SENATE BILL 328

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CF HB 933

By: **Senators Middleton ~~and Della~~, Della, Exum, Kelley, Klausmeier, and Pugh**
Introduced and read first time: January 28, 2010
Assigned to: Finance

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: February 11, 2010

CHAPTER _____

AN ACT concerning

Hospitals – Financial Assistance and Debt Collection

FOR the purpose of requiring the State Health Services Cost Review Commission to require certain chronic care hospitals to develop a certain financial assistance policy for providing free and reduced–cost care to certain patients; requiring a certain hospital financial assistance policy to provide reduced–cost medically necessary care to certain patients who have a financial hardship; requiring a hospital to apply a reduction that is most favorable to a patient under certain circumstances; providing that a patient or ~~any family member~~ certain family members of the patient shall remain eligible for certain reduced–cost care under certain circumstances; requiring the patient or family member to inform a hospital of the patient's or family member's eligibility for certain reduced–cost care under certain circumstances; altering the requirements for a notice that a hospital must post regarding patient financial assistance; specifying that, for certain purposes, the rights and obligations of a patient with regard to a hospital bill include the rights and obligations with regard to certain reduced–cost care; requiring a hospital's policy on the collection of debts owed by patients to provide for a refund of certain amounts collected from a patient or the guarantor of a patient, require the hospital to seek to vacate a judgment or strike adverse information reported to a consumer reporting agency under certain circumstances, and provide a mechanism for a patient to request a reconsideration of the denial of free or reduced–cost care and file a complaint regarding the handling of the patient's bill; requiring a hospital, beginning on a certain date, to provide for a refund of certain amounts collected from a patient or the guarantor of a patient who, within a certain time period, was found to be

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

eligible for free care; authorizing a hospital to reduce the time period under certain circumstances; requiring a hospital's refund ~~to policy~~ policy to provide for a refund that complies with a patient's means–tested government health care plan under certain circumstances; prohibiting a hospital, for a certain period of time, from reporting adverse information about a patient to a consumer reporting agency or commencing civil action against a patient for nonpayment of a bill unless the hospital documents a certain lack of cooperation; requiring a hospital to ~~promptly~~ report to a certain consumer reporting agency the fulfillment of a patient's payment obligation within a certain period of time; prohibiting a hospital from forcing the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill; authorizing a hospital to maintain its position as a secured creditor under certain circumstances; requiring a hospital to fulfill certain requirements if the hospital delegates collection activity to an outside collection agency; requiring the board of directors of each hospital to review and approve the financial assistance and debt collection policies of the hospital at certain intervals; prohibiting a hospital from altering its financial assistance and debt collection policies without approval of its board of directors; requiring a hospital to provide to a patient, on request, a written estimate of certain charges; requiring the written estimate to include a certain statement; authorizing a hospital to restrict the availability of the written estimate; providing that the requirements pertaining to written estimates do not apply to emergency services; defining certain terms; making certain conforming changes; and generally relating to hospital financial assistance and debt collection requirements.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–214.1, 19–214.2, and 19–350(b)
Annotated Code of Maryland
(2009 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 COPAYMENTS, COINSURANCE, AND DEDUCTIBLES, FOR MEDICAL COSTS BILLED BY A HOSPITAL.

[(a)**] (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% of the federal poverty level; ~~[~~and~~]~~

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

~~(III) REDUCED–COST MEDICALLY NECESSARY CARE TO PATIENTS WITH FAMILY INCOME BELOW 500% OF THE FEDERAL POVERTY LEVEL WHO HAVE A FINANCIAL HARDSHIP~~.

(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.

~~(4)~~ (5) IF A PATIENT IS ELIGIBLE FOR REDUCED–COST MEDICALLY NECESSARY CARE UNDER BOTH ~~PARAGRAPH~~ PARAGRAPHS (2)(II) AND ~~(III)~~ (4) OF THIS SUBSECTION, THE HOSPITAL SHALL APPLY THE REDUCTION THAT IS MOST FAVORABLE TO THE PATIENT.

~~(5)~~ (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.

[(b)**] (C)** A hospital shall post a notice in conspicuous places throughout the hospital, including the billing office, **[**describing the financial assistance policy and how to apply for free and reduced–cost care**] INFORMING PATIENTS OF THEIR RIGHT TO APPLY FOR FINANCIAL ASSISTANCE AND WHO TO CONTACT AT THE HOSPITAL FOR ADDITIONAL INFORMATION**.

[(c)**] (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.

[(d)**] (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.

[(e)**] (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.

(2) 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.

(3) The hospital bill shall include a reference to the information sheet.

(4) 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.

[(f)**] (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.

19–214.2.

