Chapter 470

(House Bill 1420)

AN ACT concerning

Hospitals – Financial Assistance Policies and Bill Collections

FOR the purpose of increasing the income threshold at which a hospital's financial assistance policy must provide free and reduced cost medically necessary care to patients; requiring that a certain financial assistance policy include a certain payment plan and a certain mechanism for a patient to request a certain reconsideration; requiring that a certain financial assistance policy provide presumptive eligibility for certain care to certain patients; authorizing a hospital to consider certain assets in determining eligibility for certain care under a certain policy; excluding certain assets from consideration if a hospital considers assets in making a certain determination; requiring that certain excluded assets be adjusted annually for inflation; requiring a hospital to apply a certain definition of household size; requiring a hospital to provide ~~oral~~ notice of the hospital's financial assistance policy to certain individuals at certain times; requiring that a certain notice be in a certain form; altering the contents required to be included in a certain information sheet; requiring that a certain information sheet be in a certain form and provided to certain individuals in certain communications; requiring hospitals to develop a certain procedure for determining a patient's eligibility for the hospital's financial assistance policy; prohibiting a hospital from ~~asking for or requiring a patient to make a certain disclosure or verification,~~ using a patient's citizenship or immigration status for a certain purpose or withholding certain assistance or denying a certain application on a certain basis~~, or imposing a time limit for the submission of a certain application or certain evidence~~; requiring hospitals to annually submit a certain policy and report to the Health Services Cost Review Commission; requiring the Commission to post certain information on its website; requiring the Commission to compile certain reports and make a certain report available to the public in a certain manner; requiring the Commission, on or before a certain date each year, to submit a certain report to certain committees of the General Assembly; requiring the Commission to establish a process for certain individuals to file certain complaints; requiring that a certain process include a certain option and provide the patient or the patient's authorized representative with certain information; providing that certain complaints are public record and subject to certain inspection; requiring the Commission to deny inspection of certain information; providing that the filing of a certain complaint does not prevent a person from taking certain action; ~~authorizing a person to bring certain actions in certain courts and to~~ ~~seek certain remedies;~~ providing that certain remedies are in addition to other remedies and that a person or governmental unit is not required to exhaust certain remedies before filing suit; providing that certain waivers and provisions in certain policies are null and void; ~~increasing a certain fine that may be imposed by the Commission;~~ providing that a certain violation is an unfair, abusive, and deceptive trade practice under a certain law; requiring the Commission to conduct certain ~~modeling~~ evaluations; requiring

the Commission, on or before a certain date, to report certain findings and recommendations to the Governor and the General Assembly; and generally relating to hospitals and financial assistance policies and bill collection.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–214.1 and 19–214.3
Annotated Code of Maryland
(2019 Replacement Volume)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

19–214.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Financial hardship" means medical debt, incurred by a family over a 12–month period, that exceeds 25% of family income.

(3) "Medical debt" means out–of–pocket expenses, excluding co–payments, coinsurance, and deductibles, for medical costs billed by a hospital.

(b) (1) The Commission shall require each acute care hospital and each chronic care hospital in the State under the jurisdiction of the Commission to develop a financial assistance policy for providing free and reduced–cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill.

(2) The financial assistance policy shall provide, at a minimum:

(i) Free medically necessary care to patients with family income at or below **[**150%**]** **200%** of the federal poverty level; **[**and**]**

(ii) Reduced–cost medically necessary care to low–income patients with family income above ~~150%~~ **200%** of the federal poverty level, in accordance with the mission and service area of the hospital**;**

(III) A PAYMENT PLAN THAT IS AVAILABLE TO UNINSURED PATIENTS WITH FAMILY INCOME BETWEEN 200% AND 500% OF THE FEDERAL POVERTY LEVEL, IN ACCORDANCE WITH THE MISSION AND SERVICE AREA OF THE HOSPITAL; AND

(IV) A MECHANISM FOR A PATIENT TO REQUEST THE HOSPITAL TO RECONSIDER THE DENIAL OF FREE OR REDUCED–COST CARE THAT INCLUDES IN THE REQUEST:

