Health Law and Policy Update: February 17, 2012

This week's updates

Headlines of the week

Committee delays action on Hospital Payment Assistance Act while parties negotiate

A legislative committee heard details about the proposed Hospital Payment Assistance Act on Thursday but delayed a vote on the measure, pending amendments on the bill. Sen. Irene Aguilar, the sponsor of Senate Bill 12-134, expressed a desire to continue working on a compromise.

The Colorado Center on Law and Policy is backing the bill along with the Colorado Consumer Health Initiative. CCLP is optimistic continued dialogue with Colorado hospitals will lead to a solution that, as Aguilar described it, will allow uninsured patients "the dignity to pay their bills without going bankrupt."

Thursday's hearing before the Senate Health and Human Services Committee was the first public hearing for Senate Bill 12-134. The measure gives uninsured patients the opportunity to understand and responsibly pay their hospital bills without fear of being sent to collections or going into bankruptcy. Patients who have been subject to high levels of medical debt, a bankruptcy attorney and hospital executives were among those offering testimony to the committee.

CCLP and the Colorado Consumer Health Initiative offered testimony on the lack of transparency regarding hospital prices and charity care policies. Hospital sticker prices are significantly higher than the actual amount paid by private insurers or Medicare, which leaves only the uninsured paying the full price for hospital care. The consequences for consumers can include being sent to collections, paying additional fees and ultimately bankruptcy.

A number of uninsured patients testified to the difficulty they had understanding their hospital bills. Many of the patients were never informed of or were unable to find information about hospital discount or charity care policies. Nick Wimmershoff, a local bankruptcy attorney, said he sees cases where medical debt leads to bankruptcy, but that's not necessarily the end of the problem. Even after discharging debt in a bankruptcy, patients often have ongoing need for medical care, which can result in additional unmanageable debt.

The testimony included several stories about patients who refused treatment because they were uninsured and did not want to incur the financial burden of a hospital stay. One story detailed how a pregnant woman refused a pelvic ultrasound to determine if she had an ectopic pregnancy, due to cost of the procedure. She ended up in the emergency room a few days later with a rupture and potential shock, necessitating a much more serious extensive surgery and a prolonged hospital stay.

Among the concerns expressed by the Colorado Hospital Association and two hospital executives was that requiring hospitals to charge uninsured patients no more than the cost of providing care would harm rural hospitals. Responding to the point, Aguilar shared data demonstrating that certified critical access hospitals in Colorado already charge much closer to cost than many of their urban counterparts.

Therefore, rural hospitals would not need to significantly change business practices to comply with the new legislation, she said.

Find news coverage from The Denver Post and the Denver Business Journal.

For more information about the bill, and for ways you can get involved, visit CCLP's Hospital Payment Assistance Program action center.

Exchange board plans key decisions at Feb. 27 meeting
Leaders of the Colorado Health Benefit Exchange will face some key decisions soon:

- Whether the exchange should operate as one or two entities (split between the individual and small-group markets);
- Whether the exchange should have separate or combined risk pools for the individual and small-group markets
- Whether the small-group markets should remain limited to 50 employees or expand to 100 employees as the Patient Protection and Affordable Care Act will require in 2016

The exchange board expects to make recommendations on those points at its next meeting, Feb. 27. The exchange board released a document that provides details.

Rule will help consumers understand health insurance
Health plans will be required to provide information about coverage, benefits and limitations on health insurance in a clear and uniform way under a rule published Thursday by the departments of Health and Human Services, Labor and Treasury. The rule, implemented under the Patient Protection and Affordable Care Act, requires a Summary of Benefits and Coverage (SBC) and a uniform glossary. A key component of the SBC will be a standardized tool to help consumers compare differences in plan coverage. Health plans will have to provide consumers with descriptions of coverage given two sample medical situations. Health plans will have to begin using the SBC for all plan years beginning on or after Sept. 12.

Advancing the debate

Coloradans benefit from preventive services in Affordable Care Act

An estimated 973,000 Colorado residents received at least one new free preventive service in 2011 through their private health insurance plans because of a provision of the Patient Protection and Affordable Care Act, federal officials announced Wednesday. In addition, an estimated 381,575 Colorado residents with Medicare received at least one free preventive benefit last year, including the new Annual Wellness Visit.

The estimates were part of two reports issued by the Department of Health and Human Services (HHS).

"Americans of all ages can now get the preventive services they need, like mammograms and the new Annual Wellness Visit, free of charge, as a result of the new health care law," HHS Secretary Kathleen Sebelius said in a news release. "With more people taking advantage of these benefits, more lives can be saved, and costly, and often burdensome, diseases can be prevented or caught earlier."

People with extremely high incomes will pay most of health reform tax on investment income
The 2010 Patient Protection and Affordable Care Act includes several new taxes, the largest of which is the "Unearned Income Medicare Contribution," a 3.8 percent tax on the net investment income of high-income taxpayers. In a new fact sheet, the Tax Policy Center shows the top 1 percent of earners will pay 86 percent of that tax, which is expected to raise $123 billion from
2013 through 2019.

Despite the name, revenue from the tax will not be earmarked for Medicare (it will go into general revenue), and the tax will not apply to all home sales, the Tax Policy Center reports.

People in high-deductible plans more likely to delay or forgo care, study finds
Children with chronic conditions in families with high-deductible health insurance plans were much more likely to delay or forgo health care, according to a new study funded by the Robert Wood Johnson Foundation. The study, published in the Journal of General Internal Medicine, was based on a survey of 578 families including 208 in high-deductible health plans and 370 in traditional plans. Lower-income children and adults who had high-deductible plans were the most likely to delay or forego care.

"This study is one of the first studies to focus on families with chronic conditions in HDHPs [high-deductible health plans]. Further research is needed on this topic, especially as HDHPs may be offered in the Health Insurance Exchanges proposed in national health care reform," the foundation said in a summary of the study.

Consumers have difficulty understanding and using health insurance
Consumers have serious difficulties understanding and using health insurance. Moreover, there is a lack of information on the specific barriers facing consumers. The problems create negative health and financial consequences for consumers.

Those are among the findings of a Health Insurance Literacy Expert Roundtable convened last November by Consumers Union, the University of Maryland and the American Institute of Research. The group included representatives from academia, health plans and private research firms. The group reached its conclusions using consumer testing done by Consumers Union and a literature review put together by the American Institute of Research.

Another significant conclusion: A uniform definition of consumer health insurance literacy is necessary to identify barriers and inform solutions to the lack of consumer understanding about health insurance. The group recommended a stakeholder process to create and test a definition of consumer health insurance literacy by the end of 2012. Consumer advocates who want to be involved in should contact Consumers Union.

State releases new fact sheet on Adults without Dependent Children expansion
The Department of Health Care Policy and Financing released a fact sheet describing its Medicaid expansion to adults without dependent children with incomes of up to 10 percent of the federal poverty level. The factsheet provides information on client eligibility, application processing and management of the waiting list. The expansion will be limited to 10,000 clients. Sites will begin accepting applications April 1, and a lottery will be conducted in May.