialty, the practitioners of our craft spent their energies during the 1980's and 1990's constructing and consolidating agencies necessary for a medical profession to exist; namely, educational societies, scientific journals, and a voluntary certification board. Today, however, perfusion has evolved to a point where governmental regulation is the next obvious step in protecting the public from the high liability of unqualified practitioners.

Open-heart surgery is one of the most commonly-performed operations in the United States. Perfusionists are responsible for operating the heart-lung machine and other life support devices during these surgical procedures. The heart-lung machine takes over the function of the patient's heart and lungs. Perfusionists, therefore, must use split-second skills and mechanical equipment to replace the patient's cardiac and pulmonary functions. The improper management of perfusion devices or techniques generally leads to severe impairment or death of the patient. In fact, according to one recognized source*, the number of severe injuries or death from a perfusion-related accident is 1 per 1,000 cases performed. Since there are approximately 3,500 open-heart surgeries performed in the state of Kansas each year, it's likely that 3 or 4 patients die or are injured annually in the Sunflower State as a direct result of the perfusionist's actions.

The marketplace has failed to adequately regulate the perfusion profession. First, as an entity, perfusion is very low in profile. Most open-heart surgery patients are unaware of the existence or importance of the perfusionist. In general, a poor patient outcome due to a perfusion-related accident is more likely to reflect on the surgeon's abilities, rather than on the perfusionist's incompetency. While the surgeon may exert some control over the perfusionist's future employment, there are no state regulatory processes in place to keep an incompetent perfusionist fired by Hospital A from moving down the street to practice at Hospital B. Clearly, the public safety and welfare is better served by preventative measures than retrospective punishment, when the risk to the patient is so high. Secondly, the only mechanism currently in place to protect the public from unqualified perfusionists is the Joint Commission on Accredited Healthcare Organization's (JCAHO) requirement that hospitals "credential" all healthcare workers and physicians. For perfusionists, this credentialing process generally consists of completing an application form; nothing more. Perfusionists are not only few in number

*Textbook on Cardiopulmonary Bypass 2nd Edition by Reed & Stafford, 1989

(approximately 3,000 in the United States; 45 in Kansas), but their scope of practice is not legally defined. In general, hospitals do not have access to criteria on which to judge a perfusionist's education, training, or performance. As a result, it's the perfusionists themselves who often determine their own criteria for employment and performance. Surely, public safety cannot be assured when the range of control is so broad. Furthermore, it must be stressed that the national certification process for perfusionists is voluntary. As such, hospitals are not mandated to require this credential of their practitioners. At least 3 professional societies have published ethical standards for perfusionists. While these standards are useful as guideposts, membership in these societies is, once again, voluntary. In addition, these standards deal primarily with fraudulent record keeping, the inappropriate use of credentials, and adequate staffing of personnel, not the safe performance of perfusion (or lack thereof). While these standards serve to educate and unify the perfusion community to a degree, there is no assurance to the public that the local perfusionist applies these recommended safeguards in his or her daily practice.

California was the first state to enact perfusion legislation in 1992 (Titling Act). Since then, 16 additional states have begun licensing perfusionists. In essence, over half the perfusionists working in the United States today require a license to practice in their respective states. Kansas is virtually surrounded by states that have previously enacted laws for licensing perfusionists; Nebraska, Missouri, Arkansas, and Oklahoma. At present, there are 9 additional states (Kansas included) with licensure initiatives at work.

Perfusion is a demanding profession, requiring a unique combination of highly specialized medical and mechanical training. Senate Bill No. 501 will serve to protect the citizens of Kansas from untrained and unqualified practitioners. Currently, all cardiac surgery

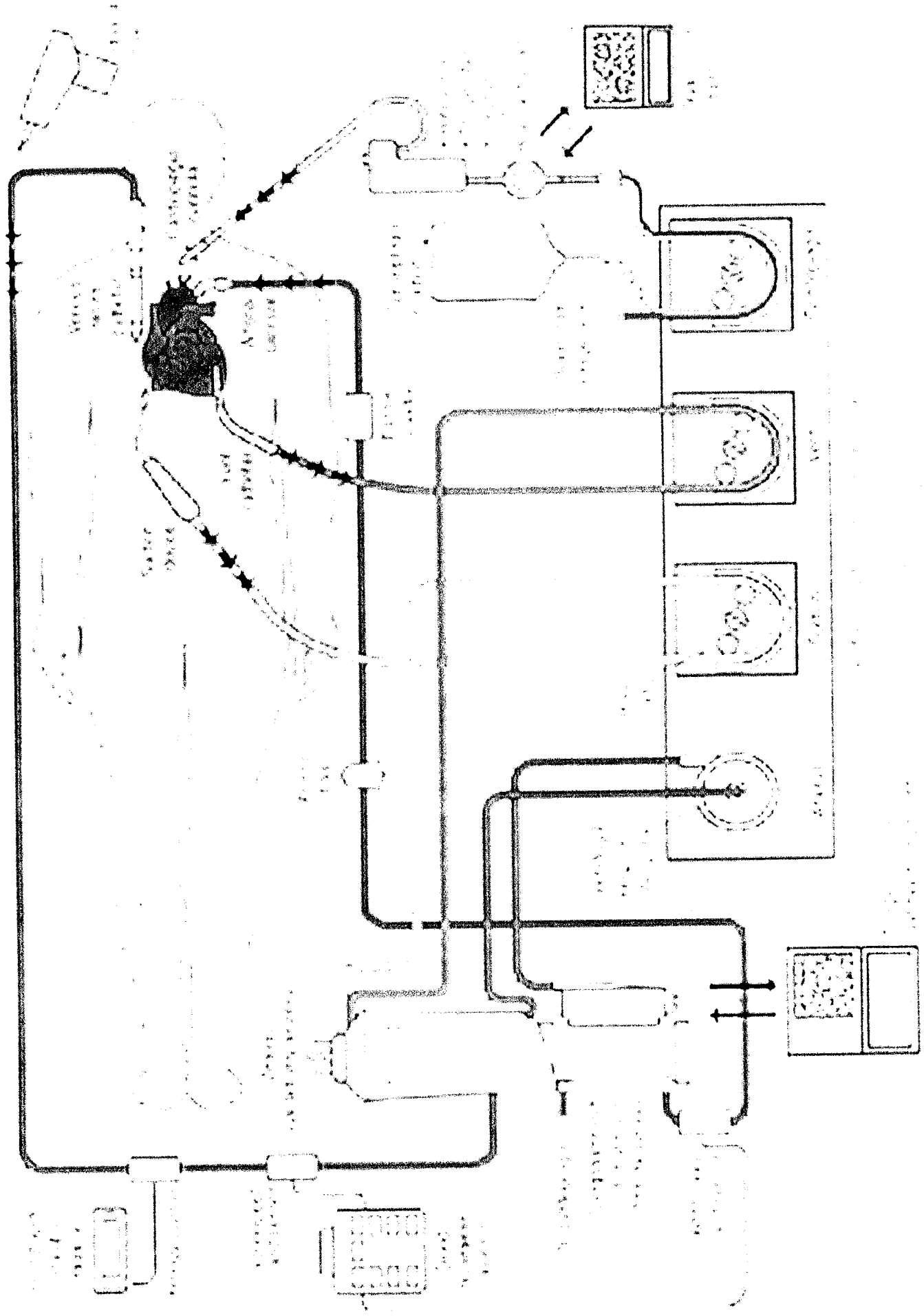
team members are recognized by the state of Kansas EXCEPT perfusionists. Essentially, the person who can do the most harm to the patient is at present unregulated. Enactment of Senate Bill No. 501 ensures that all citizens of Kansas enjoy the benefits of knowing that all members of the cardiac surgical team are qualified.

- Licensing perfusionists **WOULD** establish minimum standards of education, training, and competency for persons engaged in the practice of perfusion in the state of Kansas.
- Licensing perfusionists **WOULD** assure that the health and safety of the citizens of Kansas are protected from unqualified practitioners, or from the unprofessional practice of perfusion.
- Licensing perfusionists **WOULD** assure that in the future anyone entering Kansas to work as a perfusionist would meet Kansas' legislated high standards of patient care.

- Licensing perfusionists **WOULD NOT** permit perfusionists to privately bill for their services.
- Licensing perfusionists **WOULD NOT** prohibit the employment of anyone currently working in the state of Kansas.
- Licensing perfusionists **WOULD NOT** increase the cost of healthcare in the state of Kansas by requiring hospitals to hire more expensive professional employees.

Perfusion practitioners make judgments of consequence, independently, on a daily basis, and continually during operation of the heart-lung machine. Although the surgeon-in-charge supervises the perfusionist and may provide protocols as a guide, the actual decision-making is taking place at the heart-lung machine by the perfusionist on a minute-to-minute basis. When problems occur, split-second analysis and response is required without time for consultation with the surgeon. While a nurse anesthetist can call the anesthesiologist, and a physician's assistant can call their supervising physician, the perfusionist does not enjoy this luxury. In many centers, perfusionists work totally alone. The growth in complexity of perfusion as a discipline, and the proliferation of mechanical device options and equipment, combine to warrant strict regulation and oversight of this healthcare specialty. The citizens of Kansas who undergo open-heart surgery rarely ask about the expertise of the surgical team members. The assumption is that each is suitably qualified to perform his or her respective job. Senate Bill No. 501 will mandate minimum educational and training standards for all perfusionists working in the state of Kansas. If enacted, this legislation will help guarantee that all Kansans receive the highest quality perfusion care.

The Kansas Practicing Perfusionist Society respectfully asks for your support in passing Senate Bill No. 501. Thank you.



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Jan Lunn

From: Kelly Hedlund [khedlund@ruraltel.net]
Sent: Friday, February 12, 2010 1:22 PM
To: Jan Lunn
Subject: SB 501 Letter of Support #1

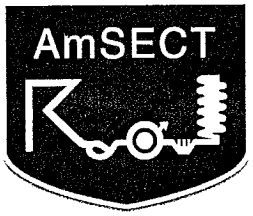
January 26, 2010

Governor Mark Parkinson, Members of the Kansas Senate, Kansas House of Representatives,

I as a Zone Representative of the American Society of Extra-Corporeal Technology (AmSECT) officially support the need for practicing perfusionists to be licensed medical professionals, and fully support the efforts of the Kansas Practicing Perfusionist Society (KPPS) in this regard. The high level of cognitive medical skill and professional judgment exercised by a perfusionist and the accompanying risks posed to the patient and the public at large merit this level of state regulation of the profession. The licensing of perfusionists would serve the best interests of the thousands of patients each year in Kansas who are affected by cardiovascular disease and depend on the services of a perfusionist.

Sincerely,

Charles E. Johnson RN/CCP
Zone Representative
American Society of Extra-Corporeal Technology



AMERICAN SOCIETY OF EXTRACORPOREAL TECHNOLOGY

January 20, 2010

Honorable Mark Parkinson
Governor
State of Kansas
Topeka, Kansas

Dear Governor Parkinson:

On behalf of the American Society of Extracorporeal Technology (AmSECT) and its Government Relations Committee (GRC), I am writing in support of professional licensure for clinical perfusionists in the State of Kansas. AmSECT's mission is to foster improved patient care by providing for continuing education and the professional needs of the extracorporeal circulation technology community. The clinical perfusionist is an individual qualified by professional credentialing and academic and clinical education to provide a myriad of extracorporeal patient care services. Perfusionists apply these services through the use of complex medical devices and related technology, such as the "heart-lung machine", to provide cardiovascular surgeons the means to successfully complete many types of cardiac and pulmonary surgical procedures. The demand for excellence from a perfusionist during surgery is substantial and continuous, since patient care and safety are top priorities. Because of these demands and the important role of perfusionists in the health care community, we believe it is necessary that perfusionists should be recognized as licensed professionals that are held to the same professional standards and accountability as physicians, nurses, physician assistants and respiratory therapists. The state recognition we are seeking in Kansas is not unique to allied health care professionals.

Perfusionists are required to attend and complete an educational curriculum in extracorporeal sciences recognized by the Commission on Accreditation of Allied Health Education (CAAHEP) to sit for the national certification board examination offered by the American Board of Cardiovascular Perfusion (ABCP). There are no restrictions in unlicensed states for employment of individuals who have not followed this prescribed pathway clearly recognized as the only appropriate means for training these highly specialized professionals. It is in the best interests of the citizens of Kansas that perfusionists attend appropriate educational programs and pass a national certification examination to provide patient care in this unique profession, or call themselves perfusionists in any healthcare facility.

Currently, there are sixteen states with legislated state licensing for perfusionists and one state with a titling act. These 17 states represent more than half of the 3600 perfusionists in the United States. Currently there are an additional nine states, plus the District of Columbia, in various levels of progress toward licensure initiatives. Kansas is one of those states.

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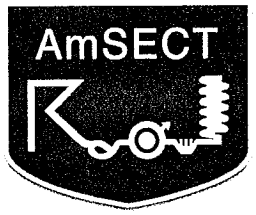

AMERICAN SOCIETY OF EXTRACORPOREAL TECHNOLOGY

The members of the Kansas Practicing Perfusionist Society (KPPS) and the Government Relations Committee of AmSECT are looking to the Kansas Legislature to establish firm and binding criteria for the licensure of perfusionists. These criteria will provide perfusionists working in Kansas the same accord that is given nearly every other person working in health care in your state. The perfusion community is well served by establishing guidelines for education, scope of practice, and examination criteria that it clearly recognizes as appropriate and necessary. The citizens of the State of Kansas are well served by legislating standards that will assure that only qualified persons provide the critical care services of a perfusionist to those in need. The members of the KPPS have worked for many years to bring this level of recognition to their profession. Their work on behalf of the citizens of your state is to be admired.

AmSECT has a model licensure act that has been used as the architectural backbone for all the other perfusionist licensed states. This model has stood the test of time and can easily be modified to suit the specific needs of any state. The AmSECT GRC has assisted the KPPS at every step during the lengthy process to establish licensure in Kansas. I strongly encourage you to endorse any proposed legislation for licensure of Kansas perfusionists, and all of us would be grateful for your support.

Sincerely,

Robert Longenecker; St. Louis, Missouri; Chairman, AmSECT Government Relations Committee (Central USA)

Lee Bechtel; Government Relations Director, AmSECT

Mark T. Lucas; Denver, Colorado; AmSECT Government Relations Committee (Western USA)

Keith Samolyk; Windsor, Connecticut; AmSECT Government Relations Committee (Eastern USA)

Mike Troike; Atlanta, Georgia; AmSECT Government Relations Committee (Southern USA)

Craig Gassmann; Lancaster, Pennsylvania; AmSECT Government Relations Committee member-elect (Eastern USA)

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KANSAS
DEPARTMENT OF HEALTH
AND ENVIRONMENT

Mark Parkinson, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony on SB 501
Licensure of Perfusionists

Presented to
Senate Public Health and Welfare Committee

By
Marla Rhoden, Director, Health Occupations Credentialing
Kansas Department of Health and Environment

February 15, 2010

Chairman Barnett and members of the committee, I am Marla Rhoden, Director of Health Occupations Credentialing for the Kansas Department of Health and Environment. Thank you for the opportunity to appear before the committee in support of SB 501.

The Kansas Department of Health and Environment is responsible for the administration of the Kansas Health Occupations Credentialing Act, (HOCA) K.S.A. 65-5001 *et seq.*, the purpose of which is to review the public's need for a new health occupation to be credentialed in Kansas or for a change in the level of credentialing according to statutory criteria.

In 2008, perfusionists sought a credentialing review in accordance with the HOCA. The technical review was completed in 2009, with the technical committee recommending licensure. Secretary Bremby concurred with that recommendation in his report to the Legislature. The provisions of this bill in establishing licensure as the level of credentialing for perfusionists are consistent with the technical review. In addition, the bill would create a perfusion council to assist the Board of Healing Arts in carrying out the provisions of the bill.

Passage of this bill serves to demonstrate the successful processing of an application by a health profession for credentialing under the law. The department asks that the legislature act favorably on this bill as the applicant group has thoroughly demonstrated the need and rationale under the legislature's criteria for the licensing of perfusionists. I will now stand for questions.

CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 200, TOPEKA, KS 66612-1365
Voice 785-296-1281 Fax 785-296

KANSAS HEALTH CONSUMER COALITION
STRENGTHENING THE VOICE OF KANSANS ON CRITICAL HEALTH CARE ISSUES.
534 S. Kansas Ave, Suite 1220 | Topeka, Kansas 66603 | Phone: 785.232.9997 | Fax: 785.232.9998 | info@kshealthconsumer.com

Testimony in Support of SB 525

Corrie Edwards, Executive Director, Kansas Health Consumer Coalition

Mr. Chair and members of the committee:

Thank you for the opportunity to express our support for SB 525, the fair hospital charges act. The Kansas Health Consumer Coalition (KHCC) advocates for accessible, affordable, and quality health care for all Kansans.