1. THE HEALTH EDUCATION AND ADVOCACY UNIT IS AVAILABLE TO ASSIST THE PATIENT OR THE PATIENT'S AUTHORIZED REPRESENTATIVE IN FILING AND MEDIATING A RECONSIDERATION REQUEST; AND

2. THE ADDRESS, PHONE NUMBER, FACSIMILE NUMBER, E–MAIL ADDRESS, MAILING ADDRESS, AND WEBSITE OF THE HEALTH EDUCATION AND ADVOCACY UNIT.

(3) (i) The Commission by regulation may establish income thresholds higher than those under paragraph (2) of this subsection.

(ii) In establishing income thresholds that are higher than those under paragraph (2) of this subsection for a hospital, the Commission shall take into account:

1. The patient mix of the hospital;

2. The financial condition of the hospital;

3. The level of bad debt experienced by the hospital; and

4. The amount of charity care provided by the hospital.

(4) (i) Subject to subparagraphs (ii) and (iii) of this paragraph, the financial assistance policy required under this subsection shall provide reduced–cost medically necessary care to patients with family income below 500% of the federal poverty level who have a financial hardship.

(ii) A hospital may seek and the Commission may approve a family income threshold that is different than the family income threshold under subparagraph (i) of this paragraph.

(iii) In establishing a family income threshold that is different than the family income threshold under subparagraph (i) of this paragraph, the Commission shall take into account:

1. The median family income in the hospital's service area;

2. The patient mix of the hospital;

3. The financial condition of the hospital;

4. The level of bad debt experienced by the hospital;

5. The amount of charity care provided by the hospital; and

6. Other relevant factors.

(5) If a patient is eligible for reduced–cost medically necessary care under paragraphs (2)(ii) and (4) of this subsection, the hospital shall apply the reduction that is most favorable to the patient.

(6) If a patient has received reduced–cost medically necessary care due to a financial hardship, the patient or any immediate family member of the patient living in the same household:

(i) Shall remain eligible for reduced–cost medically necessary care when seeking subsequent care at the same hospital during the 12–month period beginning on the date on which the reduced–cost medically necessary care was initially received; and

(ii) To avoid an unnecessary duplication of the hospital's determination of eligibility for free and reduced–cost care, shall inform the hospital of the patient's or family member's eligibility for the reduced–cost medically necessary care.

(7) THE FINANCIAL ASSISTANCE POLICY REQUIRED UNDER THIS SUBSECTION SHALL PROVIDE PRESUMPTIVE ELIGIBILITY FOR FREE MEDICALLY NECESSARY CARE TO A PATIENT WHO IS NOT ELIGIBLE FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR MARYLAND CHILDREN'S HEALTH PROGRAM AND:

(I) LIVES IN A HOUSEHOLD WITH CHILDREN ENROLLED IN THE FREE AND REDUCED–COST MEAL PROGRAM;

(II) RECEIVES BENEFITS THROUGH THE FEDERAL SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM;

(III) RECEIVES BENEFITS THROUGH THE STATE'S ENERGY ASSISTANCE PROGRAM;

(IV) ~~RECEIVES BENEFITS THROUGH THE PRIMARY ADULT CARE PROGRAM IF THE PROGRAM DOES NOT OFFER INPATIENT BENEFITS;~~

~~(V)~~ RECEIVES BENEFITS THROUGH THE FEDERAL SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN; OR

~~(VI)~~ (V) RECEIVES BENEFITS FROM ANY OTHER SOCIAL SERVICE PROGRAM AS DETERMINED BY THE DEPARTMENT AND THE COMMISSION.

(8) (I) A HOSPITAL MAY CONSIDER HOUSEHOLD MONETARY ASSETS IN DETERMINING ELIGIBILITY FOR FREE AND REDUCED–COST CARE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY IN ADDITION TO INCOME–BASED CRITERIA.

