HB 565

Department of Legislative Services

Maryland General Assembly
2021 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 565 (Delegate Charkoudian)
Health and Government Operations Finance

Health Facilities - Hospitals - Medical Debt Protection

This bill outlines requirements relating to hospital debt collection policies and payment plans and prohibits a hospital from taking specified actions when collecting debt. A hospital must annually submit its policy on the collection of debts owed by patients as well as a specified report to the Health Services Cost Review Commission (HSCRC), which HSCRC must compile into an annual medical debt collection report. By December 1, 2021, the Maryland Health Care Commission (MHCC) must examine and report on the feasibility of using the State-designated Health Information Exchange (HIE) to support determination of patients' financial status for determining eligibility for free or reduced-cost care or an income-based payment plan. By January 1, 2022, HSCRC must develop and report on guidelines for an income-based payment plan and study the impact on uncompensated care of providing specified refunds or requiring hospitals to forgive specified judgments or strike specified adverse information. **The bill generally takes effect January 1, 2022; provisions related to HSCRC and MHCC study and reporting requirements take effect June 1, 2021.**

Fiscal Summary

State Effect: No effect in FY 2021. HSCRC special fund expenditures increase by $200,000 in FY 2022 only for contractual services; HSCRC can handle other requirements with existing budgeted resources. To the extent hospital rates increase from additional uncompensated care, Medicaid expenditures (61% federal funds, 39% general funds) and federal matching revenues increase beginning as early as FY 2022, as discussed below.

(in dollars)	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026
FF Revenue	-	-	-	-	-
SF Expenditure	$200,000	$0	$0	$0	$0
GF/FF Exp.	-	-	-	-	-
Net Effect	($200,000)	($-)	($-)	($-)0	($-)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary:

Financial Assistance Policies

In 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, a patient's family income must be calculated at the time of service or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial hospital bill is provided. Each hospital must develop an information sheet that includes a section that allows for patients to initial that they have been made aware of the financial assistance policy.

Debt Collection Policies

In addition to several existing requirements, each hospital's debt collection policy must now be submitted *annually* to HSCRC and must:

- allow the patient and the hospital to mutually agree to modify the terms of a payment plan offered or entered into;
- prohibit the hospital from collecting additional fees in an amount that exceeds the approved charge for the hospital service as established by HSCRC for which the medical debt is owed on a bill for a patient eligible for free or reduced-cost care under the hospital's financial assistance policy;
- prohibit the hospital from reporting to a consumer reporting agency or filing a civil action to collect debt within 180 days after the initial bill was provided;
- provide for a refund of amounts collected from a patient found eligible for free care within 240 days after the initial bill was provided; and
- require the hospital to seek to vacate a judgment or strike adverse information reported to a consumer reporting agency if the patient was found to be eligible for free care within 240 days after the initial bill was provided.

A hospital may not charge interest or fees on any debt incurred on or after the date of service by a patient who is eligible for free or reduced-cost care.

Payment Plans

Before a patient is discharged, with the hospital bill, on request, and in each written communication regarding collection of hospital debt, the hospital must provide to a patient, the patient's family, the patient's authorized representative, or the patient's legal guardian information about the availability of an installment payment plan for any debt owed. A patient must be deemed to be compliant with a payment plan if the patient makes at least 11 scheduled monthly payments within a 12-month period.

A hospital may not seek legal action against a patient on a debt owed until the hospital has established and implemented a payment plan policy that complies with guidelines developed by HSCRC. If a patient misses a scheduled monthly payment, the patient must contact the health care facility and identify a plan to make up the missed payment within one year after the date of the missed payment. The health care facility may (but may not be required to) waive any additional missed payments that occur within a 12-month period and allow the patient to continue to participate in the income-based payment plan and not refer the outstanding balance owed to a collection agency or for legal action.

Collections and Adverse Actions

A hospital must demonstrate that it attempted, in good faith, to offer a patient a payment plan that complies with HSCRC guidelines before the hospital files an action to collect a debt owed by a patient or delegates collection activity to a debt collector. A hospital is not prohibited from using an eligibility vendor to provide outreach to a patient for purposes of assisting the patient in qualifying for financial assistance. A hospital may not report adverse information to a consumer reporting agency regarding a patient who was uninsured or eligible for free or reduced-cost care at the time of service.