While we devote much of our time to public health policies, there has been a recurring issue that rises to the top as we consider what change could most impact consumers. That issue is relief from medical debt. Medical debt brings not only ruinous financial consequences, but health problems as well as patients forego care to avoid bills. There are several points on the continuum of a process that leads to medical debt that could and should be addressed. This involves everything from notice of assistance policies to charge parity to fair collections policies. SB 525 does not provide a solution to all of these needs but it is a meaningful step in addressing the root of the problem, high health care charges. From 2000-2006, 500,000 Kansas adults avoided medical care because of cost.[i] Between 2000 and 2008, growth in insurance premiums grew three times as fast as wages.[ii]

What we are seeking in SB 525 is not special consideration for self-pay patients but simply equality in pricing. Imagine if you walked into a department store and were told the price for a pair of shoes is higher for you than the next customer purchasing the same item. Then you discover that the higher price is assessed to those with the least ability to pay. Can you imagine the consumer revolt and public outrage that would result over such disparate treatment? Yet this is an accepted practice when it comes to medical bills. Unfortunately, consumers cannot just walk away in protest, because this is not a discretionary purchase. The other major difference: We are not talking about a few dollars, but thousands of dollars. Because hospitals enjoy significant federal, state, and local tax benefits in return for providing community benefit, they are the focus of our effort to provide pricing parity.

While I would like to take credit for coming up with the parity in pricing solution that comprises this bill, it is modeled after guidelines established by the American Hospital Association. The AHA has comprehensive recommendations for hospitals as it relates to serving patients in need. One of these policies states, "financial assistance should be provided to all uninsured patients between 100 and 200 percent of the federal poverty level by asking them to pay no more than (hospital choice of) a price paid to the hospital under contract by a public or private insurer; or 125% of the Medicare rate for applicable services."[iii]

In Kansas, former Attorney General Phill Kline subpoenaed some hospital records to determine if appropriate charity care, billing and collection practices were occurring. The formation of a task force led to a draft agreement between Kline and the Kansas Hospital Association that among many recommendations included a section that reads, "Financial Assistance for Self-Pay

Senate Public Health and Welfare
Date: 02/15/10
Attachment: 3

Individuals. Uninsured patients should not be charged at a rate exceeding the maximum rate that the hospital actually bills any insurance company for the same product or service. The hospital should be encouraged to provide a self-pay discount. The hospital should base the amount of the assistance on the demographics of the patient population served by the hospital and the hospital's financial ability to provide the assistance."[iv]

Unfortunately, the guidelines for both the AHA proposal and the KHA/Attorney General are only voluntary. I believe that today you will hear about the need for more discussion of these issues and finding solutions without legislation. It is my opinion that while further discussion is always desirable, it should not preclude legislative action that provides real relief. In our experience, the laudable goals outlined in both documents are not always being put into practice. Although much of the focus of SB 525 is on charge parity, there are two other provisions that would greatly benefit consumers. The first addresses the issue that came up in our survey, unawareness of available assistance. SB 525 provides that notice will be given on invoices that inform patients that if they meet the income threshold, they may be eligible for assistance. The other provision requires hospitals to make a good faith effort in determining if a patient might be eligible for assistance before pursuing collections action.

Adoption of SB 525 will bring pricing parity for those who need it the most. I respectfully urge your support for approval of SB 525. Thank you for your consideration.

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[i] KHI Issue Brief: *The Growing Health and Financial Costs of Inadequate Health Insurance; LaClair, Barbara; Maree, Gina; January 2009.*

[ii] Kaiser Family Foundation, Focus on Health Reform, *Health Care and the Middle Class: More Costs and Less Coverage; Hoffman, Catherine; Rowland, Diane; McGinn-Shapiro, Molly; July 2009.*

[iii] *Community Accountability and Transparency: Helping Hospitals Better Serve Their Communities AHA Policies, Guidelines, and Checklist;* December 2003.

[iv] *Draft Recommended Billing, Financial Assistance and Collection Practices (between the Kansas Hospital Association and former Attorney General Phill Kline).*

Phill Kline
ATTORNEY GENERAL
120 S.W. 10TH AVE, 2ND FL
TOPEKA, KANSAS 66612-1597

DRAFT

Recommended Billing, Financial Assistance and Collection Practices

Endorsed by the
Kansas Hospital Association

PREAMBLE

Kansas hospitals exist to provide essential health care services for their communities, twenty-four hours a day, every day of the year. These essential services are provided regardless of a person's ability to pay; however, individuals have an obligation to pay for the services they receive or seek financial assistance when needed. It is the duty of hospitals to collect from those who have the ability and the resources to pay using ethical collection practices that are allowed under Kansas and federal laws. Financial assistance programs offered by the hospital should not lessen the need to find solutions to expand access to appropriate health care coverage for all persons.

I. Guiding Principles

The following principles and guidelines should be used to develop hospital billing, financial assistance and collection practices:

A. Access to Health Services. A responsible party's inability to pay should not be a barrier to receiving essential health services. The inability to pay a hospital bill should never prevent any Kansan from seeking necessary health services. The hospital should communicate this message to all responsible parties and local health and community service organizations.

B. Mission and Values. The hospital should have billing, financial assistance and collection policies that are consistent with the mission and values of the hospital. These policies, which should be broadly communicated, should reflect a commitment to provide financial assistance to patients who cannot pay for part or all of the care they receive.

C. Communication. The hospital should communicate all billing, financial assistance and collection policies in a manner that is clear, understandable, respectful and in language(s) appropriate to the communities, patients and/or responsible parties served.

D. Legal Compliance. The hospital is responsible for communicating its collection policies and practices to both relevant hospital staff and to its internal collection departments. These policies should be respectful and comply with all applicable state and federal laws.

E. Personal Responsibility. Financial assistance and collection policies are not substitutes for personal responsibility. Eligible responsible parties may be expected to access public or private insurance options in order to qualify for financial assistance. All responsible parties are expected to contribute to the cost of care based on their ability to pay. Responsible parties should comply with the application requirements, including the production of necessary information to determine financial assistance eligibility.

II. Financial Assistance

The hospital's board of directors should adopt financial assistance policies consistent with the hospital's mission and values as well as local community standards. Hospitals should develop policies to aid those individuals who do not otherwise have the ability to pay in a timely manner for health care services received. Hospitals should review and evaluate all financial assistance policies on a regular basis. Hospital financial assistance is not a substitute for employer-sponsored, public, private or individually purchased insurance.

Hospitals should consider the following when adopting financial assistance policies:

A. Communication. The hospital should maintain understandable, written financial assistance policies for low income and uninsured patients. The hospital should provide financial assistance counseling in a clear and concise manner to all responsible parties without regard to race, ethnicity, gender, religion or national origin. The hospital should communicate these policies in a manner that is respectful and in language(s) appropriate to the communities, patients and/or responsible parties served. Attachment A is an example of such communication.

The hospital should post and/or distribute financial assistance information or literature. If posted, these notices should be placed in visible locations throughout the hospital such as admitting/registration, billing office and emergency department. Financial assistance applications should be readily available to responsible parties, and should clearly state the eligibility criteria and the process used by the hospital to determine whether a patient is eligible for financial assistance.

B. Financial Assistance for Low-Income Individuals. The hospital should establish criteria to provide financial assistance to low income and uninsured patients using guidelines such as the Federal Poverty Level (FPL). The hospital should base the amount of the assistance on the demographics of the patient population served by the hospital, and the hospital's financial ability to provide the assistance. These criteria should be evaluated on an annual basis to determine the appropriate level of assistance available.

C. Financial Assistance for Self-Pay Individuals. Uninsured patients should not be charged at a rate exceeding the maximum rate that the hospital actually bills any insurance company for the same product or service. The hospital should be encouraged to provide a self-pay discount. The hospital should base the amount of the assistance on the

demographics of the patient population served by the hospital, and the hospital's financial ability to provide the assistance

D. Financial Evaluation. The hospital should consider the responsible party's assets in determining eligibility. In addition to the hospital's standard financial assistance evaluation process, the hospital should take into consideration various financial factors, including all outstanding medical bills of the patient at that hospital. The hospital should also evaluate the responsible party's prior hospital accounts to determine if financial assistance was previously authorized, and if so, attempt to utilize the financial information previously provided by the responsible party. The hospital should also access the responsible party's financial situation utilizing the information the responsible party can reasonably provide.

E. Extraordinary Circumstances. The hospital should identify, on a case-by-case basis responsible parties whose medical expenses, in relationship to their income, would make them medically indigent if they were forced to pay full charges. For the purposes of these guidelines, "medically indigent" shall mean patients whose resources, including any health insurance coverage, do not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income and other assets, would make them indigent if they were forced to pay full charges for their medical services.

III. Billing and Collection Policies – Hospital Responsibilities

Hospitals should consider the following when adopting billing and collection policies:

A. Communication. The hospital should provide information about the availability of financial assistance to responsible parties. The hospital is responsible for providing its financial assistance policy to all relevant hospital staff and third-party collection agencies engaged in the collection of debts.

When sending any statement to a patient, hospitals should include (1) a statement indicating that if the responsible party meets certain requirements the responsible party may be eligible for financial assistance from the hospital; and (2) a statement providing the patient with a telephone number the department or office from which the patient may obtain information about the hospital's financial assistance policies and how to apply for such assistance.

B. Timely Filing. The hospital should timely file insurance claims, provided the responsible party timely provides the hospital with proof of insurance and any other additional information necessary to file the claim. If a claim is denied based on improper insurance information, the hospital should attempt to resubmit the claim with the appropriate insurance information. When possible, the hospital should reference patient billing information previously obtained to determine the proper insurance information. If the hospital bears responsibility for the untimely filing of a claim, the hospital should attempt to collect from the responsible party only that portion which would have been owed had the party's insurance claim been timely filed.

C. Payment Plans. The hospital should counsel the responsible party in an effort to develop a payment plan, which allows the party to pay the account over a reasonable amount of time based on the party's ability to pay. The hospital should provide an agreed upon payment plan to the responsible party in writing. Any interest rate charged should be clearly stated.

D. Retroactive Financial Assistance When attempting to collect on any open account, the hospital should allow financial assistance to be applied if it is deemed a responsible party would have qualified for previously undetermined financial assistance when services were rendered.

E. Collection Agents. The hospital should define the policies and practices to be used by outside collection agents acting on the hospital's behalf, and require such agents to agree to these standards in writing. The hospital should make reasonable efforts to contact a responsible party regarding payment options prior to assigning the account to a third party collection agency. Hospitals should develop fair and consistent written policies regarding when and under whose authority patient debt is referred for external collection. The hospital should encourage all third-party collection agencies to include notice regarding the hospital's financial assistance programs on all written communications to responsible parties.

F. Collection Terms and Reporting. No hospital should enter into any contracts with debt collectors that include bonuses, contingencies or any other incentives that are paid out against a temporal deadline.

All hospitals should publish to the community, on an annual basis, the identity of all collection firms or attorneys, the amounts collected by each, and the fees paid to each by the reporting hospital.

G. Legal Action. The hospital should require written approval by the hospital's Chief Financial Officer, or his/her designee, before legal action is commenced against a responsible party. A collection agent should not be allowed to file a lawsuit against a responsible party without the hospital's prior written consent.

IV. Responsible Party Obligations

The responsible party is expected to cooperate with the hospital by:

A. Communication. Responsible party should inform the hospital of the need for financial assistance as soon as the need is identified.

B. Pre-designation. When possible, the patient should clearly pre-designate the responsible paying party at the time of initial treatment or admission.

When possible, the patient should clearly pre-designate all authorized visitors for inpatient stay. For the purposes of visitation eligibility and visitors hours, "family" refers to persons who play a significant role in the patient's life. This may include a person(s) not legally related to the patient Decisions concerning visitation rights and privileges

should be made by the patient or the patient's chosen designate. Patients should be encouraged to designate those persons who should be granted primary visitation rights and any persons who should not be granted visitation rights before or during the admission process. Hospitals are encouraged to educate the community on this pre-designation process and the benefits of such legal instruments as durable powers of attorney. The above provision is subject to all demands of federal and state law and does not apply to hospital staff.

C. Timely Application. When possible, the responsible party should make a timely application to the hospital if financial assistance is needed.

D. Asset and Financial Disclosure. When available, the responsible party should provide requested information in a timely manner such as available income and assets, household size and other pertinent data in order to establish a workable payment plan with the hospital. If required, the responsible party will provide the hospital with any and all financial and other information needed to enroll in a publicly or privately sponsored program (e.g., Medicaid, Health Wave, MediKan, private grants or SCHIP).

E. Notification of Changes. When possible, the responsible party should inform the hospital regarding any change in their financial situation that may impact their ability to pay their hospital bill or to honor the provisions of their payment plans.

F. Payment. The responsible party should honor any mutually agreed upon payment plan established with the hospital.

V. Implementation

In order to properly implement financial assistance policies, the Kansas Hospital Association recommends that hospitals identify and educate appropriate hospital personnel to administer the policies.

SUMMARY

Kansas hospitals are committed to providing the best possible health care services for the citizens of their communities regardless of their ability to pay. But, because of the growing number of uninsured and underinsured in the state, it is becoming an ever greater financial challenge to assist patients with limited financial resources. The Kansas Hospital Association encourages hospitals to use this document as a guide to build upon their current financial assistance practices and policies.

The Kansas Hospital Association and its member hospitals are committed to working with federal and state government, payers, businesses and consumer groups to address the underlying problems caused by the lack of health insurance coverage. Further, we would encourage other providers of health care such as surgical centers, imaging centers and other health care providers in the state to adopt similar patient-centered billing and collection practices.

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Attachment A

Sample Patient Notice of Financial Assistance
(Developed by the Kansas Hospital Association)

[NAME OF HOSPITAL] is proud of its mission to provide quality care to all who need it. If you do not have health insurance or are concerned that you may not be able to pay in full for your care, we may be able to help. **[NAME OF HOSPITAL]** provides financial assistance to responsible parties based on their level of income, assets, and needs. In addition, we may be able to help you identify other available resources or work with you to arrange a manageable payment plan. It is important that you let us know if you will have trouble paying your bill. Federal law requires hospitals to apply their billing and collection criteria consistently to all. Unpaid bills may ultimately be turned over to a collection agency, which could affect your credit status. For more information, please contact **[NAME OF PERSON]** in our financial counseling office at **[PHONE NUMBER]**. We will treat your questions with confidentiality and courtesy.

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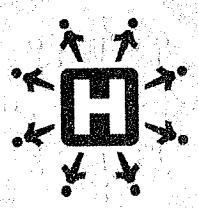

community

Community Accountability and Transparency

community
CONNECTIONS

Photos in this publication are courtesy of Doug Haight, photographer, and illustrate programs from recent Foster G. McGaw Prize winning organizations. Since 1986, the Foster G. McGaw Prize has honored health delivery organizations that have demonstrated exceptional commitment to community service. The Prize is sponsored by The Baxter International Foundation and the Cardinal Health Foundation and the American Hospital Association.

November 2007

3-11

AHA
Policies & Guidelines
on Billing, Collections, Tax-Exempt Status, and Community Health

The American Hospital Association and America's hospitals are committed to doing everything we can to better serve patients and to treat them equitably, with dignity, compassion, and respect from the bedside to the billing office. This document is a consolidation of existing AHA policies and guidelines covering billing, collections, tax-exempt status, and promotion of community health.

Hospitals exist to serve. Their ability to serve well requires a relationship with their communities built on trust and compassion. Hospitals and the communities they serve share responsibility in determining what services communities most need. Every day, hospitals across the country work to meet their unique community needs while keeping the hospital doors open 24-7, 365 days a year.

America's hospitals are united in providing care based on the following principles:

- Treat all patients equitably and with dignity, respect, and compassion.
- Serve the emergency health care needs of everyone, regardless of ability to pay.
- Assist patients who cannot pay for part or all of the care they receive.

Many states have requirements that may dictate hospital policies or reporting and many state, regional, and metropolitan hospital associations have provided specific guidance to help hospitals navigate state requirements. This AHA resource is not intended to replace those materials. Instead, these policies and guidelines work as a supplement to further strengthen community hospital relationships and to reassure patients, regardless of their ability to pay, of hospitals' commitment to caring.

3-11

Providing Financial Assistance for the Uninsured of Limited Means

- Financial assistance and counseling should be provided to uninsured people of limited means, without regard to race, ethnicity, gender, religion, or national origin.

- Financial assistance provided by hospitals to uninsured people of limited means should in no way substitute for state efforts to provide or expand coverage to the uninsured. State Medicaid programs should be required, at a minimum, to sustain a "maintenance of effort," keeping programs' eligibility at least at their current levels. Further, state Medicaid programs also should be required to expand coverage to all individuals at or below the poverty level. Until that time:
  - Hospitals should have policies to provide services to uninsured patients below 100% of the federal poverty level at no charge. Existing clinical and geographical criteria used by hospitals to determine eligibility for certain services would apply.