(II) SUBJECT TO SUBPARAGRAPH (III) OF THIS PARAGRAPH, IF A HOSPITAL CONSIDERS HOUSEHOLD MONETARY ASSETS UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH, THE FOLLOWING TYPES OF MONETARY ASSETS THAT ARE CONVERTIBLE TO CASH SHALL BE EXCLUDED:

1. AT A MINIMUM, THE FIRST $10,000 OF MONETARY ASSETS;

2. A SAFE HARBOR EQUITY OF $150,000 IN A PRIMARY RESIDENCE;

3. RETIREMENT ASSETS THAT THE INTERNAL REVENUE SERVICE HAS GRANTED PREFERENTIAL TAX TREATMENT AS A RETIREMENT ACCOUNT, INCLUDING DEFERRED–COMPENSATION PLANS QUALIFIED UNDER THE INTERNAL REVENUE CODE OR NONQUALIFIED DEFERRED–COMPENSATION PLANS;

4. ONE MOTOR VEHICLE USED FOR THE TRANSPORTATION NEEDS OF THE PATIENT OR ANY FAMILY MEMBER OF THE PATIENT;

5. ANY RESOURCES EXCLUDED IN DETERMINING FINANCIAL ELIGIBILITY UNDER THE MEDICAL ASSISTANCE PROGRAM UNDER THE SOCIAL SECURITY ACT; AND

6. PREPAID HIGHER EDUCATION FUNDS IN A MARYLAND 529 PROGRAM ACCOUNT.

(III) MONETARY ASSETS EXCLUDED FROM THE DETERMINATION OF ELIGIBILITY FOR FREE AND REDUCED–COST CARE UNDER SUBPARAGRAPH (II) OF THIS PARAGRAPH SHALL BE ADJUSTED ANNUALLY FOR INFLATION IN ACCORDANCE WITH THE CONSUMER PRICE INDEX.

(9) (I) IN DETERMINING THE FAMILY INCOME OF A PATIENT, A HOSPITAL SHALL APPLY A DEFINITION OF HOUSEHOLD SIZE THAT CONSISTS OF THE PATIENT AND, AT A MINIMUM, THE FOLLOWING INDIVIDUALS:

1. A SPOUSE, REGARDLESS OF WHETHER THE PATIENT AND SPOUSE EXPECT TO FILE A JOINT FEDERAL OR STATE TAX RETURN;

2. BIOLOGICAL CHILDREN, ADOPTED CHILDREN, OR STEPCHILDREN; AND

3. ANYONE FOR WHOM THE PATIENT CLAIMS A PERSONAL EXEMPTION IN A FEDERAL OR STATE TAX RETURN.

(II) FOR A PATIENT WHO IS A CHILD, THE HOUSEHOLD SIZE SHALL CONSIST OF THE CHILD AND THE FOLLOWING INDIVIDUALS:

1. BIOLOGICAL PARENTS, ADOPTED PARENTS, OR STEPPARENTS OR GUARDIANS;

2. BIOLOGICAL SIBLINGS, ADOPTED SIBLINGS, OR STEPSIBLINGS; AND

3. ANYONE FOR WHOM THE PATIENT'S PARENTS OR GUARDIANS CLAIM A PERSONAL EXEMPTION IN A FEDERAL OR STATE TAX RETURN.

~~**(III) A PREGNANT WOMAN SHALL BE COUNTED AS HERSELF PLUS THE NUMBER OF CHILDREN SHE IS EXPECTED TO DELIVER FOR PURPOSES OF DETERMINING HOUSEHOLD SIZE UNDER THIS PARAGRAPH.**~~

(10) A HOSPITAL SHALL PROVIDE ~~ORAL~~ NOTICE OF THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY TO THE PATIENT, THE PATIENT'S FAMILY, OR THE PATIENT'S AUTHORIZED REPRESENTATIVE BEFORE DISCHARGING THE PATIENT AND IN EACH ~~ORAL~~ COMMUNICATION TO THE PATIENT REGARDING COLLECTION OF THE HOSPITAL BILL.