A hospital may not report adverse information about a patient to a consumer reporting agency, commence a civil action against a patient for nonpayment, or delegate collection activity to a debt collector if (1) the hospital was notified in accordance with federal law by the patient or an insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days or (2) the hospital has completed a requested reconsideration of the denial of free or reduced-cost care that was appropriately completed by the patient within the immediately preceding 60 days. If adverse information about a patient has been reported to a consumer reporting agency, the hospital must instruct the agency to delete the information if one of these criteria is met. Also, for at least 180 days after issuing an initial patient bill, a hospital may not report adverse information about a patient to a consumer reporting agency or commence civil action against a patient for nonpayment, regardless of whether the hospital can document the lack of cooperation of the patient (or the guarantor of the patient) in providing information needed to determine the patient's obligation with regard to the hospital bill.

In an attempt to collect debt owed on a hospital bill, a hospital may not, among other things:

- request a lien against a patient's primary residence;
- request the issuance of or take action causing a court to issue a body attachment or an arrest warrant against a patient;
- request a writ of garnishment of wages or file an action resulting in an attachment of wages if the patient is eligible for free or reduced-cost care;
- make a claim against the estate of a deceased patient if the deceased patient was known by the hospital to be eligible for free care or if the value of the estate after tax obligations are fulfilled is less than half of the debt owned (however, a hospital may offer the family of the deceased patient the ability to apply for financial assistance);
- file an action against a patient or give notice to a patient until after 180 days after the initial bill was provided; or
- file an action against a patient until the hospital determines whether the patient is eligible for free or reduced-cost care.

A spouse or another individual may not be held liable for the debt owed on a hospital bill of an individual who is at least 18 years old. However, an individual may voluntarily consent to assume liability for the debt owed, under specified circumstances.

At least 45 days before filing an action against a patient to collect on the debt owed, a hospital must send the patient written notice of the *intent* to file an action. The notice required must (1) be sent to the patient by certified mail and first-class mail; (2) be in simplified language; (3) include specified contact and procedural information; and (4) be provided in the patient's preferred language or another language, as specified. The notice must be accompanied by (1) an application for financial assistance under the hospital's financial assistance policy and instructions for completing the application; (2) the availability of a payment plan to satisfy the medical debt; and (3) a specified information sheet.

A complaint by a hospital in an action to collect a debt must include (1) an affidavit with specified information; (2) a copy of the original and most recent hospital bill; (3) a statement of the amount due; (4) a copy of the notice of intent to file an action; and (5) a copy of the patient's signed certified mail acknowledgement of receipt of the written notice of intent to file an action, if received by the hospital.

If a hospital delegates collection activity to a debt collector, the hospital must require a debt collector to, along with the hospital, be jointly and severally responsible for meeting the hospital debt collection requirements.

Required Reports

Hospital Reports: Each hospital must submit an annual report to HSCRC including (1) the number of patients against whom the hospital (or a debt collector used by the hospital) has filed an action to collect debt owed; (2) the number of patients the hospital has and has not reported or classified a bad debt; and (3) the total dollar amount of the charges for hospital services provided to patients but not collected by the hospital for patients covered by insurance, including the out-of-pocket costs for patients covered by insurance, and patients without insurance. Each report must be posted on the HSCRC website.

Annual Medical Debt Collection Report: By February 1, 2023, and annually thereafter, HSCRC must prepare a medical debt collection report based on the compiled information from hospitals. The report must be (1) made available to the public free of charge and (2) submitted to the Senate Finance Committee and the House Health and Government Operations Committee.

Guidelines for an Income-based Payment Plan: By January 1, 2022, HSCRC, with input from specified stakeholders, must develop guidelines for an income-based payment plan and report on the guidelines to the Senate Finance Committee and the House Health and Government Operations Committee. The guidelines must include (1) the amount of medical debt owed to the hospital; (2) the duration of the payment plan based on a patient's annual gross income; (3) guidelines for requiring appropriate documentation of income; (4) guidelines for the payment amount, which may not exceed 5% of the patient's adjusted gross monthly income and must consider financial hardship; (5) guidelines for the determination of possible interest payments for patients who do not qualify for free or reduced-cost care, which may not begin before 180 days after the due date of the first payment, and a prohibition on interest payments for patients who qualify for free or reduced-cost care; (6) guidelines for modification of a payment plan that does not create a greater financial burden on the patient; and (7) a prohibition on penalties or fees for prepayment or early payment.