- Financial assistance should be provided to all uninsured patients between 100% and 200% of the poverty level by asking them (based on a hospital's choice) to pay no more than:
  - A price paid to the hospital under contract by a public or private insurer; or
  - 125% of the Medicare rate for applicable services, given that in the aggregate today, Medicare pays less than the cost of care.

  For these patients, hospitals may choose to charge on a sliding scale up to the stated limits. Hospitals also may choose to provide greater assistance.

- Financial assistance may be offered to uninsured patients with incomes in excess of 200% of the federal poverty level at the discretion of the hospital.

- Hospital financial assistance/discounting policies should clearly state the eligibility criteria, amount of discount, and payment plan options.

- Hospital financial assistance is contingent upon the cooperation of a patient in providing the information necessary for a hospital to qualify that patient for its programs of assistance or for public or other coverage or assistance that may be available. Patients receiving financial assistance from hospitals have a responsibility to pay according to the terms of that policy.

Cosmetic surgery and other non-medically necessary services are exempt.

Hospitals should provide the training and oversight necessary to ensure that financial assistance policies are applied accurately and consistently, recognizing that hospitals need the flexibility to extend assistance to patients who may not fit within their policy but need assistance due to special circumstances.

Communicating Charity Care and Financial Assistance Policies

Hospitals should make information available to the public on hospital-based charity care and financial assistance policies.

Hospitals should communicate this information to patients in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in their communities.

Hospitals should have understandable, written policies to help patients determine if they qualify for public assistance programs or hospital-based assistance programs.

Hospitals should share these policies with appropriate community health and human services agencies and other organizations that assist people in need.

Helping Patients Qualify for Financial Assistance

Hospitals should provide financial counseling to patients about their hospital bills, the hospital's financial programs, and public or other assistance programs.

Hospitals should make the availability of financial counseling for patients widely known.

Hospitals should respond promptly to patients' questions about their bills and to requests for financial assistance.

Ensuring Fair and Transparent Billing and Collection Practices

- ◇ Hospitals should use a billing process that is clear, concise, correct, and patient-friendly.
- ◇ Hospitals should make available for review by the public specific information in a meaningful format about what they charge for services. Charge information should be made available in different languages and in different forms consistent with the diversity of the hospital's community.
- ◇ Hospitals should have staff readily available to explain how and why the price of a patient's care can vary.
- ◇ Hospitals should work to create common definitions and explanations of complex pricing information, including working toward and using innovative and understandable ways for displaying pricing information for use by consumers.[1]
- ◇ Hospitals should ensure that staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections, as well as nurses, social workers, hospital receptionists, and others) are educated about hospital billing, financial assistance, and collection policies and practices.
- ◇ Hospitals should ensure that patient accounts are pursued fairly and consistently, reflecting the public's high expectations of hospitals.
- ◇ Hospitals should implement written policies about when and under whose authority patient debt is advanced for collection and when and under whose authority a lien can be placed on a patient's primary residence.
- ◇ Hospitals should define the standards and scope of practices to be used by outside collections agencies acting on their behalf and should obtain from such agencies agreement to these standards in writing, including written assurances of compliance with the *Fair Debt Collections Practices Act* and the ACA International's (ACA International: The Association of Credit and Collection Professionals) Code of Ethics and Professional Responsibility.

1 For more information or assistance, visit www.patientfriendlybilling.org – a Healthcare Financial Management Association initiative supported by the AHA and others to promote clear, concise, and correct patient-friendly financial communications.

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Promoting Community Health

- Hospitals' commitment to community health as reflected in its mission, values, and goals should be understood and applied by everyone throughout the organization.
- Hospitals should understand their communities' unique health needs and work with others in the community to meet those needs.
- Hospitals should periodically conduct a community needs assessment and assign responsibility for the hospital's community benefit plan to a hospital employee.
- Hospitals should have ongoing processes for planning and monitoring how their commitment to community health is met through services and programs for the community.
- Hospitals should develop and make readily available to the public a comprehensive inventory of all the community programs and services offered, including specialty services, extended care, and programs that address social and basic needs, access, coverage, and quality of life.
- Hospitals should understand and publicly communicate the impact of their programs and services on their communities.

Reporting Community Benefit (applies to non-government, tax-exempt hospitals)[2]

- Hospitals should voluntarily, publicly, and proactively report to their communities on the full value of benefit a hospital provides.
- Hospitals' community benefit reports should be easy to locate on their Web sites and/or at their offices.
- In addition, IRS Form 990 filings should be posted on hospitals' Web sites. When finalized, hospitals should use Schedule H of the IRS Form 990 to inform their community, as fully as the schedule will permit, about the entire range of benefits they provide, including those that are not easily quantifiable. In addition, if the IRS' revised forms permit, hospitals should attach or include a Web link to their community benefit reports.
- Hospitals should increase their financial accountability by:
  - Having the highest ranking officer of the hospital or the CFO sign the Form 990; and
  - Prohibiting loans to board members or executives.

2 The IRS is revising the reporting forms for tax-exempt organizations. This section will be revised, consistent with the new reporting requirements, when those forms are finalized.

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A Strategy Checklist for Leaders

Effective leadership requires well-defined goals, policies that support those goals, and well-designed action plans to implement the goals. While clear vision and mission statements are a critical beginning for a publicly accountable hospital, they are by no means sufficient. It is the policies that support the vision and mission and the action plans to implement the policies that enable a hospital to be truly accountable to its community.

Through their vision and mission statements, hospitals around the country have made commitments to promote the health and well-being of their communities. To meet these commitments many have adopted policies and practices to identify and implement services that meet the health care needs of their communities, to provide health care services to their communities regardless of ability to pay, and to make available an increasing amount of information about the price and quality of hospital care.

As the national advocate for hospitals, the American Hospital Association supports the nation's hospitals in meeting community needs, implementing fair and compassionate policies to help the uninsured, and providing meaningful information about the delivery and cost of services. Hospitals are committed to their communities, and the AHA is committed to providing the support and tools needed to help hospitals promote the health and well-being of their communities.

As part of that commitment, the AHA has adopted the public accountability policies described in the first section of this resource. In this section, there is a checklist to help CEOs and trustees evaluate and monitor the effective implementation of these and other public accountability policies.

How to Use this Strategy Checklist

Every hospital is different in how it meets the needs of its community and ensures public accountability. This tool offers a basic framework that leaders can use to evaluate how successfully community accountability goals are being met. It is not intended to be a benchmark against the performance of others. Rather, it should be used to help promote the effective implementation of policies and practices that support public trust and accountability.

A series of questions are organized under the following major headings:

- Providing Financial Assistance for the Uninsured of Limited Means
- Communicating Charity Care and Financial Assistance Policies
- Helping Patients Qualify for Financial Assistance
- Ensuring Fair and Transparent Billing and Collection Practices
- Promoting Community Health
- Reporting Community Benefit (applies to non-government, tax-exempt hospitals)

Some of the questions are specific. Some are general to stimulate thinking about overall organizational activities. Alongside each are three boxes: "Yes," "No," and "More Needs To Be Done."

Providing Financial Assistance for the Uninsured of Limited Means

		Yes	More needs to be done	No
1.	Do you proactively identify uninsured patients of limited means and qualify them for financial assistance and counseling without regard to race, ethnicity, gender, religion, or national origin?	O	O	O
2.	Do the hospital's financial assistance/discounting written policies provide a clear explanation of the eligibility criteria, information needed to qualify the patient for its assistance programs, the discount amount for patients meeting various criteria, the types of services covered by these policies, payment plan options, and information needed to qualify for other available public assistance?	O	O	O
3.	Does your financial assistance program provide services to uninsured patients at or below 100% of the federal poverty level at no charge?	O	O	O
4.	For uninsured patients between 100% and 200% of the federal poverty level, do you provide financial assistance and, at minimum, ask them to pay no more than the price paid by a public or private insurer under contract to the hospital or 125% of the Medicare rate for applicable services?	O	O	O
5.	Do you offer financial assistance to uninsured patients with incomes in excess of 200% of the federal poverty level?	O	O	O
6.	Do you have well-trained counselors that work with uninsured patients to help them understand the hospital's financial assistance/discounting policies and how they can qualify for assistance and/or discounts, including how they can enroll in all public and private programs for which they are eligible?	O	O	O
7.	Do you have well-trained financial counselors that work with uninsured patients on an ongoing basis to establish payment assistance plans and schedules that address both patient and hospital needs?	O	O	O
8.	Does the organization monitor the implementation of its financial assistance policies and conduct evaluations to ensure that all written policies for assisting low-income patients are applied consistently?	O	O	O

3-20

Communicating Charity Care and Financial Assistance Policies

		Yes	More needs to be done	No
1.	Are your hospital-based charity care and financial assistance policies and procedures easily accessible and readily available to the hospital's patients and the public?	O	O	O
2.	Is information about the hospital's charity care and financial assistance policies and procedures posted on the hospital's Web site?	O	O	O
3.	Do you proactively communicate information about your charity care and financial assistance policies and procedures to patients in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in the community?	O	O	O
4.	Is information about the hospital's charity care and financial assistance policies and procedures posted or readily available to patients in written form in the Emergency Department and other hospital waiting rooms?	O	O	O
5.	Do you share information about your charity care policies and financial assistance programs with appropriate community health and human services agencies and other organizations in your community that assist people in need?	O	O	O

Helping Patients Qualify for Financial Assistance

		Yes	More needs to be done	No
1.	Is the hospital proactive in informing patients that financial counselors are available to assist them and respond to questions about their bills?	O	O	O
2.	Do financial counselors respond promptly with the needed information to address patient issues and questions?	O	O	O
3.	Do financial counselors actively follow-up and continue to work with patients and their families when there are unresolved questions or concerns until these are resolved?	O	O	O
4.	Does your organization provide 24-hour access to respond to questions about financial assistance, such as a hotline or Web-based information page?	O	O	O

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A Strategy Checklist for Leaders

Ensuring Fair and Transparent Billing and Collection Practices

		Yes	More needs to be done	No
1.	Is the organization's billing process clear, concise, correct, and patient-friendly?	O	O	O
2.	Is the organization's charge information easily accessible and presented in a way that is understandable to and usable by the general public?	O	O	O
3.	Is charge information available in different languages and in different forms consistent with the diversity of the hospital's community?	O	O	O
4.	Do you have well-trained staff readily available to answer patient questions about charge information and to provide patients with additional explanations about how charges are established and how they might vary from average charges depending on the patient's care requirements?	O	O	O
5.	Do you have training programs for all staff that have contact with patients about hospital billing, financial assistance, and collection policies and procedures, including how to connect patients with specifically trained hospital staff knowledgeable about hospital charges, billing practices, and financial assistance?	O	O	O
6.	Do you provide patients and the community with opportunities to offer input and feedback on the usefulness of the charge information provided by the hospital?	O	O	O
7.	Are the debt collection policies and practices easily accessible and available to the public?	O	O	O
8.	Do you have written policies as to when and under whose authority a patient account is advanced for collection?	O	O	O
9.	Does your debt collection policy prohibit advancing an account for collection if the patient has a pending hospital application for financial assistance?	O	O	O
10.	Are there written policies as to when and under whose authority a lien can be placed on a patient's primary residence?	O	O	O
11.	Are your financial counselors trained and instructed to clearly and thoroughly explain the hospital's debt collection practices to uninsured and/or underinsured patients?	O	O	O
12.	Do you comply with the *Fair Debt Collection Practices Act* and the America Collectors Association (ACA) International's Code of Ethics and Professional Responsibility in your debt collection policies and practices?	O	O	O
13.	If you use an outside debt collection organization, do you obtain written assurances that this organization complies with the *Fair Debt Collection Practices Act* and the ACA International's Code of Ethics and Professional Responsibility?	O	O	O

3-22

Promoting Community Health

		Yes	More needs to be done	No
Make sure your mission, values, and goals reflect a commitment to community health and are understood and applied by everyone throughout the organization.				
1.	Do the organization's mission and vision describe your commitment to the community and to meeting community health needs?	O	O	O
2.	Are the mission and vision used to establish the strategic direction and evaluate key decisions?	O	O	O
3.	Are the organization's mission, values, and goals easily understood?	O	O	O
4.	Are your written mission/values/goals communicated throughout the organization and to the broader community?	O	O	O
5.	Are the organization's goals continually adjusted to reflect changing community health needs?	O	O	O
6.	Do you have procedures in place at all levels of the organization to ensure your commitment to mission/values/goals is maintained and consistently applied to decision making, business practices, and the delivery of patient care?	O	O	O
7.	Can you show how specific activities and services further your mission/ values/goals?	O	O	O
8.	Is there a designated staff person or department that is responsible for the planning and implementation of the hospital's activities related to community health promotion?	O	O	O
9.	Are there regular reports prepared for the board on the plan, operations, and impact of the hospital's activities related to community health promotion?	O	O	O
Demonstrate your community connection.				
1.	Do you regularly evaluate the unique social, geographic, economic, or other special characteristics of your community?	O	O	O
2.	Have you identified the community's highly vulnerable populations...teenagers, the elderly, the indigent, and ethnic or racial minorities?	O	O	O

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Promoting Community Health *continued*

		Yes	More needs to be done	No
3.	Have you researched the unique health needs of the community and its unmet or underserved needs?	O	O	O
4.	Have you worked with others in the community (i.e., other governmental, community, and/or social service organizations) to conduct a community health needs assessment?	O	O	O
5.	Do you use the health needs assessment to establish programs to address identified community health needs, including addressing the needs of highly vulnerable populations and the economic, social, cultural, and/or geographic barriers to care that exist within the community?	O	O	O
6.	Do you work with others in the community to develop and implement programs to address community health needs?	O	O	O
7.	Do you reach out and involve vulnerable populations in the design and operation of services and programs targeted to meet the needs of these populations?	O	O	O
8.	Do you have a community advisory board to help guide the development of community services and programs?	O	O	O
Develop and make available a comprehensive inventory of the benefits provided to the community.				
1.	Do you have a comprehensive list of all the community programs and services the organization offers, including: specialty services; extended care; health promotion; and programs that address social and basic needs, access, coverage, and quality of life?	O	O	O
2.	Are you making ongoing efforts to increase community awareness and utilization of programs and services, particularly with highly vulnerable populations?	O	O	O
3.	Does the hospital have, or participate in, an organized program to coordinate community support services after a patient has been discharged from the hospital?	O	O	O
4.	Is the hospital a teaching hospital or affiliated with a teaching hospital or college for training physicians, nurses, or other allied health professionals?	O	O	O
5.	Are the organization's educational programs included in its list of community programs and services?	O	O	O

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Promoting Community Health *continued*

		Yes	More needs to be done	No
6.	Does the hospital undertake, support, or facilitate basic scientific or clinical research at its facilities?	O	O	O
7.	Are the organization's research programs included in its list of community programs and services?	O	O	O
8.	Have you collaborated with other hospitals to meet community health needs?	O	O	O
9.	Has the organization worked to ensure that there is continued and sustainable support for its community services and programs?	O	O	O
10.	Has the organization worked to secure outside funding, if necessary, to maintain community services and programs?	O	O	O
11.	Does the organization provide financial assistance for start-up and/or continued operation of programs and services offered by other community and social service organizations?	O	O	O
	Understand and communicate the impact of the hospital's programs and services on the community.			
1.	Do you evaluate or measure the number of people served by your community programs and services?	O	O	O
2.	Have you measured recipient and/or community satisfaction with these programs and services?	O	O	O
3.	Have you gathered information on the impact of your programs and services on community health status?	O	O	O
4.	Are evaluation results shared with the hospital's board of trustees?	O	O	O
5.	Do you share evaluation results with a community advisory board or other community partners?	O	O	O
6.	Do you regularly modify, expand, and/or change community programs and services in response to results of your satisfaction and impact evaluations as well as updated community health assessments?	O	O	O
7.	Do you regularly communicate through public newsletters, readily available patient information, and/or the local media about the existence and impact of your community programs and services?	O	O	O

3-25

Reporting Community Benefit (applies to non-government, tax-exempt hospitals)

		Yes	More needs to be done	No
1.	Do you regularly report to the community on the full value of benefit the hospital provides?	O	O	O
2.	Does your community benefit report detail the full range of services, programs, and support provided to the community even if these are difficult to quantify?	O	O	O
3.	Is the organization's community benefit report easily accessible on its Web site and/or in its offices?	O	O	O
4.	Do you attach the calculation of community benefit to Schedule H as part of your Form 990 submission?	O	O	O
5.	Does the CEO, CFO, or highest ranking officer sign your Form 990?	O	O	O
6.	Do you have a policy that prohibits loans to board members or executives?	O	O	O

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2-15-09

Public Health & Welfare Committee

SB 525 (KFU supports)

Good afternoon Chairman Barnett, ranking minority member Kelly, and members of the committee.

My name is Donn Teske and I currently have the honor of serving as president of Kansas Farmers Union. I appreciate this time to testify in support of SB 525, The Fair Hospital Charges Act.