(c) **(1)** A hospital shall post a notice in conspicuous places throughout the hospital, including the billing office, informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

(2) THE NOTICE REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL:

(I) BE IN SIMPLIFIED LANGUAGE IN AT LEAST 10 POINT TYPE; AND

(II) BE PROVIDED IN THE PATIENT'S PREFERRED LANGUAGE OR, IF NO PREFERRED LANGUAGE IS SPECIFIED, EACH LANGUAGE SPOKEN BY A LIMITED ENGLISH PROFICIENT POPULATION THAT CONSTITUTES ~~3%~~ 5% OF THE OVERALL POPULATION WITHIN THE CITY OR COUNTY IN WHICH THE HOSPITAL IS LOCATED AS MEASURED BY THE MOST RECENT CENSUS.

(d) The Commission shall:

(1) Develop a uniform financial assistance application; and

(2) Require each hospital to use the uniform financial assistance application to determine eligibility for free and reduced–cost care under the hospital's financial assistance policy.

(e) The uniform financial assistance application:

(1) Shall be written in simplified language; and

(2) May not require documentation that presents an undue barrier to a patient's receipt of financial assistance.

(f) (1) Each hospital shall develop an information sheet that:

(i) Describes the hospital's financial assistance policy;

(ii) Describes a patient's rights and obligations with regard to hospital billing and collection under the law;

(iii) Provides contact information for the individual or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative in order to understand:

1. The patient's hospital bill;

2. The patient's rights and obligations with regard to the hospital bill;

3. How to apply for free and reduced–cost care; and

4. How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill;

(iv) Provides contact information for the Maryland Medical Assistance Program; **[**and**]**

(v) Includes a statement that physician charges are not included in the hospital bill and are billed separately**; AND**

(VI) INFORMS PATIENTS OF THE RIGHT TO REQUEST AND RECEIVE A WRITTEN ESTIMATE OF THE TOTAL CHARGES FOR HOSPITAL

NONEMERGENCY SERVICES, PROCEDURES, AND SUPPLIES THAT REASONABLY ARE EXPECTED TO BE PROVIDED FOR PROFESSIONAL SERVICES BY THE HOSPITAL.

(2) THE INFORMATION SHEET SHALL:

(I) BE IN SIMPLIFIED LANGUAGE IN AT LEAST 10 POINT TYPE;

(II) BE IN THE PATIENT'S PREFERRED LANGUAGE OR, IF NO PREFERRED LANGUAGE IS SPECIFIED, EACH LANGUAGE SPOKEN BY A LIMITED ENGLISH PROFICIENT POPULATION THAT CONSTITUTES ~~3%~~ 5% OF THE OVERALL POPULATION WITHIN THE CITY OR COUNTY IN WHICH THE HOSPITAL IS LOCATED AS MEASURED BY THE MOST RECENT CENSUS.

[(2)**] (3)** The information sheet shall be provided to the patient, the patient's family, or the patient's authorized representative:

(i) Before discharge;

(ii) With the hospital bill; **[**and**]**

(iii) On request**; AND**

(IV) IN EACH WRITTEN COMMUNICATION TO THE PATIENT REGARDING COLLECTION OF THE HOSPITAL BILL.

[(3)**] (4)** The hospital bill shall include a reference to the information sheet.

[(4)**] (5)** The Commission shall:

(i) Establish uniform requirements for the information sheet; and

(ii) Review each hospital's implementation of and compliance with the requirements of this subsection.

(g) Each hospital shall ensure the availability of staff who are trained to work with the patient, the patient's family, and the patient's authorized representative in order to understand:

(1) The patient's hospital bill;

(2) The patient's rights and obligations with regard to the hospital bill, including the patient's rights and obligations with regard to reduced–cost medically necessary care due to a financial hardship;

(3) How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the hospital bill; and

(4) How to contact the hospital for additional assistance.