Study on the Impact on Uncompensated Care: By January 1, 2022, HSCRC must study and report to the Senate Finance Committee and the House Health and Government Operations Committee on the impact on uncompensated care of (1) providing for a refund of amounts collected from patients who were later found to be eligible for reduced-cost care and (2) requiring a hospital to forgive a judgment or strike adverse information if a hospital obtains a judgment against, or reports adverse information to a consumer reporting agency about, patients who were later found to be eligible for reduced-cost care. If HSCRC determines that additional hospital data is required for the study, HSCRC must notify the hospital of the data required, and a hospital must submit the required data no later than 30 days after receiving the request.

Feasibility of Using the Health Information Exchange: MHCC must examine the feasibility of using the State-designated HIE to support the determination of financial status for purposes of determining eligibility for free or reduced-cost care or for an income-based payment plan. MHCC must report its findings to the Senate Finance Committee and the House Health and Government Operations Committee by December 1, 2021.

Current Law:

Hospital Financial Assistance and Hardship Policies

HSCRC requires each hospital 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. Hospital financial assistance policies must, at a minimum, provide free medically necessary care to patients with family income at or below 200% of the federal poverty level (FPL) and reduced-cost medically necessary care to patients with family income above 200% FPL.

HSCRC may establish higher income thresholds for financial assistance, but financial assistance policies must provide reduced-cost medically necessary care to patients with family income less than 500% FPL who have a financial hardship. For patients eligible for reduced-cost medically necessary care, the hospital must apply the reduction that is most favorable to the patient, whether that is the reduced-cost policy or financial hardship policy.

If a patient has received reduced-cost medically necessary care due to financial hardship, the patient (or any immediate family member living in the same household) remains eligible for reduced-cost care when seeking further care at the same hospital for 12 months following the initial care. The patient or family member must inform the hospital of his or her eligibility.

Hospital Debt Collection

A hospital must reasonably attempt to collect charges owed for care provided before writing the charges off as bad debt. A hospital will pursue payments from patients that do not apply or qualify for financial assistance or receive free or reduced-cost care and do not pay the remaining balance owed. Currently, there are no limits to the actions hospitals may take to collect debt owed.

Each hospital must develop and submit a debt collection policy to HSCRC. The debt collection policy must (1) provide for active oversight of any contract for collection of debts on behalf of the hospital; (2) prohibit the hospital from selling any debt; (3) prohibit the charging of interest on bills incurred by self-pay patients before a court judgment is obtained; (4) describe in detail the consideration by the hospital of patient income, assets,

and other criteria; (5) describe the hospital's procedures for collecting a debt; (6) describe the circumstances in which the hospital will seek a judgment against a patient; (7) provide for a refund of amounts collected from a patient who was later found to be eligible for free care; and (8) require the hospital to vacate the judgment or strike the adverse information reported if a patient is later found to be eligible for free care.

The policy must also provide a mechanism for a patient to (1) request the hospital reconsider the denial of free or reduced-cost care and (2) file with the hospital a complaint against the hospital or an outside collection agency regarding the handling of the patient's bill.

A hospital must provide a refund of amounts exceeding $25 collected from a patient (or the patient's guarantor) who, within a two-year period after the date of service, was found to be eligible for free care on the date of service. A hospital may reduce the two-year period to no less than 30 days after the date the hospital determines the patient's eligibility for free care, if the hospital documents the lack of cooperation of the patient in providing the requested information.

Health Services Cost Review Commission

HSCRC is an independent State agency charged with constraining hospital growth and establishing hospital rates to promote cost containment, access to care, equity, financial stability, and hospital accountability. HSCRC oversees acute and chronic care hospitals.

HSCRC may review costs and rates and make any investigation it considers necessary to assure each purchaser of health care facility services that (1) the total costs of all hospital services are reasonable; (2) the aggregate rates of the facility are related reasonably to the aggregate costs of the facility; and (3) the rates are set equitably among all purchasers. HSCRC may review and approve or disapprove the reasonableness of any rate that a facility sets or requests. Consistent with Maryland's all-payer model contract, HSCRC may establish hospital rate levels and rate increases in the aggregate or on a hospital-specific basis and promote and approve alternate methods of rate determination and payment that are of an experimental nature.