Why is a farm organization testifying on a health care bill? Our membership base consists of agricultural producers from across the state. Often, we end up purchasing health insurance without the benefit of participating in a group health plan and are forced to participate in the individual market arena. As you well know those of us who are in this market for health insurance often pay more for less coverage and we tend to purchase more catastrophic only insurance and end up paying for a lot of charges ourselves. Thus we get caught right in the middle of the predatory practice of hospitals forcing us to pay full price while insurance companies routinely settle the claim for a fraction of full-pay charges. This is an unfair system of charging and SB 525 is a good start to addressing this problem in Kansas.

Several years ago Kansas Farmers Union participated, along with the Access Project, in a professional survey of our membership base on rural medical debt in Kansas. The results of that survey were startling, showing that 17% of our membership had SIGNIFICANT medical debt even though they had health insurance! This reflects catastrophic health insurance and the resulting private-pay charges forcing my membership base into deeper debt because of family illness, something we have no control over. As a result of this our farms and way of life is threatened by a system of unfair charging.

There is an old saying out there that farmers live poor and die rich. There's some truth to that because it takes so much capitol investment to operate a farm while cash-flows are always extremely tight. It doesn't take much to tip the cash-flow into a severe negative plunge when a family illness adds additional debt and it's common for land and livestock (our factories) to be forced to be liquidated to pay this debt, or worse, send us to bankruptcy.

Imagine our frustration in rural Kansas when we know the insurance companies are paying a fraction of what we are forced to pay just because they can? It's unjust!

In our personal situation, my wife Kathy and I are proud parents of four grown children. During our years of childbearing we did not have maternity insurance and we were forced to pay full price for each child, and each child doubled in price from the previous one, so in a span from 1982 to 1991 our cost to have a child was increased four-fold. My other siblings worked off the farm and their birthing costs, through their insurance company, was half what our charges were! At the SAME hospital! And this all happening at a time in our lives when we are trying to get our feet under us for that race through life. Talk about frustrating!

My wife Kathy has worked professionally for over ten years in the health care profession, working with insurance companies and patients in their billing charges. Her experience with hospital billing is that the practice of insurance companies paying much, much less than private pay is not only routine but a standard acceptable billing practice.

Having no will of self-discipline in a warped health care billing system we as the state of Kansas need to step in and set parameters.

SB 525 does that.

Thank you for your time.

Testimony from Meg Braun in support of SB 525

Senate Public Health and Welfare Committee

Mr. Chair and members of the committee, thank you for holding this hearing and giving us the chance to talk to you this afternoon. My name is Meg Braun and I live in Topeka. I am here today to share my personal story as it relates to the issues of medical debt and charity care. I hope that by sharing my story, you will make policy changes that will help people like me in the future by lowering the cost of care and telling us about financial assistance that may be available to us.

I have two children with cystic fibrosis. Their medical needs have resulted in several hospitalizations over the last couple of years. Up until 2008, we had been able to take care of their medical needs on an out-patient basis. But in 2008, my daughter contracted pneumonia, resulting in her first in-patient care. Since that first bout with pneumonia, she has had to return to the hospital several times. In addition to her hospital stays, my daughter occasionally requires home nursing care while on IV medication.

When my daughter was first hospitalized in 2008, we had insurance but had a co-pay that was simply out of our budget. My daughter was treated, but we were left with several thousands of dollars in out-of-pocket co-insurance. What I didn't know back then is that my family would have been eligible for charity care. When my daughter was hospitalized again in 2009, we were already buried in debt, behind on our mortgage, and starting to talk about filing for bankruptcy. My husband requested help from the billing department again. His request must have sounded more like desperate pleas, because someone in the billing department finally suggested we complete an application for financial assistance. For 19 years, we have been dealing with the billing offices of local hospitals and we had never heard of such a thing. I completed an application for my family and we were approved! Unfortunately, we learned about this option too late to receive financial assistance for our bills from 2008 and so we are battling collection agencies and trying to keep our house. An order of garnishment has been in place now for about 6 months, but because of low wages, no money has been withdrawn. I am amazed that my hard-working family is in this situation, when had we known, we could have applied for, and been eligible for charity care, possibly for many years.

You'd think that having sick children, fighting to keep our home, and then being told assistance was always there would be enough. But to make matters worse, there is a humiliating event taking place right here in Topeka every Tuesday at Ag Hall. Families in Shawnee County receive a summons to show up at Ag Hall, less than 3 miles from the capitol building, and endure what can only be called a debtor's court. I have only been there once, but I have already received another summons and will have to appear in March. It is an eye opening experience to see hundreds of Topekans line up like cattle in front of attorneys, law enforcement, and what appears to be one lone judge. While I haven't spoken to everyone who is summoned, many of us are there because we had an illness in our family and ended up with medical debt. How many of those people would have been eligible for charity care but were never told? How many of them might be better off today if they had simply been charged lower prices?

There has got to be a better way. I know that we cannot solve all of our health care system's problems today, but the bill you are considering could go a long way in helping many, many families. Kansans just

like me, who work hard to support our families but have medical events, in particular chronic illnesses, could be helped if better information and fairer prices were made available to us

Thank you again for this opportunity and for listening to my story.

Testimony in Support of SB 525
Mrs. Margaret Pender
Senate Public Health and Welfare Committee

Mr. Chairman and members of the Committee, I am pleased to have the opportunity to share my story with you today. My name is Margaret Pender and I live in Kansas City, Kansas. I am here today because I believe in equality and rights for all. I know that I must fight for the dignity and rights of those with no health insurance and who don't have enough money to pay for their medical care. I am also here today because of my personal story about our health care system.

My husband is covered by Medicare. While he was employed, I was covered by his health insurance plan. I am not yet 65. So I am one of thousands of Kansans stuck in the middle. I am not eligible for Medicare but don't make enough money to purchase adequate private insurance. Now, my husband and I can only afford supplemental insurance for me, which covers very little. Since we purchased this insurance in 2007, I have prayed for good health. But, as we all know, things happen. Last year, I developed different ailments that required me to go through a series of MRI's, cat scans, sonograms, and x-rays. As I get older, of course I also need regular colonoscopies and mammograms. I am now almost $20,000 in medical debt, most of that debt related to hospital stays. My husband and I receive social security and a great portion of that income goes toward medical expenses. About a third of my social security income alone goes toward making payments on my outstanding medical debt. I am grateful that the hospital has worked with me on a payment plan, but my monthly payments are not affordable on my fixed income.

My husband and I regularly wonder how in the world we will be able to cover our health care expenses along with our other needs, such as food, clothing, shelter, and utilities. Sometimes, the only option we feel we have is to consider refusing some medical care. This is a game that too many of us are forced to play. In 2006, my husband almost died because he was fearful of incurring more medical debt. I consider the effect of possible financial ruin on me and my husband and think maybe it's just better to suffer.

I am here today because I have personally experienced the devastating effects of medical debt. But the horrific choices faced by me and my husband are what so many others in Kansas face every day. I was never told about charity care that might be available to me to help pay my medical bills. And I might not have been eligible. But other Kansans might be eligible who were never even told they could apply. How many Kansans are seeing their finances ruined because they never even had the chance to fill out an application for assistance?

I know I am not alone. So I am here today because this is not just about me, but about our community. This is about Kansas. I look at all of you and no matter our faith, our race, or our ethnic background, we are all Kansans. Pure and simple. We must right wrongs and help the neediest among us receive the medical care they need.

Tom Bell
President and CEO

To: Senate Committee on Public Health and Welfare

From: Fred J. Lucky, FHFMA
Senior Vice President

Date: February 15, 2010

RE: Senate Bill 525

The Kansas Hospital Association, on behalf of our 125 community hospital members, appreciates the opportunity to comment on Senate Bill 525. Senate Bill 525 would impose billing restrictions on the state's not-for-profit 501(c)(3) hospitals for "eligible self-pay patients" whose total household income is equal to or less than 300% of the current federal poverty guidelines. For the record, 300% of the 2009 federal poverty guidelines for a family of four was $66,150.

Medical debt, regardless of an individual's financial status, is a terrible thing. It is one of the leading causes of bankruptcy filings in our country. As well meaning as this bill seems on the surface, it will not change that fact at all. In some ways, it will only serve to exacerbate the problem. Kansas hospitals take this issue very seriously and they all have in place policies and procedures to help their patients deal with paying for the services they receive.

Attached to my testimony are two documents that are relevant to this bill and affirm what hospitals are doing to help their patients. The first is the Kansas Hospital Association's Set of Recommended Billing, Financial Assistance and Collection Practices. This model policy was developed in 2005 in conjunction with Kansas Attorney General Phill Kline. It was worked out after months of negotiations between the Attorney General's Consumer Protection division and a task force of Kansas hospitals from all across the state. It was endorsed not only by the Attorney General but by the KHA Board of Directors and sent to every KHA member hospital in early 2006. In the three years since this policy was released, Kansas' community hospitals have provided over $930 million in free or reduced care to un and under insured patients.

The second document is from Schedule H of IRS Form 990 that every 501(c)(3) must submit to the IRS yearly. Parts I, II, and III of the form require a hospital to report every single aspect of community benefit and charity care they provide. The assertion that hospitals somehow disregard their community benefit and charity care obligations is simply not true.

For the past year, one of the most contentious political debates in the history of our country has been waged in attempt to reform the health care delivery system. Well meaning and reasonable men and women on both sides of the debate have not been able to come to an agreement on even the smallest of issues. How to deal with the growing number of uninsured, the biggest issue of all, seems remote to those of us who will be most impacted by an improvement in those numbers. Each and every one of those uninsured individuals that seek care in hospitals adds to the total health care cost that we all must pay.

As I mentioned earlier, as well meaning as Senate Bill 525 attempts to be, it will not help those to whom it is intended to help the most. The unfortunate reality is if you are at or below 300% of Federal Poverty Guidelines and you have to be admitted to a hospital for any reason, you are very unlikely to be able to pay for those services regardless of what 125% of a hospital's highest volume private payer would pay. What is most important for the citizens of Kansas is an assurance that their hospitals have in place a reasonable and workable policy to assist them in handling their hospital medical debt when the situation arises, not some arbitrary process that works to the contrary. Kansas hospitals have those assurances in place, and that is why Senate Bill 525 is not necessary.

We have asked several of our members to come before this committee and tell how they deal with this issue in their communities. With us today are Shannon Flach, Administrator of Wamego City Hospital, a small Critical Access Hospital, Cynthia Smith from the Sisters of Charity of Leavenworth Health System that has hospitals in Kansas City, Leavenworth and Topeka, and Dr. Peter Bath from Shawnee Mission Medical Center.

I am happy to address any questions the committee may have.

WAMEGO
CITY HOSPITAL

TO: Senate Public Health and Welfare Committee

FROM: Shannan Flach
CEO, Wamego City Hospital

DATE: February 12, 2010

RE: Senate Bill 525

On behalf of Wamego City Hospital, I appreciate the opportunity to comment in opposition of Senate Bill 525.

Wamego City Hospital is a small, not-for-profit Critical Access Hospital located in a town of approximately 4500 residents. We have always provided and continue to provide an increasing amount of patient financial assistance in our community.

Our current charity care policy includes:

- 15% discount for all uninsured patients
- Sliding scale up to 200% Federal Poverty Guidelines which range from 25% to 100% write-off
- 25% prompt pay discount and payment plans
- Assistance with third party applications

As the co-chair of the Kansas Hospital Association Council on Finance and Reimbursement, I have received assurance from many Kansas hospitals indicating similar policies with several noting more generous eligibility criteria.

Fiscal Management of a small community hospital is a stressful and complex process. We annually review our policy to meet the needs of our own community while making sure we stay financially viable. Passing such legislation may tremendously slow down the revenue cycle providing yet another burden for small hospitals with cash flow difficulty.

Additionally, Senate Bill 525 would force hospitals to violate non-disclosure agreements in managed care contracts by requiring hospitals to disclose the amount the individual hospital's highest volume private payer would pay for the same goods and services.

As the nation works toward insuring 100% of the population, passing legislation that may possibly encourage noncompliance may jeopardize the effectiveness of health reform.

Thank you for your consideration of my comments.

The Kansas Hospital Association's Set of Recommended Billing, Financial Assistance and Collection Practices

PREAMBLE

Kansas hospitals exist to provide essential health care services for their communities, twenty-four hours a day, every day of the year. These essential services are provided regardless of a person's ability to pay; however, individuals have an obligation to pay for the services they receive or seek financial assistance when needed. It is the duty of hospitals to collect from those who have the ability and the resources to pay using ethical collection practices that are allowed under Kansas and federal laws. Financial assistance programs offered by the hospital should not lessen the need to find solutions to expand access to appropriate health care coverage for all persons.

I. Guiding Principles

The following principles and guidelines should be used to develop hospital billing, financial assistance and collection practices:

A. Access to Health Services. A responsible party's inability to pay should not be a barrier to receiving medically necessary health services. The inability to pay a hospital bill should never prevent any patient from seeking medically necessary health services. The hospital should communicate this message to all known responsible parties and local health and community service organizations.

B. Mission and Values. The hospital should have billing, financial assistance and collection policies that are consistent with the mission and values of the hospital. These policies, which should be broadly communicated, should reflect a commitment to provide financial assistance to patients who cannot pay for part or all of the medically necessary health service they receive.

C. Communication. The hospital should communicate all billing, financial assistance and collection policies in a manner that is clear, understandable, respectful and in language(s) appropriate to the communities, patients and/or responsible parties served.

D. Legal Compliance. The hospital is responsible for communicating its collection policies and practices to both relevant hospital staff and to its internal collection departments. These policies should be respectful and comply with all applicable state and federal laws.

E. Personal Responsibility. Financial assistance and collection policies are not substitutes for personal responsibility. Eligible responsible parties may be expected to access public or private insurance options in order to qualify for financial assistance. All responsible parties are expected to contribute to the cost of care based on their ability to pay. Responsible parties should comply with the application requirements, including the production of necessary information to determine financial assistance eligibility.

II. Financial Assistance

The hospital's board of directors should adopt financial assistance policies consistent with the hospital's mission and values as well as local community standards. Hospitals should develop policies to aid those individuals who do not otherwise have the ability to pay in a timely manner for health care services received. Hospitals should review and evaluate all financial assistance policies on a regular basis. Hospital financial assistance is not a substitute for employer-sponsored, public, private or individually purchased insurance.

Hospitals should consider the following when adopting financial assistance policies:

A. Communication. The hospital should maintain understandable, written financial assistance policies. The hospital should provide financial assistance counseling in a clear and concise manner to all responsible parties without regard to race, ethnicity, gender, religion or national origin. The hospital should communicate these policies in a manner that is respectful and in language(s) appropriate to the communities, patients and/or responsible parties served. Attachment A is an example of such communication.

The hospital should post and/or distribute financial assistance information or literature. If posted, these notices should be placed in visible locations throughout the hospital such as admitting/registration, billing office and emergency department. Financial assistance applications should be readily available to responsible parties, and list the information needed by the Hospital to determine whether a patient is eligible for financial assistance.

B. Financial Assistance Guidelines. The hospital should establish criteria to provide financial assistance using guidelines such as the Federal Poverty Level (FPL). The hospital should base the amount of the assistance on the demographics of the patient population served by the hospital, and the hospital's financial ability to provide the assistance. These criteria should be evaluated on an annual basis to determine the appropriate level of assistance available.

The hospital should consider the responsible party's assets in determining eligibility. In addition to the hospital's standard financial assistance evaluation process, the hospital should take into consideration various financial factors, including all outstanding medical bills of the patient at that hospital. The hospital should also evaluate the responsible party's prior hospital accounts to determine if financial assistance was previously authorized, and if so, attempt to utilize the financial information previously provided by the responsible party if such information remains relevant to the evaluation. The hospital should also assess the responsible party's financial situation utilizing the information the responsible party can reasonably provide.

C. Extraordinary Circumstances. The hospital should identify, on a case-by-case basis responsible parties whose medical expenses, in relationship to their income, would make them medically indigent if they were forced to pay full charges. For the purposes of these guidelines, "medically indigent" shall mean patients whose resources, including any health insurance coverage, do not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income and other assets, would make them indigent if they were forced to pay full charges for their medical services.

III. Billing and Collection Policies – Hospital Responsibilities

Hospitals should consider the following when adopting billing and collection policies:

A. Communication. The hospital should provide information about the availability of financial assistance to responsible parties. In addition, the hospital should provide contact information on all billing statements sent to the responsible party. The hospital is responsible for providing its financial assistance policy to all relevant hospital staff and third-party collection agencies engaged in the collection of debts.

B. Timely Filing. The hospital should timely file insurance claims, provided the responsible party timely provides the hospital with proof of insurance and any other additional information necessary to file the claim. If a claim is denied based on improper insurance information, the hospital should attempt to resubmit the claim with the appropriate insurance information. When reasonably possible, the hospital should reference patient billing information previously obtained to determine the proper insurance information. If the hospital bears responsibility for the untimely filing of a claim, the hospital should not attempt to collect from the responsible party.