(H) EACH HOSPITAL SHALL DEVELOP A PROCEDURE TO DETERMINE A PATIENT'S ELIGIBILITY UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY IN WHICH THE HOSPITAL:

(1) DETERMINES WHETHER THE PATIENT HAS HEALTH INSURANCE;

(2) DETERMINES WHETHER THE PATIENT IS PRESUMPTIVELY ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER SUBSECTION (B)(7) OF THIS SECTION;

(3) DETERMINES WHETHER UNINSURED PATIENTS ARE ELIGIBLE FOR PUBLIC OR PRIVATE HEALTH INSURANCE;

(4) ~~OFFERS~~ TO THE EXTENT PRACTICABLE, OFFERS ASSISTANCE TO UNINSURED PATIENTS IF THE PATIENT CHOOSES TO APPLY FOR PUBLIC OR PRIVATE HEALTH INSURANCE;

(5) ~~DETERMINES~~ TO THE EXTENT PRACTICABLE, DETERMINES WHETHER THE PATIENT IS ELIGIBLE FOR OTHER PUBLIC PROGRAMS THAT MAY ASSIST WITH HEALTH CARE COSTS;

(6) USES INFORMATION IN THE POSSESSION OF THE HOSPITAL, IF AVAILABLE, TO DETERMINE WHETHER THE PATIENT IS QUALIFIED FOR FREE OR REDUCED–COST CARE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY; AND

(7) ~~IF~~ WHEN A PATIENT SUBMITS ~~AN~~ A COMPLETED APPLICATION FOR FINANCIAL ASSISTANCE, DETERMINES THE PATIENT'S ELIGIBILITY UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY WITHIN 14 DAYS AFTER THE PATIENT APPLIES FOR FINANCIAL ASSISTANCE AND SUSPENDS ANY BILLING OR COLLECTIONS ACTIONS WHILE ELIGIBILITY IS BEING DETERMINED.

(I) A HOSPITAL MAY NOT:

(1) ~~ASK OR REQUIRE A PATIENT TO DISCLOSE OR VERIFY THE~~ USE A PATIENT'S CITIZENSHIP OR IMMIGRATION STATUS ~~IN ORDER TO RECEIVE OR APPLY~~ AS AN ELIGIBILITY REQUIREMENT FOR FINANCIAL ASSISTANCE; OR

(2) WITHHOLD FINANCIAL ASSISTANCE OR DENY A PATIENT'S APPLICATION FOR FINANCIAL ASSISTANCE ON THE BASIS OF RACE, COLOR,

RELIGION, ANCESTRY OR NATIONAL ORIGIN, SEX, AGE, MARITAL STATUS, SEXUAL ORIENTATION, GENDER IDENTITY, GENETIC INFORMATION, OR ON THE BASIS OF DISABILITY~~; OR~~

~~(3) IMPOSE A TIME LIMIT ON A PATIENT TO SUBMIT AN APPLICATION FOR FREE OR REDUCED–COST CARE OR TO SUBMIT EVIDENCE OF ELIGIBILITY FOR FREE OR REDUCED–COST CARE~~.

(J) EACH HOSPITAL SHALL SUBMIT TO THE COMMISSION ANNUALLY AT TIMES PRESCRIBED BY THE COMMISSION:

(1) THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY DEVELOPED UNDER THIS SECTION; AND

(2) AN ANNUAL REPORT ON THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY THAT INCLUDES:

(I) THE TOTAL NUMBER OF PATIENTS WHO COMPLETED OR PARTIALLY COMPLETED AN APPLICATION FOR FINANCIAL ASSISTANCE DURING THE PRIOR YEAR;

(II) THE TOTAL NUMBER OF INPATIENTS AND OUTPATIENTS WHO RECEIVED:

1. FREE CARE DURING THE IMMEDIATELY PRECEDING YEAR; AND

2. REDUCED–COST CARE FOR THE PRIOR YEAR;

(III) THE TOTAL NUMBER OF PATIENTS WHO RECEIVED FINANCIAL ASSISTANCE DURING THE IMMEDIATELY PRECEDING YEAR BY RACE OR ETHNICITY~~,~~ AND GENDER~~, AND ZIP CODE OF RESIDENCE~~;