Under the Total Cost of Care Model (TCOC), the successor to the Maryland All-Payer Model Contract, hospital population-based revenues (commonly referred to as global budgets) are regulated by HSCRC. TCOC is designed to (1) improve population health; (2) improve care outcomes for individuals; and (3) control growth in the total cost of care for Medicare beneficiaries. Maryland commits to reaching a compounded annual Medicare savings target of $300 million through the end of calendar 2023 in Medicare Part A (*i.e.*, hospital services) and Part B (*i.e.*, doctor visits, preventive services, and other nonhospital services) under TCOC. Net TCOC savings are estimated to be $1.065 billion.

Prior to the end of calendar 2022, the federal Center for Medicare and Medicaid Innovation will assess the State's progress and determine if TCOC is on track to meet its savings goal.

Uncompensated Care

Any medical debt incurred by patients and not collected by a hospital will result in uncompensated care provided by the hospital. Uncompensated care is care provided for which no compensation is received, typically a combination of charity care, financial assistance, and bad debt. HSCRC must factor the cost of uncompensated care into the State's hospital rate-setting structure. Each year, HSCRC determines the total amount of uncompensated care that will be placed in hospital rates for the year and the amount of funding available for the uncompensated care pool. Regulated hospitals draw funds from the pool if they experience greater-than-average levels of uncompensated care, and pay into the pool if they experience a below average level of uncompensated care, ensuring the total cost of uncompensated care is shared equally across all hospitals within the State.

According to the Maryland Department of Health, uncompensated care has decreased due to coverage expansions implemented in 2014 under the federal Patient Protection and Affordable Care Act, which included expansion of Medicaid eligibility to 138% FPL. The uninsured rate has decreased from 10.2% in 2013, to 5.9% in 2019. As a result, the uncompensated care provision included in rate setting has remained relatively stable in recent years. For fiscal 2021, the uncompensated care provision included in rates was 4.41%.

State-designated Health Information Exchange

MHCC designated the Chesapeake Regional Information System for our Patients (CRISP) as the statewide HIE in 2009, and the infrastructure became operational in 2010. An HIE allows clinical information to move electronically among disparate health information systems. CRISP offers tools aimed at improving the facilitation of care for the region's health care providers. Consumers can opt out of having their information included in an HIE.

State Fiscal Effect: The bill restricts the actions hospitals may take to recover medical debt owed by patients, which in turn increases uncompensated care, by a potentially significant amount, and hospital rates from which uncompensated care is funded. Hospital rates are paid by all payers in the State. As such, expenditures for health insurers, Medicaid, and self-pay patients will increase. However, the amount of any such impact cannot be reliably estimated without knowing the total balance of medical debt owed by each patient in the State and the impact of the bill on each hospital's ability to collect such debt.

To the extent hospital rates increase, Medicaid expenditures (61% federal funds, 39% general funds) increase and federal matching revenues increase accordingly. Any impact of the bill on TCOC savings is also indeterminate and is not reflected in this analysis. Assuming the bill applies to debt existing on January 1, 2022, these impacts may be observed as early as fiscal 2022; otherwise, they are likely delayed to fiscal 2023 and beyond.

HSCRC can compile reports from hospitals, post them on the HSCRC website, produce an annual medical debt report, and submit the required report on the impact on uncompensated care using existing budgeted resources. However, the bill also requires HSCRC, by January 1, 2022, to develop guidelines for an income-based payment plan, which must include multiple factors. HSCRC advises that it does not have expertise in consumer debt policy, interest, collection processes, or the legal processes related to actions on consumer debt to prepare these guidelines. Thus, HSCRC special fund expenditures increase by an estimated $200,000 in fiscal 2022 for one-time-only contractual services to develop the guidelines for an income-based payment plan.

MHCC can examine the feasibility of using the State-designated HIE to support the determination of financial status for purposes of determining eligibility for free or reduced-cost care or for an income-based payment plan using existing budgeted resources.

Additional Information

Prior Introductions: HB 1081 of 2020, a similar bill, received a hearing in the House Health and Government Operations, but was withdrawn. Its cross file, SB 873, was referred to the Senate Finance Committee, but was withdrawn.

Designated Cross File: SB 514 (Senator Feldman, *et al.*) - Finance.

Information Source(s): Office of the Attorney General; Judiciary (Administrative Office of the Courts); Maryland Department of Health; Maryland Department of Labor; Department of Legislative Services

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