C. Payment Plans. The hospital should counsel the responsible party in an effort to develop a payment plan, which allows the party to pay the account over a reasonable amount of time based on the party's ability to pay. The hospital should confirm the agreed upon payment plan to the responsible party in writing. Any interest rate charged should be clearly stated.

D. Collection Agents. The hospital should define the policies and practices to be used by outside collection agents acting on the hospital's behalf, and require such agents to agree to these standards in writing. The hospital should make reasonable efforts to contact a responsible party regarding payment options prior to assigning the account

to a collection agent. Hospitals should develop fair and consistent written policies regarding when and under whose authority patient debt is referred for external collection. The hospital should encourage all third-party collection agents to make the responsible party aware of the hospital's financial assistance programs.

E. Collection Terms and Reporting. No hospital should enter into any contracts with collection agents that utilize a collection deadline to trigger bonuses, contingencies or any other incentives.

F. Legal Action. The hospital should require written approval by the hospital's Chief Financial Officer, or his/her designee, before legal action is commenced against a responsible party. A collection agent should not be allowed to file a lawsuit against a responsible party without the hospital's prior written authorization.

IV. Responsible Party Obligations

The responsible party is expected to cooperate with the hospital by:

A. Communication. Responsible party should inform the hospital of the need for financial assistance as soon as the need is identified.

B. Timely Application. The responsible party should make a timely application to the hospital if financial assistance is needed.

C. Asset and Financial Disclosure. The responsible party should provide requested information in a timely manner such as available income and assets, household size and other pertinent data in order to establish a workable payment plan with the hospital. If applicable, the hospital will assist the responsible party to initiate enrollment in a publicly or privately sponsored program (e.g., Medicaid, Health Wave, MediKan, private grants or SCHIP) when the responsible party provides all of the necessary financial and other information.

D. Notification of Changes. The responsible party should inform the hospital regarding any change in their financial situation that may impact their ability to pay their hospital bill or to honor the provisions of their payment plans.

E. Payment. The responsible party should honor any mutually agreed upon payment plan established with the hospital.

V. Implementation

In order to properly implement financial assistance policies, the Kansas Hospital Association recommends that hospitals identify and educate appropriate hospital personnel to administer the policies.

SUMMARY

Kansas hospitals are committed to providing the best possible health care services for the citizens of their communities regardless of their ability to pay. But, because of the growing number of uninsured and underinsured in the state, it is becoming an ever greater financial challenge to assist patients with limited financial resources. The Kansas Hospital Association encourages hospitals to use this document as a guide to build upon their current financial assistance practices and policies.

The Kansas Hospital Association and its member hospitals are committed to working with federal and state government, payers, businesses and consumer groups to address the underlying problems caused by the lack of health insurance coverage. Further, we would encourage other providers of health care such as surgical centers, imaging centers and other health care providers in the state to adopt similar patient-centered billing and collection practices.

Attachment A

Sample Patient Notice of Financial Assistance
(Developed by the Kansas Hospital Association)

[NAME OF HOSPITAL] is proud of its mission to provide quality care to all who need it. If you do not have health insurance or are concerned that you may not be able to pay in full for your care, we may be able to help. **[NAME OF HOSPITAL]** provides financial assistance to responsible parties based on their level of income, assets, and needs. In addition, we may be able to help you identify other available resources or work with you to arrange a manageable payment plan. It is important that you let us know if you will have trouble paying your bill. Federal law requires hospitals to apply their billing and collection criteria consistently to all. Unpaid bills may ultimately be turned over to a collection agency, which could affect your credit status. For more information, please contact **[NAME OF PERSON]** in our financial counseling office at **[PHONE NUMBER]**. We will treat your questions with confidentiality and courtesy.

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ See separate instructions.

OMB No. 1545-0047

2009

Open to Public Inspection

Name of the organization

Employer identification number

Part I Charity Care and Certain Other Community Benefits at Cost

		Yes	No
1a	Does the organization have a charity care policy? If "No," skip to question 6a	1a	
b	If "Yes," is it a written policy?	1b	
2	If the organization has multiple hospitals, indicate which of the following best describes application of the charity care policy to the various hospitals. ☐ Applied uniformly to all hospitals ☐ Applied uniformly to most hospitals ☐ Generally tailored to individual hospitals		
3	Answer the following based on the charity care eligibility criteria that applies to the largest number of the organization's patients.		
a	Does the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing *free* care to low income individuals? If "Yes," indicate which of the following is the family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☐ Other _____ %	3a	
b	Does the organization use FPG to determine eligibility for providing *discounted* care to low income individuals? If "Yes," indicate which of the following is the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____ %	3b	
c	If the organization does not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization uses an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.		
4	Does the organization's policy provide free or discounted care to the "medically indigent"?	4	
5a	Does the organization budget amounts for free or discounted care provided under its charity care policy?	5a	
b	If "Yes," did the organization's charity care expenses exceed the budgeted amount?	5b	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c	
6a	Does the organization prepare an annual community benefit report?	6a	
b	If "Yes," does the organization make it available to the public?	6b	
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.		

7 Charity Care and Certain Other Community Benefits at Cost

Charity Care and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Charity care at cost (from Worksheets 1 and 2)						
b Unreimbursed Medicaid (from Worksheet 3, column a)						
c Unreimbursed costs—other means-tested government programs (from Worksheet 3, column b)						
d **Total** Charity Care and Means-Tested Government Programs						
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)						
j **Total.** Other Benefits						
k **Total.** Add lines 7d and 7j						

8-8

Part II Community Building Activities Complete this table if the organization conducted any community building activities.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support						
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development						
9	Other						
10	**Total**						

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

			Yes	No
1	Does the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		
2	Enter the amount of the organization's bad debt expense (at cost)	2		
3	Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's charity care policy.	3		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including other bad debt amounts in community benefit.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5		
6	Enter Medicare allowable costs of care relating to payments on line 5	6		
7	Subtract line 6 from line 5. This is the surplus or (shortfall)	7		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☐ Cost to charge ratio ☐ Other			

Section C. Collection Practices

9a	Does the organization have a written debt collection policy?	9a		
b	If "Yes," does the organization's collection policy contain provisions on the collection practices to be followed for patients who are known to qualify for charity care or financial assistance? Describe in Part VI	9b		

Part IV Management Companies and Joint Ventures

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					

8-9

Sisters of Charity of Leavenworth Health System

Senate Health and Public Welfare Committee
State of Kansas
February 15, 2010

Written Testimony on Senate Bill 525

The fair hospital charges act

The Sisters of Charity of Leavenworth religious community was founded in 1858 by Mother Xavier Ross and the early Sisters responding to a call for health and social services in the ranching and mining communities throughout the Western states. From such humble origins, these committed women built the Sisters of Charity of Leavenworth Health System (SCLHS), which is made up of eleven hospitals and four stand-alone clinics located in the states of Kansas, Colorado, Montana and California.

SCLHS operates three hospitals in Kansas – St. Francis Health Center in Topeka, Providence Medical Center in Kansas City, Kansas, and Saint John Hospital in Leavenworth – as well as three safety net clinics.

The Mission of SCL Health System is *to improve the health of the individuals and communities we serve*…which is realized through our Vision, including the *unyielding pursuit of clinical excellence.* Our Core Values encompass not only that we owe excellent service to the people we serve, but also that we treat each and every person with respect and dignity.

SCLHS asserts that Senate Bill 525 is unnecessary. We, like all hospitals, have comprehensive financial assistance policies. We assert our policies are more thoughtful and superior to the policy which would be mandated in Senate Bill 525. Our policies are attached, and the income guidelines are stated on pages 68-69. Generally, discounts vary according to income and balance owed.

We notice several deficiencies with this bill, as follows:

- It is reasonable to expect that a self-pay patient should not be eligible to receive financial assistance unless they cooperate with the hospital and are willing to provide information about their income and resources. Our policy addresses the responsibility of the patient to cooperate with us by filling out an assistance application and providing us with their income information. The bill as drafted

does not place any obligation on the patient to provide information, but the hospital can be charged with a violation if they seek to collect for services, regardless.

- The term "insufficient" in Section 2(f) in regard to insurance or benefits is not defined. Potentially every patient would quality as "self-pay patient" under the definition.

- Section 3(c) refers to 125% of the insurance reimbursement, but it doesn't take into account the deductible, co-pay or co-insurance which is also owed.

- The term "medically necessary act" in Section 2(d) is not defined, which leaves the bill open to an overly broad interpretation. For example, our financial assistance policy is not intended to apply to elective services.

- We note that the bill does not address charges for services rendered by physicians and laboratories during a hospital stay, so does nothing to relieve self-pay patients of this significant source of medical debt.

- We are confused by the scenario that only tax-exempt hospitals would be required to have the financial assistance policy proposed. Few patients would probably know whether the hospital where their doctor has arranged for their services is tax-exempt or not.

Again, we believe this legislation is unnecessary, and would interfere with superior financial assistance policies at Kansas hospitals such as the policy we have in effect at SCLHS.

Respectfully submitted,
Cynthia Smith, JD
Advocacy Counsel

Original Date: 1/5/01 Revision Date(s): 10/11/02	Section:	Financial Stewardship Finance
	Policy:	Patient Accounting

POLICY:

Guided by the vision and mission of the Sisters of Charity of Leavenworth Health System this policy reflects the efforts of the Affiliate Hospitals to improve the human condition of the individuals and communities served, with special concern for the poor and underserved.

The core values of Response to Need, Respect, Wholeness, Excellence and Stewardship permeate and shape the manner in which the payment status of those who come to the Affiliate Hospitals for patient care is determined.

Affiliate Hospitals operated by the Sisters of Charity of Leavenworth Health System, will provide medically necessary services to patients who are unable to pay for such services. The hospital provides for Charity write-offs that are budgeted annually and distributed monthly to assist identified needy patients.

Charity is defined as free or discounted services provided to those who do not have the ability to pay. They may be uninsured, are insured with inadequate coverage for a situation or whose income is sufficient to pay for basic living cost but not medical care.

If a self-pay balance is due or estimated for a patient meeting the definition above, then a recommendation for Charity under this policy should be initiated. An account will be eligible for Charity pending final resolution of the account and review of all available information. The determination of eligibility will occur as soon as circumstances permit.

The Chief Financial Officer is responsible to take steps to put this policy in effect. Chief Financial Officer shall bring forward to the local Affiliate Governing Board the income guidelines, as set forth in Exhibit C, to be used in applying this policy.

The System CFO will establish procedures and guidelines to affect this policy.

Original Date: 1/5/01 Revision Date(s):	Section:	Financial Stewardship Finance
	Policy:	Patient Accounting
	Implementation Guidelines:	*Patient Accounting:*

IMPLEMENTATION GUIDELINES:

A patient's / guarantor's net worth, gross income, expenses, financial obligations, household size, employment status are taken into consideration in determining what the patient is able to pay on the account(s). Extenuating circumstances such as catastrophic illness, unusual family circumstances, or lack of official resident status will be considered as well. Regardless of ability to pay, the hospital will provide medical services necessary to stabilize a patient's condition from life-threatening or emergent circumstances. The hospital will provide patients with necessary medical services or assist patients in finding those services at other local or county healthcare facilities, as the obligation of stewardship may dictate.

An account should not be approved as a Bad Debt until these Charity factors are considered.

Once the hospital determines that a patient will have a self-pay balance and the patient may not have the means to make payment, the hospital should provide to the patient an Assistance Application (Exhibit A). Hospital personnel should provide this application to any patient/guarantor who requests financial assistance as well. The process of completing the application should not hinder or circumvent the application for financial assistance from other sources. Charity should not be approved until all assistance options have been exhausted.

A potential Charity case should be identified as quickly as possible to shorten the determination period and avoid unnecessary collection efforts. Once identified, the Admission / Registration Clerk, Business Office Staff or the Financial Counselor should discuss the Charity policy of the hospital with the patient and provide the Assistance Application for completion. The applicant should be instructed to return the application as soon as possible.

Once a Charity determination is made, then collection efforts will cease or be modified (partial Charity).

The following describes the process the hospital will follow upon receipt of the application. However, it should be understood that having an application completed may not be possible in all cases given unusual family and / or living circumstances for some patients. The exercise of judgment will be necessary at those times.

RESPONSIBILITY	ACTION
Financial Counselor or Patient Account Representative	1. Complete Part I of the Charity Eligibility Determination form (Exhibit B) from information obtained from the Assistance Application. 2. Complete Part II, Line 1. Monthly Income for the Household should be pulled from page 1 of the Assistance Application in the TOTAL column. The amount should be multiplied by 12 to annualize the monthly amount. 3. Complete Part II, Line 2 from information on page 1 of the Assistance Application. 4. Complete Part II, Line 3 by cross-referencing information on Part II, Lines 1 and 2 to the hospital's Charity Care Annual Income Guidelines (Exhibit C). Find the line that matches the size household then move across to the right to find the first column that is equal to or exceeds the annualized income amount, then look at the Percent Reduction for that column. 5. Complete Part II, Lines 4 and 5 based upon the information in the Assistance Application. 6. Part II, Line 6 should be completed based upon the judgment of the reviewer. If extenuating circumstances should be considered for the applicant, then "Yes" should be indicated. 7. Part II, Line 7 is the recommendation of the reviewer for charity adjustment percentage and amount. 8. Sign and date the form. If approving charity adjustment of less than $1,000, then input comment into the system, adjust account using proper charity adjustment code for charity amount and notify patient of charity approval. If charity is declined, then input comment into the system on reason for denial and change status for future follow-up. If charity adjustment is approved for $1,000 or more, or Part II, Line 6 is marked "Yes", then forward information to the Director of Patient Financial Services.

RESPONSIBILITY	ACTION
Director of Patient Financial Services	9. Review Charity adjustment recommendation and the information related to the applicant. If appropriate, then indicate agreement with recommendation, sign and date. If revised recommendation is warranted based upon facts or judgment, then indicate revised percent and amount, sign and date. If approving charity adjustment of less than $5,000, then input comment into the system, adjust account using proper charity adjustment code for charity amount and notify patient of charity approval. If charity is declined, then input comment into the system on reason for denial and change status for future follow-up. If charity adjustment is approved for $5,000 or more, or Part II, Line 6 is "Yes", then forward information to the Chief Financial Officer.
Chief Financial Officer	10. Review Charity adjustment recommendation and the information related to the applicant. Indicate the Final Charity adjustment to be made on the account(s), sign and date. 11. Forward all documents back to Director of Patient Financial Services for appropriate processing in system and patient notification.

Approved:

/s/ William M. Murray
William M. Murray, SCLHS President

Date: January 5, 2001

Original Date: 1/5/01 Revision Date(s):	Section:	Financial Stewardship Finance
	Policy:	Patient Accounting
	Implementation Guidelines:	*Patient Accounting Exhibits A, B, and C*

The following Exhibits are on the next 6 pages:

Exhibit A (4 pages)

Assistance Application

Exhibit B (1 page)

Charity Eligibility Determination

Exhibit C (1 page)

Charity Care Annual Income Guidelines

Approved:

/s/ William M. Murray
William M. Murray, SCLHS President

Date: January 5, 2001

Original Date: 2/12/07 Revision Date(s):	Section:	Financial Stewardship Finance
	Policy:	Patient Accounting
	Implementation Guidelines:	*Patient Accounting* *Code of Conduct Guideline Statement*

IMPLEMENTATION GUIDELINES:

SCLHS is a Catholic health system with a mission to reach out especially to the poor and underserved in the community. In order to sustain this mission SCLHS must attempt to secure payment from all sources including directly from patients who are able to pay. Accordingly, SCLHS has established a comprehensive process to qualify patients for charitable and self-pay discounts. Access to the discounts requires the patient to provide sufficient information to verify their circumstances. Absent information confirming eligibility and failure of the patient to respond to requests for such information, SCLHS must pursue all reasonable efforts to collect unpaid balances due including, if necessary, filing lawsuits and levying garnishments against bank accounts and paychecks.

SCLHS recognizes that the living circumstances of the poor in the community may make it difficult for them to access or be informed of the charity care procedures. Some patients may be afraid to enter the health system for fear of the financial implications. They may be unwilling or unable to read or understand signage or letters explaining these policies due to language or educational difficulties. And, their living circumstances may make it difficult to communicate with them by either mail or telephone. Family circumstances can also interfere with their ability to learn about their options or impede them from taking the initiative required by the policies. As a result, the collection process may be initiated and be the process through which SCLHS first gains any indication a patient may be eligible for charity care discounts. In the worst case scenario, legal judgments may be obtained and served before the patient takes responsibility to assert their qualifications under SCLHS policies.

THEREFORE:

1. All SCLHS hospitals will communicate by:
   a. Posting notices in a public location (such as the admissions desks or ER)
   b. Declaring the existence of charity care and self-pay discount policies to all patients who do not present verified evidence of insurance at the time of admission while still in the hospital
   c. Produce and make generally available in public areas a brochure explaining key aspects of the program and how to access further information (see SCLHS Communications Manual for further details)

d. Provide training to registration/admissions personnel to help them identify such patients and communicate appropriately with them.

e. Including information on the hospital web site that explains the existence of charity care and self-pay discount policies and how to obtain further information.