(IV) THE TOTAL NUMBER OF PATIENTS WHO WERE DENIED FINANCIAL ASSISTANCE DURING THE IMMEDIATELY PRECEDING YEAR BY RACE OR ETHNICITY~~,~~ AND GENDER~~, AND ZIP CODE OF RESIDENCE~~;

(V) THE TOTAL AMOUNT OF THE COSTS OF HOSPITAL SERVICES PROVIDED TO PATIENTS WHO RECEIVED FREE CARE; AND

(VI) THE TOTAL AMOUNT OF THE COSTS OF HOSPITAL SERVICES PROVIDED TO PATIENTS WHO RECEIVED REDUCED–COST CARE THAT WAS EITHER

COVERED BY THE HOSPITAL AS FINANCIAL ASSISTANCE OR THAT THE HOSPITAL CHARGED TO THE PATIENT.

(K) (1) THE COMMISSION SHALL POST ON ITS WEBSITE EACH HOSPITAL'S FINANCIAL ASSISTANCE POLICY AND ANNUAL REPORT.

(2) THE COMMISSION SHALL COMPILE THE REPORTS REQUIRED UNDER SUBSECTION (J) OF THIS SECTION AND ISSUE A HOSPITAL FINANCIAL ASSISTANCE REPORT.

(3) THE HOSPITAL FINANCIAL ASSISTANCE REPORT REQUIRED UNDER PARAGRAPH (2) OF THIS SUBSECTION SHALL BE MADE AVAILABLE TO THE PUBLIC FREE OF CHARGE.

(4) ON OR BEFORE DECEMBER 1 EACH YEAR, THE COMMISSION SHALL SUBMIT A COPY OF THE ANNUAL HOSPITAL FINANCIAL ASSISTANCE REPORT ISSUED UNDER PARAGRAPH (2) OF THIS SUBSECTION, IN ACCORDANCE WITH § 2–1257 OF THE STATE GOVERNMENT ARTICLE, TO THE SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE.

19–214.3.

(A) (1) (I) THE COMMISSION SHALL ESTABLISH A PROCESS FOR A PATIENT OR ~~ANY MEMBER OF THE PUBLIC~~ A PATIENT'S AUTHORIZED REPRESENTATIVE TO FILE WITH THE COMMISSION A COMPLAINT AGAINST A HOSPITAL~~, A MEDICAL CREDITOR, OR AN OUTSIDE COLLECTION AGENCY REGARDING THE COLLECTION OF A PATIENT'S BILL~~ FOR AN ALLEGED VIOLATION OF § 19–214.1 OR § 19–214.2 OF THIS SUBTITLE.

(II) THE PROCESS ESTABLISHED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL:

1. INCLUDE THE OPTION FOR A PATIENT OR A PATIENT'S AUTHORIZED REPRESENTATIVE TO FILE THE COMPLAINT JOINTLY WITH THE COMMISSION AND THE HEALTH EDUCATION AND ADVOCACY UNIT; AND

2. PROVIDE THE PATIENT OR THE PATIENT'S AUTHORIZED REPRESENTATIVE WITH THE FOLLOWING INFORMATION:

A. THE HEALTH EDUCATION AND ADVOCACY UNIT IS AVAILABLE TO ASSIST THE PATIENT OR THE PATIENT'S AUTHORIZED REPRESENTATIVE IN FILING AND MEDIATING A RECONSIDERATION REQUEST; AND

B. THE ADDRESS, PHONE NUMBER, FACSIMILE NUMBER, E–MAIL ADDRESS, MAILING ADDRESS, AND WEBSITE OF THE HEALTH EDUCATION AND ADVOCACY UNIT.

(2) (I) ~~A~~ SUBJECT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH, A COMPLAINT FILED WITH THE COMMISSION IS A PUBLIC RECORD AND IS SUBJECT TO REASONABLE INSPECTION.

(II) THE COMMISSION SHALL DENY INSPECTION OF THE COMPLAINANT'S NAME, ADDRESS, OR ANY OTHER PERSONAL IDENTIFYING INFORMATION.

(3) THE FILING OF A COMPLAINT UNDER THIS SUBSECTION DOES NOT PREVENT AN INDIVIDUAL FROM:

(I) EXERCISING ANY RIGHT OR SEEKING ANY REMEDY TO WHICH THE INDIVIDUAL MAY OTHERWISE BE ENTITLED; OR

(II) FILING A COMPLAINT WITH ANY OTHER AGENCY OR A COURT.

~~**(B) IN ADDITION TO ANY ACTION BY THE COMMISSION AUTHORIZED UNDER THIS TITLE OR ANY OTHER ACTION AUTHORIZED BY LAW, AN INDIVIDUAL MAY BRING AN ACTION IN A COURT OF COMPETENT JURISDICTION IN THE STATE:**~~

~~**(1) TO RECOVER FOR INJURY OR LOSS SUSTAINED BY THE INDIVIDUAL AS THE RESULT OF A VIOLATION OF § 19–214.1, § 19–214.2, OR § 19–214.4 OF THIS SUBTITLE OR ANY REGULATION ADOPTED UNDER THIS SUBTITLE; AND**~~

~~**(2) FOR INJUNCTIVE OR OTHER EQUITABLE RELIEF INCLUDING:**~~

~~**(I) ENFORCING A HOSPITAL'S FINANCIAL ASSISTANCE POLICY ESTABLISHED UNDER § 19–214.1 OF THIS SUBTITLE;**~~

~~**(II) ENFORCING A HOSPITAL'S POLICY ON THE COLLECTION OF DEBTS OWED ON A HOSPITAL BILL BY PATIENTS ESTABLISHED UNDER § 19–214.1 OF THIS SUBTITLE; OR**~~

~~**(III) FOR ANY OTHER CONDUCT IN VIOLATION OF § 19–214.1, § 19–214.2, OR § 19–214.4 OF THIS SUBTITLE OR ANY REGULATION ADOPTED UNDER THIS SUBTITLE.**~~

~~(C) AN INDIVIDUAL WHO BRINGS AN ACTION UNDER THIS SECTION MAY ALSO SEEK:~~

~~(1) REASONABLE ATTORNEY'S FEES AND COSTS, INCLUDING EXPERT WITNESS FEES AND EXPENSES; AND~~

~~(2) PUNITIVE DAMAGES.~~

~~(D)~~ (B) **(1) THE REMEDIES AUTHORIZED UNDER THIS SECTION ARE IN ADDITION TO ANY OTHER STATUTORY, LEGAL, OR EQUITABLE REMEDIES THAT MAY BE AVAILABLE AND ARE NOT INTENDED TO BE A PREREQUISITE TO, OR EXCLUSIVE OF, ANY OTHER REMEDY.**

(2) AN INDIVIDUAL OR A GOVERNMENTAL UNIT IS NOT REQUIRED TO EXHAUST THE ADMINISTRATIVE REMEDY AUTHORIZED UNDER THIS SUBTITLE BEFORE FILING SUIT.

~~(E)~~ (C) **(1) A WAIVER BY ANY PATIENT OR OTHER INDIVIDUAL OF ANY PROTECTION PROVIDED BY § 19–214.1, § 19–214.2, OR § 19–214.4 OF THIS SUBTITLE OR ANY REGULATION ADOPTED UNDER THIS SUBTITLE IS NULL AND VOID AS BEING AGAINST THE PUBLIC POLICY OF THE STATE.**

(2) EXCEPT AS PROHIBITED BY FEDERAL LAW, A PROVISION IN A HOSPITAL'S FINANCIAL ASSISTANCE POLICY OR AGREEMENT BETWEEN THE PATIENT AND A HOSPITAL THAT WAIVES ANY SUBSTANTIVE OR PROCEDURAL RIGHT OR REMEDY RELATED TO CONDUCT PROHIBITED BY § 19–214.1, § 19–214.2, OR § 19–214.4 OF THIS SUBTITLE OR ANY REGULATION ADOPTED UNDER THIS SUBTITLE IS NULL AND VOID AS BEING AGAINST THE PUBLIC POLICY OF THE STATE.