2. The hospital shall instruct all contractors performing collection services, including early out, standard collections, and legal collections, as to the philosophy and content of the charity policy of the hospital. To document this instruction, contracts shall include:

   a. Acknowledgement that all such contractors will encounter patients who are not but should have been previously qualified for charity discounts.

   b. Before any further collection activity takes place, an expectation that "service recovery" will immediately take place if such a patient is identified to include: restarting the charity application procedure, responding to the patient with appropriate compassion, and allowing sufficient reasonable time for the patient to comply with policy.

   c. That the contractor will communicate with and seek direction from the hospital business office leadership if in any doubt as to the appropriate handling of a given account.

   d. SCLHS Affiliates should consider including appropriate compensation for contractors that assist in securing charity applications such as a per application fee.

3. Prior to obtaining a garnishment order, collection firms shall make reasonable attempts to determine whether or not a patient may in fact be qualified by charity care policy by using all information at their disposal. In general, this may be inferred from the annual salary information obtained during debtor examination or the course of perfecting a claim.

4. Only if the contractor determines and documents that there is no reason to suspect an unfilled charity application, should the garnishment be formalized.

5. This Code of Conduct also clarifies the intent of the self-pay policy is NOT to apply discounts to patient co-pays and deductible balances that may arise from the handling of their insurance contracts. These patient balances are only open to discount when they qualify for charity care. When a patient does qualify for a discount on such a residual balance, that discount shall be applied to the amount of the residual balance and not to the original account as a whole.

6. Nothing in this Code of Conduct or in any other policy shall preclude a hospital from making a special allowance to any patient where contractual obligations, other hospital policies (especially those affecting employees, physicians and other parties in interest) and the law permit an allowance and where circumstances of particular hardship justify doing so in the sole judgment of the hospital administration.

7. SCLHS Hospitals may be periodically asked to provide non-identified details of liens and garnishments held for further review by the System Office.

Approved:

/s/ William M. Murray
William M. Murray, SCLHS President

Date: February 12, 2007

Original Date: 6/1/04	Section:	Financial Stewardship Finance
Revision Date(s):	Policy:	Patient Accounting
	Implementation Guidelines:	*Patient Accounting Self-Pay*

IMPLEMENTATION GUIDELINES:

SCLHS Hospital affiliates will always treat patients with respect and dignity while attempting to resolve a patient's balance.

All Self Pay patients must agree to be screened for benefits by completing a financial statement and/or other related paper work in order to qualify for discounts under this policy. In addition, patients will be required to pay a nominal up front cash fee for screening.

If patients are found to be eligible for benefits from Medicaid or other government sponsored funding, all efforts to collect from that patient will cease at the time that determination is made and the discounts contained in this policy shall NOT apply. Self Pay patients, having no applicable health insurance coverage of any kind (including broad coverage exceptions such as mental health exclusions), who complete the screening of benefits and who do not qualify for assistance are eligible for the following discounts (these discounts do not apply to any balance attributable to insurance agreements, co-payments, coinsurance or deductibles):

1. Household income less than 200% of the Federal Poverty Guideline - 100% Charity Care write off.
2. Household income between 200% and 399% of the Federal Poverty Guideline –
    a. Outpatient Balances < $5,000 – sliding discount from 0% to 100% at a rate of 1% for each 2% of household income under 400% of the FPG.
    b. All Inpatient balances and Outpatient balances > $5,000, discount to the greatest discount given to any managed care plan or the overall annual hospital managed care realization rate, whichever produces the higher discount.
3. Household income at or above 400% of the Federal Poverty Guideline –
    a. Outpatient Balances < $5,000 – no discount
    b. All Inpatient balances and Outpatient balances > $5,000, discount to the lowest discount given to any managed care plan.

4. The nominal fee for screening shall be set by each hospital with consideration of local alternatives for care such as free care clinics and the like. The screening fee should be slightly higher than fees at such centers in order to avoid unintended shifting of patients to the hospital from preferable alternative treatment centers.
5. The discounts outlined in this policy do not extend to physician services rendered by SCLHS hospitals under professional services agreements with hospital-based doctors or other third party service providers (transportation, specialists, etc).
6. All SCLHS hospitals will endeavor to make programs of financing available to all patients for the remaining balances after the discounts provided in this policy or insurance payments have applied. The SCLHS CFO shall review prevailing interest rates annually and adjust the maximum interest permitted on these programs if necessary. In general, the maximum rate shall approximate prime rate plus four (4) percent.
7. When pursuing collection of all patient account balances (whether self-pay or otherwise), all SCLHS hospitals, collection agencies and third party bill handlers working accounts on behalf of SCLHS hospitals, shall not employ debtors prison. Liens on principal residences may only be imposed with the prior approval of the local Affiliate Finance Committee of the Board of Directors and such liens will not be used to force foreclosure and sale of such properties. Foreclosures on any other appropriately attached assets may be exercised through garnishments or other means as permitted by state law.
8. The policy is not intended to apply to services which are deemed to be elective in nature. The determination of whether or not a service is elective shall reside with the hospital.
9. Patients seeking repeat services may be required to resubmit an application and pay the applicable application fee as often as deemed necessary by the hospital.
10. This policy does not apply to any non-hospital SCLHS affiliate or related entity.
11. All SCLHS Affiliates are free to adopt additional policies and procedures as needed to address other charity care needs in their communities provided that the benefits created under such policies are at least equal to those contained herein. An example of a situation where this could be appropriate is if there exists a prevalent practice in the community by employers to underinsure for psychiatric care.

Approved:

/s/ William M. Murray
William M. Murray, SCLHS President

Date: June 1, 2004

Exhibit A

Sisters of Charity of Leavenworth Health System
Assistance Application

This information is confidential. **Please complete all information, attach copies of supporting documents, sign, date and return this form by:** _____

Patient Name(s)	Patient Number	Date(s) of Service	$ Amount

Patient / Guarantor: _____
Name Social Sec # Date of Birth

Spouse: _____
Name Social Sec # Date of Birth

Address: _____
Street City State Zip Phone Number

Patient / Guarantor Employer: _____
Name Address Occupation Phone Number

Spouse's Employer: _____
Name Address Occupation Phone Number

Marital Status:(Check one) ___ Married ___ Single ___ Divorced ___ Widow(er)

Number of persons in the household (include yourself) ____ Adults ____ Children

Have you ever filed for bankruptcy? ____ Yes ____ No
If yes, then list the date : _____

Financial Information - Monthly Income for Household
(Attach copies of check stubs)

Sources of Income	Guarantor	Spouse	Others	TOTAL
Gross Monthly Wages				
Self Employment Income				
Public Assistance				
Social Security				
Unemployment				
Workmen's Compensation				
Strike Benefits				
Alimony				
Child Support				
Military Allotments				
Pensions / Retirement				
Rental Income				
Other Sources				
Total Monthly Income				

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Financial Information - Monthly Expenses

	TOTAL
Rent	
Alimony	
Child Support	
Groceries / Food	
Electricity	
Gas	
Water / Sewer	
Telephone	
Cable	
Clothing	
Auto Insurance	
Health Insurance	
Medical (Not Paid by Ins.)	
Total	(A)

Financial Information - Liabilities
(Attach copies of current statements)

Organization Name	Account Number	Amount Owed	Current Value / Credit Available	Monthly Payment
Mortgage -				
Auto #1 -				
Auto #2 -				
Credit Card -				
Department Store Cards -				
Other Outstanding Loans-				

Total Liability Payments (B) _____

Total Monthly Cash Outlays (A) + (B) _____

9-14

Financial Resources - Assets
(Attach copies of current statements)

	Institution	Account Number	Current Balance
Cash Checking Account			
Savings Account			
Credit Union			
Investments (List)			

Total **(C)** _____

Other Assets	**Circle**		**Value**
Boat	Yes	No	_____
Camper Trailer	Yes	No	_____
Jet Ski	Yes	No	_____
Snowmobile	Yes	No	_____
All Terrain Vehicle (ATV)	Yes	No	_____
Motorcycle	Yes	No	_____
Other Assets (list) _____	Yes	No	_____
_____	Yes	No	_____

Total **(D)** _____

(C) + (D) _____

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Additional Information

If you expect a change in income, health, other circumstances, or cannot provide the requested information, then please explain. Attach additional pages to this application, if you require more space for your information.

I (we) certify that the information provided is true and accurate to the best of my (our) knowledge. I (we) hereby authorize the hospital and / or its agents to verify the information provided in this application. I (we) hereby authorize that verification can include, but not limited to, the inquiry of my (our) credit history through a credit reporting agency. If any of the information given proves to be untrue, then I (we) understand that the hospital may re-evaluate my (our) financial status and take whatever action it deems appropriate.

Print Name	Print Name
Signature	Signature
Date	Date

9-16

Exhibit B

Sisters of Charity of Leavenworth Health System
Charity Eligibility Determination

Part I

1. Total Potential Adjustment Amount (Account balance(s)) $ _____

2. Applicant has provided:
   * Complete Application — Yes No
   * Attached Supporting Documents — Yes No
   * Signed and Dated Application — Yes No

3. Has application for financial assistance from other sources been completed? Yes No

4. Credit Report Requested (Only if line 1 is $5,000 or more) N/A Yes No

5. Credit Report Verifies Information (If No, then modify application) N/A Yes No

Part II - Recommendation

1. Total Monthly Income for Household _____ X 12 = _____

2. Size of Household _____

3. Percent Reduction indicated by Charity Care Annual Income Guidelines _____ %

4. Does the applicant have sufficient resources to satisfy the account(s)? Yes No

5. Does the applicant have sufficient credit available to satisfy the account (s)? Yes No

6. Are there any extenuating circumstances? Yes No
   (Unexpected and/or unusual circumstances that may justify adjustment, such as catastrophic illness.)

7. Charity adjustment recommended (list both % and $) _____ % $ _____

Patient Account Representative _____ Sign _____ Date

Note: If Line 7 is $1,000 or more OR line 6 is marked "Yes", then forward to Director of Patient Financial Services. If forwarding not required, then adjust account and notify applicant.

8. Does Director of Patient Financial Services agree with recommendation? Yes No

9. If No, then provide revised recommendation _____ % $ _____

Director of Patient Financial Services _____ Sign _____ Date

Note: If Line 9 is $5,000 or more OR line 6 is marked "Yes", then forward to Chief Financial Officer.

10. Final Charity adjustment approved _____ % $ _____

Chief Financial Officer _____ Sign _____ Date

Chief Executive Officer _____ Sign _____ Date

Exhibit C

Sisters of Charity of Leavenworth Health Systems

Charity Care Annual Income Guidelines

Percent of Guideline		100%	100.0%	125.0%	150.0%	175.0%	200.0%
Percent Reduction if less than Guideline			100%	80%	60%	40%	20%
Size of Household	1	8,350	8,350	10,438	12,525	14,613	16,700
	2	11,250	11,250	14,063	16,875	19,688	22,500
	3	14,150	14,150	17,688	21,225	24,763	28,300
	4	17,050	17,050	21,313	25,575	29,838	34,100
	5	19,950	19,950	24,938	29,925	34,913	39,900
	6	22,850	22,850	28,563	34,275	39,988	45,700
	7	25,750	25,750	32,188	38,625	45,063	51,500
	8	28,650	28,650	35,813	42,975	50,138	57,300
	9	31,550	31,550	39,438	47,325	55,213	63,100
	10	34,450	34,450	43,063	51,675	60,288	68,900
	11	37,350	37,350	46,688	56,025	65,363	74,700
	12	40,250	40,250	50,313	60,375	70,438	80,500

Add for each additional member 2,900

Source: Federal Register, Vol. 65, No. 31, February 15, 2000

Note: Enter revised information into the shaded areas as appropriate.

SHAWNEE MISSION MEDICAL CENTER

Senate Public Health and Welfare Committee
SB 525
February 15th, 2010

Mr. Chairman and members of the committee my name is Peter Bath. I serve as Vice President of Spiritual Wellness and Human Development with Shawnee Mission Medical Center. I am here today on behalf of Shawnee Mission to provide comments on SB 525, *The Fair Hospital Charges Act.*

Shawnee Mission Medical Center in located in Merriam Kansas was Johnson County's first hospital and has been caring for the health and well being of the Kansas City community since 1962. In 2009, SMMC had 21,000 hospital admissions, provided more than 200,000 outpatient visits, provided 24/7 Ask a Nurse support to over 130,000 community phone calls, e-mails for medical questions and information, cared for 57,000 Emergency admissions and have had 3,700 births at our hospital. The Foundation for our Medical Center has encouraged philanthropy and focuses on improving the health of our community's residents – young and old, insured and uninsured, current and future patients. Through our community hospital and charitable work we have fostered and produced innovative approaches to community wellness and support.

By way of example, our Lee Ann Britain Infant Development Center is a program for children with developmental disabilities such as cerebral palsy, Down syndrome, autism spectrum disorder and other chromosomal abnormalities. The center provides services to any child in need of the program, regardless of his or her family's ability to pay. Charity care, measured in terms of cost not charges exceeded $13.7 million in 2009, an increase of 6% over 2008. The community has come to rely on SMMC and the Foundation as trusted partners with the state as they face challenges of increasing health care costs and demand on and for our services.

Although we believe SB 525 is well intended we ask that the committee take into consideration what is already in place that makes certain patients are treated fairly. In addition to the background which was presented by the Kansas Hospital Association, we thought it would be helpful to provide the committee with the manner in which Shawnee Mission Medical Center ensures these safeguards for consumers are in place.

Shawnee Mission Medical Center has compassionate and supportive policies and practices in place that support the self-pay patient. We are intentional about helping the patient realize that the cost side of health care while worrisome is not something they face alone. Financial counselors appropriately asses a patient's financial status to determine if the are truly self pay, charity or might qualify for government support such as Medicaid. Household income and number of members are the two key factors that help direct the course of support. If they might be eligible for government support, and many are not

aware of their eligibility, significant time and resources are spent helping them apply for support.

Our policy states that charity care is available for those who have household income up to 400% of the federal poverty guidelines. The proposed legislation stipulates 300% which may be an arbitrary floor disqualifying some for whom policies, such as ours, might benefit. Charity care, for those up to 200% of the Federal poverty guidelines at Shawnee Mission Medical Center means we seek to collect only $50, the rest of the cost being written off.

For those between 200% and 400% a sliding scale is used to determine a patient's financial contribution. Under Shawnee Mission Medical Center's practices, we cap patient total liability at 25% of their annual gross income regardless of the size of the bill.
For those who neither have eligibility for Charity or other government support our policies are to discount the charges by 60%. We then arrange appropriate payment plans which, if they cannot be met, then qualify the patient for charity status.

Our invoices all have a statement reminding the patient of the financial support resources available to them. This is in addition to the information and counseling that is given during their care encounter at the hospital.

It might be of interest to consider that disclosing the highest volume provider payment level might be troublesome for the Insurance entities as their closely negotiated rates vary from hospital to hospital, market to market and procedure to procedure.

In conclusion, we ask the committee to evaluate the necessity for this statutory change in light of the efforts taken and the policies and practices already in place to ensure a level playing field for our patients.

Respectfully submitted on behalf of Shawnee Mission Medical Center,

Peter Bath, D Min.
Shawnee Mission Medical Center

Community Health Ministry

Faith in Action
Serving Pottawatomie and Wabaunsee Counties

Jubilee Ministry

903 6th St
Wamego KS, 66547
785-456-7872

Testimony in Support of SB 525

Deb Kiker RN MSN Community Health Ministry, Wamego, KS

Senate Public Health and Welfare Committee

Mr. Chairman and Members of the Committee:

My name is Deb Kiker. I am the nurse and clinic administrator for the Community Health Ministry in Wamego, Kansas. This ministry was established in August of 2001, serving Pottawatomie and Wabaunsee Counties. Our mission is drawn from Matthew 25:35-38, encouraging us to meet the needs of people where they are and providing for their needs. Our ministry seeks to develop creative ways of addressing needs and identifying resources to promote health, wellness and healing. We are able to serve the whole person by providing housing, utility and food assistance and medical, dental and mental health care.

Pottawatomie and Wabaunsee Counties have a population of 19,695 and 6,922, respectively. Both counties have at or close to 8% of the population at Federal Poverty Level, and 10% of the population without health insurance. Nearly 30% of our clients are struggling with medical debt and the effect it has on their family on a daily basis.

Because of a lack of insurance many of our clients have incurred a medical bill at one time. The cost of that bill often makes them choose between rent, utilities, food, medication and seeking further care. Once a bill goes to collection and garnishment, up to 65% of gross income can be taken. Some of our clients have 7 and 8 garnishments from medical bills.