[(a)**]** ~~(F)~~ (D) **(1)** If a hospital knowingly violates any provision of § 19–214.1 or § 19–214.2 of this subtitle or any regulation adopted under this subtitle, the Commission may impose a fine not to exceed ~~**[**~~$50,000~~**]**~~ **~~$100,000~~** per violation.

[(b)**]** **(2)** Before imposing a fine, the Commission shall consider the appropriateness of the fine in relation to the severity of the violation.

(3) A VIOLATION BY A HOSPITAL OR AN OUTSIDE COLLECTION AGENCY OF § 19–214.1 OR § 19–214.2 OF THIS SUBTITLE OR ANY REGULATION ADOPTED UNDER THIS SUBTITLE IS AN UNFAIR, ABUSIVE, AND DECEPTIVE TRADE PRACTICE UNDER THE MARYLAND CONSUMER PROTECTION ACT.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) ~~The~~ To the extent practicable, the Health Services Cost Review Commission shall ~~model~~ evaluate the impact that the changes ~~modeled~~ evaluated under subsection (b) of this section would have on:

(1) the amount of hospital uncompensated care included in hospital rates; and

(2) the total cost of care for:

(i) Medicare;

(ii) the Maryland Medical Assistance Program;

(iii) commercial insurers; and

(iv) self–pay individuals.

(b) ~~The~~ To the extent practicable, the Commission shall ~~model~~ evaluate the impact that the following changes to § 19–214.1 of the Health – General Article would have:

(1) increasing the ~~minimum~~ maximum free care ~~policy~~ threshold and minimum reduced–cost care threshold from 200% to:

(i) 250%;

(ii) 300%; and

(iii) 350%;

~~(2) increasing the reduced–cost care policy from 300% to:~~

~~(i) 350%;~~

~~(ii) 400%; and~~

~~(iii) 450%;~~

~~(3)~~ increasing the ~~medical hardship policy from~~ reduced–cost care with financial hardship threshold from 500% ~~to~~

~~(i) 550%;~~

~~(ii) 600%; and~~

~~(iii) 650%~~;

~~(4)~~ (3) reducing the financial hardship threshold for medical debt as a percentage of family income from 25% ~~of family income to:~~

~~(i) 20%;~~

~~(ii) 15%; and~~

~~(iii) 10%~~;

~~(5)~~ (4) including copays, coinsurance, and deductibles in the definition of medical debt; and

~~(6)~~ (5) in consultation with Maryland Department of Health and the Department of Human Services, expanding presumptive eligibility for reduced–cost care determination to patients who:

(i) are homeless;

(ii) receive benefits through the State Family Investment Program;

(iii) receive benefits through the Emergency Assistance to Families with Children Program;

(iv) ~~receive benefits through Maryland's Children's Health Insurance Program under Title XXI of the Social Security Act;~~

~~(v)~~ receive benefits through the Maryland Medical Assistance Program under Title XIX of the Social Security Act;

~~(vi)~~ (v) receive benefits through any federal Medicare savings program, including the Qualified Medicare Beneficiary program, and the specified low–income Medicare Beneficiary Program;

~~(vii)~~ (vi) ~~receive benefits through Maryland's Long–Term Care Medical Assistance Program;~~

~~(viii)~~ receive benefits through the Public Assistance to Adults Program;

~~(ix)~~ (vii) receive benefits through the Temporary Disability Assistance Program;

~~(x)~~ (viii) receive benefits through any other public assistance activities financed wholly or partly by the Family Investment Administration in the Department of Human Services; or

(xi) receive benefits from any other federal, State, or local public assistance program.

(c) On or before January 1, 2021, the Health Services Cost Review Commission shall report its findings and any recommendations to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2020.

Enacted under Article II, § 17(c) of the Maryland Constitution, May 8, 2020.