One family we work with has a usual bring home income of $1,000.00 per month. That supports an adult and two children. Paying back medical debt takes $800.00 per month from that amount. They seek assistance often for food and utilities.

We worked last spring with two families that both had a new diagnosis of cancer and no insurance. Bills mount up quickly and one family brought us $36,000.00 worth of bills. To not feel well, undergo chemo, and wade through a mountain of bills is a hard job. Both individuals lost jobs that help keep money coming in at a critical time.

Most of the people we serve have diabetes, hypertension or asthma. All expensive diseases to treat, more expensive to ignore. A trip to the emergency room for an asthma treatment and the resulting medications can cost as much as $3,000.00. With a mean income of $861.00 per month, rent of $450.00 or more, and utilities, there is nothing left to begin to pay on outstanding medical bills.

Medical debt forces hard decisions. Pay the bill or rent, utilities, or put food on the table. Go back to the doctor for the required follow-up or stay home and wonder. Take the required medication or pay the bills, and it starts all over again.

Having a provision in place that allows for a level charge and notice to the patient that help is available would make a difference in the daily lives of many of these people.

Cross-Lines Community Outreach, Inc.
A Place of Hope...

736 Shawnee Avenue, Kansas City, KS 66105
Telephone: (913) 281-3388 Fax: (913) 281-2344
www.cross-lines.org

Testimony in Support of SB 525

Roberta Lindbeck, Executive Director Cross-Lines Community Outreach, Kansas City, KS

Senate Public Health and Welfare Committee

Mr. Chairman and Members of the Committee:

Thank you for allowing me the opportunity to be here and to testify in favor of SB 525.

Cross-Lines Community Outreach is a social service agency serving the Wyandotte County population. We provide rent and utility assistance, and work through the Medicine Cabinet to help clients obtain durable medical equipment, medications, glasses, etc. Cross-Lines also has an emergency food pantry, an emergency clothing closet and a food kitchen. Because of the close contact the case managers and the licensed professional counselor have with the clients, we are aware of the struggles they are facing in many areas of their lives. These range from the effects of the loss or lack of employment to mental illness.

When the Kansas Health Institute ranked the health status of the state's 105 counties in 2009, Wyandotte County came in last. As of December 2009, Kansas Labor Force estimates show Wyandotte County with a 10.3% unemployment rate. Kansas City KS had a 10.7% unemployment rate. Wyandotte County has approximately 154,000 residents. 19.5% of the population is below poverty. In 2005, 14.2% of the population was uninsured.

The cost of medical care for our clients has a detrimental effect on both the person needing care and their family. A conservative 50% of the clients served by Cross-Lines have no insurance, are not on Medicaid or Medicare, or have private insurance with very limited benefits and/or very high deductibles. This does not take into consideration those over the age of 60 who are not yet eligible for Medicare or those who are homeless.

I would like to share one situation with you that, unfortunately, is not all that unique to the clients we work with. We have worked with a client since mid December. This client came to us needing rental assistance after temporarily being laid off work. The client passed out and became unconscious on a work site. Not having medical insurance, he went to the emergency room at a local hospital where they did a basic check up and ran an EKG. They referred him to a local clinic for follow-up. The client is unable to pay the medical bills from the ER visit because he is awaiting medical clearance from the doctor before he is allowed to return to work. The client is going to doctor's appointments on a regular basis; however, he rarely sees the same

doctor. In all, the client has no real medical home or medical physician to know his story. The client has yet to receive a diagnosis or medical clearance and therefore is unable to return to work.

Our families are faced with difficult situations. We watch the disintegration of the family as financial difficulties mount. We see those struggling to stay afloat lose hope when faced with another bill that they are unable to pay. They eat at the food kitchen to save on groceries so they can divert their money to rent and utilities. When medical needs become part of the equation, often the person in need just does without. When faced with medical bills they simply can't pay, they often become depressed and hopeless.

Senate Bill 525 would provide our uninsured and underinsured clients an opportunity to avoid financial debt and ruin if, and when, they need medical care. This would have a significant impact on the families and the health of the neighborhoods we serve.

Thank you.

American Heart Association® | American Stroke Association®
Learn and Live®

you're the cure™

February 15, 2010

TO: Senate Committee on Public Health & Welfare

FROM: Linda J. De Coursey, Advocacy Director—Kansas

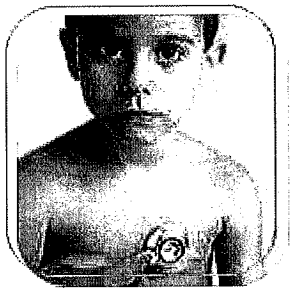
RE: HB 525—Fair Hospital Charges Act

Mr. Chairman and members of the Committee:

My name is Linda De Coursey, and on behalf of the American Heart Association, I thank you for allowing me to speak to you on this very important matter.

OUR MISSION: ***Building healthier lives, free of cardiovascular diseases and stroke.***

- **CVD (including congenital heart defects and stroke) is the #1 killer in America.**
  - CVD affects an estimated 80 million American adults (1 in 3 people).
    - kills 1 American every 37 seconds — nearly 2,400 each day — 1 or every 2.8 deaths
    - killed 864,480 Americans in 2005 — 35.3% of all deaths. (In 2005, cancer deaths = 559,312; HIV deaths = 2,543)
    - killed 5,681 Kansans in 2008
  - Total estimated direct and indirect cost of CVD in the U.S. in 2009: $475.3 billion.
  - Since 1900, CVD has been the #1 killer in U.S. every year but 1918 (year of flu epidemic).
  - CVD kills about as many people each year as cancer, accidents, lower respiratory disease and diabetes *combined*.
  - In 2005, CVD killed nearly 151,000 Americans under age 65; 32% of CVD deaths in 2005 were premature (before age 75).
    - If all CVD were eliminated, life expectancy would rise nearly 7 years.



- **Stroke is the #3 killer and a leading cause of serious, long-term disability in the U.S.**
  - Each year, about 795,000 Americans have a new or repeat stroke (1 every 40 seconds); 6.5 million stroke survivors alive in 2005.
    - Stroke killed 143,579 Americans in 2005 (1 of every 17 deaths). One American dies of stroke every 3-4 minutes.
    - Killed 1,534 Kansans in 2008.

The American Heart Association and its American Stroke Association division recognize that the current crisis in our healthcare system threatens our mission of "building healthier lives, free of cardiovascular diseases and stroke." With more than 46 million uninsured people in the United States, and many more struggling with the rising costs of health insurance and health care, the need for meaningful health reform is urgent.

Senate Public Health and Welfare
Date: 02/15/10
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American Heart Association. | American Stroke Association.
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The association has a longstanding commitment to approaching health reform from the patient's perspective and believes there are six critical principles that must be addressed if health care in the United States is to be effective, equitable and excellent. These principles concentrate on access to care, preventive services, quality health care, the elimination of health disparities, continued biomedical research to improve the prevention and treatment of heart disease and stroke, and an adequate and diverse workforce.

The burden of heart disease, stroke and other cardiovascular diseases can be particularly problematic for those without health insurance. The uninsured with CVD experience higher mortality rates and poorer blood pressure control. People who lack health insurance experience a 24 percent to 56 percent higher risk of death from stroke than those who are insured. The uninsured are also less likely to take needed medications. Millions of Americans who suffer from cardiovascular disease (CVD) are uninsured. These individuals are far less likely than their insured counterparts to receive appropriate and timely medical care and as a consequence, suffer worse medical outcomes. The underinsured may encounter similar problems.

Working to ensure that all residents of the United States have meaningful, affordable healthcare coverage is a federal priority for the American Heart Association. I want to share with you a new survey that the American Heart Association commissioned. It was just released on February 10, 2010. It finds that patients and their families suffering from heart disease and stroke face significant challenges gaining access to affordable medical care and preventive services.

Respondents identified making health care more affordable as the top need of those with cardiovascular disease (CVD). Making coverage more available and investing more in prevention ranked second and third, respectively. The survey highlights the real-life problems many patients face in getting the care they need and reaffirms the American Heart Association's work to promote common-sense reforms that will make health care more accessible, affordable, and adequate for those with CVD.

Affordability of health care is seen as the most important need among these patients. Availability of health care and investing in prevention programs are also judged as important.

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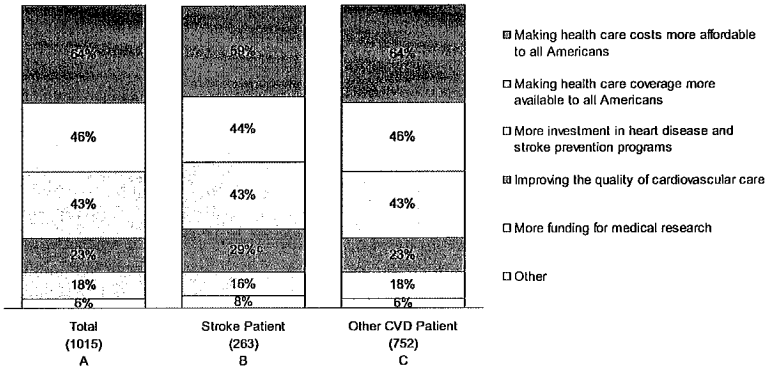
Research reinvented

What Needs To Be Done To Help CVD Sufferers (% Ranked 1st or 2nd Most Important)



Q.7 What do you think needs to be done to help people suffering with these cardiovascular conditions? (Rank 1-6)
B/C = Significantly higher at the 95% (upper case) or 90% (lower case) confidence level

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13-2

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you're the cure.

I would like to share a real person's story with you.

Stephanie's Story

The high cost of health care, including the cost of her prescription medications, led to the loss of Stephanie's home and worsened her health.

Stephanie is 37 years-old and lives in Columbia, SC with her husband, Jason, and their 12-year-old son, Jake. While in her late 20s, Stephanie was diagnosed with coronary artery disease, which means that her blood vessels are very prone to blockages. There's a strong history of this disease in her family – her sister died of the disease when she was only 28. Stephanie had quadruple bypass at age 30 and since then has undergone multiple operations for the placement of 10 stents. Stephanie is also fighting the debilitating effects of Lupus and a seizure disorder. She can no longer work and receives Social Security Disability benefits.

Until January, 2006, Jason worked full-time and the family received health insurance through his job. Stephanie qualifies for Medicare, but relied on her husband's plan because it required less cost sharing. But shortly after Jason was laid off, his health benefits were terminated. For six months, the family struggled to get by on unemployment and disability benefits, but it was hard to make ends meet. The couple's first priority was to buy the medicine Jake needs but paying for Stephanie's drugs was out of the question and she stopped taking them. As a result, she was hospitalized five times in one year and required five additional stents. Medicare paid some of these bills, although she still owes more than $10,000 for her share.

With their pre-existing conditions, buying coverage in the individual health insurance market was not an option for Stephanie or Jake: they would have been turned down as "uninsurable." COBRA and help through South Carolina's high-risk pool were both unaffordable and the family wasn't poor enough to qualify for Medicaid.

By October, Stephanie and Jason had fallen behind on the mortgage and were forced to sell their home. A month later, Jason found a job with health benefits and the family is covered once again, although their premium alone is 10 percent of their total income.

Looking back on last year, Stephanie is amazed at how quickly their finances and her health spiraled downward and how long it will take them to climb out of that hole. She's frustrated to be so far in debt and dreads going to the mailbox each day, though she says she won't even consider declaring bankruptcy ("That's a cop out.") She's angry that the loss of health coverage caused such stress on her own health and cost her family their home. And she worries about this happening again. "I can't believe we treat each other like this. Can't America do better?"

American Heart Association. | American Stroke Association.
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you're the cure.

She asks, Can't America do better? Nationally, we are trying to tackle the phenomenal health care problems, and we appreciate that Kansas legislators are trying as well. As stated, cost is the number concern for heart disease patients. We appreciate all you can do to help them.

Thank you again for allowing me to speak out on this important topic.

Karen's Story

Karen's story illustrates how the high cost of health care for people with chronic heart disease undermines "the American dream."

Jeremy's Story

Millions of young adults like Jeremy become uninsured every year as they lose coverage under their parents' health plan. Individual coverage is costly and is often unavailable for those with pre-existing conditions.

Joshua's Story

Joshua's story underscores the need for adequate and affordable coverage when care outside of the insurer's provider network is needed.

NAMI Kansas
National Alliance on Mental Illness

Senate Committee on Public Health & Welfare

February 15, 2010

Presented by:
Rick Cagan, Executive Director

NAMI Kansas is a statewide grassroots membership organization dedicated to improving the lives of individuals with mental illness. Our members are individuals who are living with mental illnesses and the family members who provide care and support.

One in seventeen lives with a serious mental illness, such as schizophrenia, major depression or bipolar disorder[1], and about one in ten children have a serious mental or emotional disorder.[2] Close to 95,000 adults in Kansas are affected by a serious mental illness[3] and about 31,000 children live with serious mental health conditions.[4]

We support SB 525 as a modest effort to stem the tide of medical debt for consumers who are uninsured or underinsured. We are specifically concerned with individuals who are living with a serious mental illness. One in five people with a serious mental illness are uninsured.[5] People with low income and no insurance are twice as likely to have a psychiatric disorder.[6] Approximately 15 percent of the uninsured have a serious mental health condition.[7] Without treatment, individuals with a serious mental illness are at an increased risk of hospitalization.[8] If an individual is uninsured, they are less likely to use community-based services and more likely to rely on emergency services.[9]

Taken together these data raise serious concerns about the fate of a significant number of uninsured and underinsured Kansans who are living with a serious mental illness, who are likely to have encounters in emergency departments of community hospitals and be admitted to psychiatric beds in those hospitals. It is for these individuals and many other Kansans of limited means that SB 525 has been drafted. Their ability and their families' ability to carry more debt related to their ongoing treatment are severely limited. SB 525 is a reasonable effort to limit the expense that qualified individuals will have to incur and as a result protect them from higher debt levels due to medical expenses. The notice provision in the bill is especially important for those who would otherwise not be aware of the protections offered in this legislation.

Thank you for the opportunity to provide these comments.

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[1] National Institute of Mental Health. NIMH: The numbers count— Mental disorders in America. National Institute of Health. Available at http://www.nimh.nih.gov/publicat/numbers.cfm.
[2] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1999, pp. 408-409, 411.
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[5] SAHMSA, Office of Applied Studies, National Survey on Drug Use and Health, 2005.
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[9] Yanos, P.T., et al. Correlates of Health Insurance Among Persons with Schizophrenia in a Statewide Behavioral Health Care System. Psychiatric Services, 55(1).

KSNA
KANSAS STATE NURSES ASSOCIATION
The Voice & Vision of Nursing in Kansas

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President Pat Plank, MSN, RN

Written Testimony in Support of
SB 525
Public Health and Welfare Committee

Chairman Barnett and members of the Committee, thank you for taking KSNA's written comments today on SB 525 regarding the disparity self pay patients can experience when receiving hospital services. The Kansas State Nurses Association (KSNA) is the professional association for the more than 29,000 registered nurses in the state. We support the passage of SB 525.

The increase in self pay patients has been related to the downturn in the economy, with self-pay patients most often the uninsured and underinsured. Studies document the higher rates that are assessed to self-pay patients than insured patients, creating an unlevel playing field for those who are suffering the most economically. A presentation by the Healthcare Financial Management Association in November of 2009 demonstrated a national study that showed 97% of hospitals were experiencing an increase in self pay patients, with small hospitals most likely to experience an increase of 10% or more.[1] This would appear to apply to Kansas hospitals also. The same presentation also provided several key ideas for hospitals to financially manage the increased number of self pay patients, many of which are included in SB 525.

The majority of nurses in the State work in hospitals. They observe the concern ability to pay has on hospitalized patients and see patients who choose to prematurely leave or limit their care based on this concern. They are also aware of the hospitalization costs that often lead self pay patients to financial ruin. On the other hand, nurses own financial security is based on the hospitals ability to collect fees.

SB 525 includes solutions that would deal with this dilemma; encouraging hospitals to utilize financial practices to reduce the disparity, providing patient's notification of assistance that might be available for those meeting the 300% federal poverty level, and ending unfair treatment of the uninsured and underinsured in our state. For these reasons, we ask you to support SB 525.

Thank you,

Sarah Tidwell, RN, MS
Legislative Chair
785-233-8638

1 "The Changing Face of Self-Payment in Hospitals" Healthcare Financial Management Association, Healthcare Financial Plus. November 2009, p. 4. (Available at http://www.hfma.org/pulse/surveys/Self-Pay_Nov09_SlideDeck.htm)

Senate Public Health and Welfare
Date: 02/15/10
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Testimony from Shane Hessman to support SB 525

Senate Public Health and Welfare Committee

Mr Chair and members of the Committee, my name is Shane Hessman. I am a consultant with Hampton Consulting Corp in Pratt, Kansas. Hampton Consulting Corp has a client base of about 3500, in both Kansas and Missouri. Our clients come to us for a variety of services, including financial planning, budget counseling, and investment advice. The majority of our clients learn of our firm by word of mouth.

During an initial consultation with potential clients, I conduct a complete overview of their financial situation, including debt. Medical debt frequently arises as a major issue. These clients have experienced a significant health issue and have both emptied their bank accounts and maxed out their credit cards to pay for their out-of-pocket expenses, which are often higher than what they would be charged if the services were covered by their insurance. Often, all they have left is to cash out their retirement or take out their 401K and they come to us to seek advice on how to accomplish this. I attempt to steer them towards other options.

I probably see as many as 10-15 clients a year who find themselves in similar situations and are grasping at their last straws to pay their medical bills.

One client suffered a heart condition that severely limited her ability to work, by doctor's orders. Over time, she accumulated nearly $80,000 in credit card debt, with about 60% of that debt being hospital related. Only $8,000 of her credit card debt is non-medical and between 8-10 % of the $80,000 is interest. From her limited income, she makes monthly credit card payments totaling $1,200, which only goes toward her interest. She is considering bankruptcy but fears the long term effect that a filing would have on her credit score. What is devastating about her situation is that before putting the hospital bills on her credit card, she was not told that charity care might be available. Had the potential for charity care been made clear to her, she certainly would have applied prior to accumulating the credit card debt.

Another client was diagnosed with cancer and is unable to work. She is also undergoing extensive chemotherapy treatments at a local hospital and enduring monthly visits to a Wichita hospital for additional treatment. Her college-age daughter was awarded a scholarship to a 4-year college but instead opted to stay close to home and attend a local community college so that she could work and care for her mother. The client has to pay for her chemotherapy/radiation treatments out-of-pocket, totaling $2000 every two weeks. She has closed out her last 401K.

There are numerous Kansans in the rural parts of our state who are in similar situations. The majority of them are self-employed, as farmers or truck drivers, while others work in the oil fields. It would be a significant help for these Kansans to receive better information about the kind of financial assistance that might be available to them before their finances are devastated. Limiting how much they are charged in the first place would also be tremendously valuable.

American Cancer Society®

THE OFFICIAL SPONSOR OF BIRTHDAYS.™

TO: SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
HON. JIM BARNETT, CHAIR

FROM: CHRISTOPHER J. MASONER
AMERICAN CANCER SOCIETY

DATE: FEBRUARY 15, 2010

RE: SB 525 – FAIR HOSPITAL CHARGES ACT

Senator Barnett, Members of the Committee, thank you for the opportunity to provide written testimony in support of SB 525 – The Fair Hospital Charges Act.

The American Cancer Society believes that no one should have to choose between saving their life and their life savings. But the current health care system puts many Americans in that terrible predicament. According to a 2007 survey, 72 million working-age Americans, and another 7 million adults over the age of 65, struggled to pay medical bills and accumulated medical debt—that is 7% more than in 2005. Nearly two-thirds of bankruptcies in the United States in 2007 were due to unaffordable medical bills. We further note that the foregoing statistics were compiled well before the country found itself in the depths of the financial crisis we have experienced over the past two years.

The predicament is especially acute for families dealing with a diagnosis of cancer. According to a 2009 poll conducted by the American Cancer Society's Cancer Action Network, one in five of those families has used up all or most of their savings because of health care costs, and one in seven has incurred thousands of dollars of medical debt. Furthermore, one in four people currently receiving cancer-related care has delayed treatment in the past year, and nearly one in three people under age 65 who have been diagnosed with cancer has been uninsured at some point since their diagnosis.

The American Cancer Society supports efforts to avoid excessive healthcare costs for families facing cancer. We believe SB 525 is a reasonable means of controlling those costs by capping hospital charges for lower-income, self-paying patients at 125% of the amount charged to the hospital's highest volume private payer. This will continue to allow the hospital a reasonable profit for its services while reducing the substantial cost burden faced by lower-income families already faced with the devastating diagnosis of cancer or another significant health problem.

Thank you for your time and attention.

Kansas Faith Alliance for Health Reform

Testimony in Support of SB 525, the Fair Hospital Charges Act

Before the Senate Public Health and Welfare Committee

1:30 p.m., February 15, 2010

Room 546-S, Kansas State Capitol

The Rev. Dr. Matthew Cobb

Mr. Chair and members of the committee, I am Fr. Matthew Cobb, priest of St. Luke's Episcopal Church in Wamego here to speak in support of SB525, the Fair Hospital Charges Act. Thank you for the opportunity to support legislation that would improve the lives or our citizens without health insurance. The Kansas Faith Alliance for Health Reform represents a group of Clergy, conference leadership, and lay persons from sixteen faith traditions. Our members from across Kansas share a vision of equitable access to health care for all people of our state.

In addition to my parish position, I am the Director of Chaplaincy Care at Mercy Regional Health Center in Manhattan and president-elect of the Kansas Association of Chaplains who hold positions in not only health care but corrections, industry, disaster response, law enforcement, and fire and rescue. I will be presenting my personal views and those of the Faith Alliance, not those of the health center or the Association of Chaplains.

The Faith Alliance is aware that many factors contribute to inadequate health care accessibility. The cost of hospital care and the fear of unmanageable medical debt are common problems. As you are aware, self-pay patients are often charged a "price" for services that is much higher than the payment(s) it will receive from insured patients. SB 525 would improve hospital billing consistency by limiting the amount charged to self-pay patients to the amount paid by the highest volume group insurance payer (e.g. Blue Cross/Blue Shield) plus 25%. I have provided an example of a billing statement and calculations of charges at the proposed self-pay rate of 125% of the payment provided to the largest private insurance plan.

Example:

Date of Service	Total Charges	Other Insurance Payment	Provider Contractual Write-off	Amount Paid	Total Patient Responsibility
12/21/09	30.00		23.06	6.94	0
12/21/09	48.50		38.95	9.55	0
12/21/09	107.25		93.93	13.32	0
12/21/09	100.75		69.93	30.82	0
Claim Total	286.50		225.87	60.63	0

$ 286.50	Total Charges
60.63	Amount Paid by insurance
225.87	Contractual "write-off" (adjustment in bill to the third party)
75.79	125% of amount paid by insurance

In this instance, total charges of $286 were discounted $225 as "contractual write-off" to the insurance plan and the amount accepted as payment in full was $60.63. The self-pay patient would have been expected to pay full charges or 4 ½ times more than the insured. With the proposed legislation, the self-pay patient would be billed $75.79, which is only 25% higher than the payment accepted from the insured patient.

This proposed move toward more fairness in charges would not apply exclusively to the uninsured population but would also include those with insurance plans that have inadequate coverage. This legislation will assist persons whose annual incomes are at or below 300% of the federal poverty level, or about $55,000 for a family of three. I have attached an income table for the federal poverty guidelines currently in effect.

For generations before there was health insurance, non-profit hospitals cared for patients who were unable to pay the full cost of their care. These hospitals received gifts and donations to support the costs of care provided to the poor. With this charitable mission, non-profit hospitals, including those with religious affiliations, have received tax advantages from state and federal government in recognition of their benefit to the "public good." We believe that community benefit should still be recognized with these tax exemptions. In 2007, Kansas had a total of 128 licensed community hospitals. By ownership, sixty-two (62 or 48.4%) are public hospitals owned by state or local government, fifty-five (55 or 43.0%) are private non-profit, and eleven

(11 or 8.6%) are for-profit hospitals. We recommend that SB525 also include in the definition of "hospital" those 55 hospitals owned by state and local government that also receive income tax exemptions as government entities.

Although the uninsurance rate for Kansans remains lower than the national average, it has been climbing for the past six years from 10.5% in 2004 to perhaps 15% or higher after the economic downturn. According to the Kansas Department of Health and Environment hospital inpatient discharge statistics received from the Kansas Hospital Association, from 2003 through 2008, an average of 5.08% of patients were in the self-pay category which includes both the uninsured and charity care. The highest insured patient payment source from the private sector is Blue Cross with a six-year average of 13.04% of patients being covered by their insurance plans.

SB 525 also improves the information available to those who currently don't know about financial discounts or payment plans for which they might qualify. With passage of SB 525 hospitals would be required to publically post and provide notice to patients that they might qualify for discounted charges if their household income is equal to or less than 300% FPL. In addition, hospitals could not turn accounts over to collection agencies without making an effort to determine if the patient/family is eligible for this assistance.

Mr. Chairman, we thank you for an opportunity to submit our recommendations and for your consideration of this helpful legislation.

2009 POVERTY GUIDELINES

ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.

Number in Household	Annual Income				
	<100% FPL:	100-149% FPL	150-174% FPL	175-199% FPL	200-300% FPL
1	< 10,830	10,830 to 16,244	16,245 to 18,952	18,953 to 21,659	21,660 to 32,490
2	< 14,570	14,570 to 21,854	21,855 to 25,497	25,498 to 29,139	29,140 to 43,710
3	< 18,310	18,310 to 27,464	27,465 to 32,042	32,043 to 36,619	36,620 to 54,930
4	< 22,050	22,050 to 33,074	33,075 to 38,587	38,588 to 44,099	44,100 to 66,150
5	< 25,790	25,790 to 38,684	38,685 to 45,132	45,133 to 51,579	51,580 to 77,370
6	< 29,530	29,530 to 44,294	44,295 to 51,677	51,678 to 59,059	59,060 to 88,590
7	< 33,270	33,270 to 49,904	49,905 to 58,222	58,223 to 66,539	66,540 to 99,810
8	< 37,010	37,010 to 55,514	55,515 to 64,767	64,768 to 74,019	74,020 to 111,030

For family units of more than 8 members, add $3,740 for each additional member

Number in Household	Monthly Income				
	<100% FPL:	100-149% FPL	150-174% FPL	175-199% FPL	200-300% FPL
1	< 903	903 to 1,354	1,354 to 1,579	1,579 to 1,805	1,805 to 2,708
2	< 1,214	1,214 to 1,821	1,821 to 2,125	2,125 to 2,428	2,428 to 3,643
3	< 1,526	1,526 to 2,289	2,289 to 2,670	2,670 to 3,052	3,052 to 4,578
4	< 1,838	1,838 to 2,756	2,756 to 3,216	3,216 to 3,675	3,675 to 5,513
5	< 2,149	2,149 to 3,224	3,224 to 3,761	3,761 to 4,298	4,298 to 6,448
6	< 2,461	2,461 to 3,691	3,691 to 4,306	4,307 to 4,922	4,922 to 7,383
7	< 2,773	2,773 to 4,159	4,159 to 4,852	4,852 to 5,545	5,545 to 8,318
8	< 3,084	3,084 to 4,626	4,626 to 5,397	5,397 to 6,168	6,168 to 9,253

Number in Household	Hourly Income				
	<100% FPL:	100-149% FPL	150-174% FPL	175-199% FPL	200-300% FPL
1	< 5.21	5.21 to 7.81	7.82 to 9.11	9.12 to 10.41	10.42 to 15.62
2	< 7.00	7.00 to 10.51	10.52 to 12.26	12.27 to 14.01	14.02 to 21.01
3	< 8.80	8.80 to 13.20	13.21 to 15.40	15.42 to 17.61	17.62 to 26.41
4	< 10.60	10.60 to 15.90	15.91 to 18.55	18.56 to 21.20	21.21 to 31.80
5	< 12.40	12.40 to 18.60	18.61 to 21.70	21.71 to 24.80	24.81 to 37.20
6	< 14.20	14.20 to 21.30	21.31 to 24.84	24.86 to 28.39	28.40 to 42.59
7	< 16.00	16.00 to 23.99	24.00 to 27.99	28.00 to 31.99	32.00 to 47.99
8	< 17.79	17.79 to 26.69	26.70 to 31.14	31.15 to 35.59	35.60 to 53.38

Derived from poverty guidelines as published in the **Federal Register** on January 23, 2009

* *In accordance with section 1012 of the Department of Defense Appropriations Act of 2010, the poverty guidelines published on January 23, 2009 willl remain in effect until updated poverty guidelines are published in March 2010.*

Table produced by Kansas Faith Alliance for Health Reform 2/13/10

KANSAS HEALTH INSTITUTE

For additional information contact:

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Senate Public Health and Welfare Committee

February 15, 2010

Medical Debt

Suzanne Cleveland, J.D.,
Senior Analyst
Kansas Health Institute

Information for policymakers. Health for Kansans.

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multiyear grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

KANSAS HEALTH INSTITUTE

MEMO

To: Senator Jim Barnett
Chair, Senate Public Health and Welfare Committee

From: Suzanne Cleveland, J.D.
Senior Analyst, Kansas Health Institute

Date: February 15, 2010

Re: Medical Debt

Chairman Barnett and members of the committee, thank you for allowing us to submit this written testimony as neutral witnesses on the topic of medical debt. The prevalence of medical debt makes this a timely and important issue to address. The purpose of this testimony is to provide information about how some states have addressed the issue of medical debt.

I. Identifying the Problem

Medical debt can be defined as outstanding financial balances owed to medical providers for services rendered; medical debtors can be both insured and uninsured. According to a 2007 Harvard study, nearly half of all personal bankruptcies filed in the United States were related to medical debt. Between 2002-2006, approximately 500,000 insured Kansans did not seek medical care because of cost and 45% of uninsured Kansans reported that cost was a barrier to medical care. Preventing illness or treating medical conditions in early stages is far less expensive than managing late or critical stage patients with long-standing disease. This delay in care can result in higher overall costs to the healthcare system.

II. Policy Approaches Used in Other States

Identifying policy options to address medical debt is difficult because the issue spans the continuum of care. That continuum of care can be divided into five spans of time; the period prior to seeking care, the period when seeking care, the period when being billed for care, the period when carrying a medical debt balance, and the period when rebuilding financial status after having medical debt. Given this large span of events during which medical debt can arise or become problematic, drafting comprehensive medical debt legislation would be challenging. Several states have enacted legislation that more singularly addresses medical debt by honing in on one aspect of either debt accrual or debt reduction. This testimony focuses on those state policies that seek to prevent the accumulation of medical debt. It is important to note that most of these laws are intended

to prevent a *consumer* from accruing medical debt, but that uncompensated care costs to hospitals and providers are also a substantial issue. Laws to address medical debt from a patient's perspective should take into account any potential impact on uncompensated care costs to providers and institutions.

Among the regulations implemented to reduce the likelihood that patients will acquire medical debt are laws that set a minimum charity care requirement, laws that require price transparency and laws that limit the allowable amount charged to patients who are particularly vulnerable to medical debt.

- Hospital Charity Care
  Alabama, Mississippi, and Rhode Island have all enacted laws that mandate a certain level of hospital charity care. In Alabama, a hospital seeking tax exempt status must dedicate 15% of its care to charity patients; hospitals seeking tax exempt status in Mississippi dedicate at least one hospital ward to charity care. Alternatively, Rhode Island hospitals provide a specific amount of charity care as a condition of their hospital licensure in the state.
- Hospital/Provider Price Transparency
  Some states require that average charges or costs of care are either directly provided to patients prior to an admission or procedure or posted publicly via internet. A South Dakota transparency law requires that all fees and charges for a procedure be disclosed to a patient if a patient requests that information. In Minnesota, patients do not have to request the information because average hospital and provider charges must be displayed on a website. Arizona statute goes farther by establishing a uniform reporting system for hospitals and other facilities, which includes prices charged per patient and per physician.
- Fair Price/Fair Charge Laws
  New Jersey, Nevada, and Illinois passed laws that address the uninsured being charged higher rates for services than those that are insured. Insurance companies often negotiate reimbursement rates based on volume of services; therefore benefit from lower rates. New Jersey law sets the maximum allowable hospital charge for uninsured patients with gross family income of up to 500% of Federal Poverty Level (FPL) at 115% of the Medicare reimbursement rate. In Nevada, hospitals must charge uninsured patients at least 30% less than average when a patient is ineligible for public assistance programs. A similar but more detailed Illinois law limits charges for uninsured patients to up to 135% of cost, requires discounts for families at up to 600% of FPL, and caps the yearly out of pocket expense for a family of up to 25% of their annual income.

III. Policy Considerations

Although much work has been done defining and quantifying the issue of medical debt and surveying the number of people impacted by rising healthcare costs, less research exists for measuring the effectiveness of policies aimed to address medical debt. Many of the laws listed above are relatively new and have not been evaluated.

Although the policy examples in this testimony address medical debt from the consumers' perspective, the potential impact to providers cannot be ignored. The effect of these policies could have both a positive and negative impact. For example, providers may be negatively affected by not getting fully compensated for the cost of care provided. However, they may also save money by reducing administrative costs they would otherwise incur from debt collection efforts and by realizing some compensation for services that might otherwise go uncompensated.

Policy makers are in a difficult but important role of balancing the lack of information to support the effectiveness of these policies, the positive and negative impact these policies have on providers, with the need to address the prevalence of Kansans facing the financial challenge of medical debt. Knowing how other states are addressing this issue can inform policy decisions in Kansas.

If the committee is interested in more examples of policy options other states have used, the Kansas Health Institute can provide that information.