(a) Each hospital shall submit to the Commission, at times prescribed by the Commission, the hospital's policy on the collection of debts owed by patients.

(b) The policy shall:

(1) Provide for active oversight by the hospital 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; **[**and**]**

(6) Describe the circumstances in which the hospital will seek a judgment against a patient**;**

(7) IN ACCORDANCE WITH SUBSECTION (C) OF THIS SECTION, PROVIDE FOR A REFUND OF AMOUNTS COLLECTED FROM A PATIENT OR THE GUARANTOR OF A PATIENT WHO WAS LATER FOUND TO BE ELIGIBLE FOR FREE CARE ON THE DATE OF SERVICE;

(8) IF THE HOSPITAL HAS OBTAINED A JUDGMENT AGAINST OR REPORTED ADVERSE INFORMATION TO A CONSUMER REPORTING AGENCY ABOUT A PATIENT WHO LATER WAS FOUND TO BE ELIGIBLE FOR FREE CARE ON THE DATE OF THE SERVICE FOR WHICH THE JUDGMENT WAS AWARDED OR THE ADVERSE INFORMATION WAS REPORTED, REQUIRE THE HOSPITAL TO SEEK TO VACATE THE JUDGMENT OR STRIKE THE ADVERSE INFORMATION; AND

(9) PROVIDE A MECHANISM FOR A PATIENT TO:

(I) REQUEST THE HOSPITAL TO RECONSIDER THE DENIAL OF FREE OR REDUCED–COST CARE; AND

(II) FILE WITH THE HOSPITAL A COMPLAINT AGAINST THE HOSPITAL OR AN OUTSIDE COLLECTION AGENCY USED BY THE HOSPITAL REGARDING THE HANDLING OF THE PATIENT'S BILL.

(C) (1) BEGINNING OCTOBER 1, 2010, A HOSPITAL SHALL PROVIDE FOR A REFUND OF AMOUNTS EXCEEDING $25 COLLECTED FROM A PATIENT OR THE GUARANTOR OF A PATIENT WHO, WITHIN A 2–YEAR PERIOD AFTER THE DATE OF SERVICE, WAS FOUND TO BE ELIGIBLE FOR FREE CARE ON THE DATE OF SERVICE.

(2) A HOSPITAL MAY REDUCE THE 2–YEAR PERIOD UNDER PARAGRAPH (1) OF THIS SUBSECTION TO NO LESS THAN 30 DAYS AFTER THE DATE THE HOSPITAL REQUESTS INFORMATION FROM A PATIENT, OR THE GUARANTOR OF A PATIENT, TO DETERMINE THE PATIENT'S ELIGIBILITY FOR FREE CARE AT THE TIME OF SERVICE, IF THE HOSPITAL DOCUMENTS THE LACK OF COOPERATION OF THE PATIENT OR THE GUARANTOR OF A PATIENT IN PROVIDING THE REQUESTED INFORMATION.

(3) IF A PATIENT IS ENROLLED IN A MEANS–TESTED GOVERNMENT HEALTH CARE PLAN THAT REQUIRES THE PATIENT TO PAY OUT–OF–POCKET FOR HOSPITAL SERVICES, A HOSPITAL'S REFUND POLICY SHALL PROVIDE FOR A REFUND THAT COMPLIES WITH THE TERMS OF THE PATIENT'S PLAN.

(D) (1) FOR AT LEAST 120 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 UNLESS THE HOSPITAL DOCUMENTS 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.

(2) A HOSPITAL ~~PROMPTLY~~ SHALL REPORT THE FULFILLMENT OF A PATIENT'S PAYMENT OBLIGATION WITHIN 60 DAYS AFTER THE OBLIGATION IS FULFILLED TO ANY CONSUMER REPORTING AGENCY TO WHICH THE HOSPITAL HAD REPORTED ADVERSE INFORMATION ABOUT THE PATIENT.

(E) (1) A HOSPITAL MAY NOT FORCE THE SALE OR FORECLOSURE OF A PATIENT'S PRIMARY RESIDENCE TO COLLECT A DEBT OWED ON A HOSPITAL BILL.

(2) IF A HOSPITAL HOLDS A LIEN ON A PATIENT'S PRIMARY RESIDENCE, THE HOSPITAL MAY MAINTAIN ITS POSITION AS A SECURED CREDITOR WITH RESPECT TO OTHER CREDITORS TO WHOM THE PATIENT MAY OWE A DEBT.

(F) IF A HOSPITAL DELEGATES COLLECTION ACTIVITY TO AN OUTSIDE COLLECTION AGENCY, THE HOSPITAL SHALL:

(1) SPECIFY THE COLLECTION ACTIVITY TO BE PERFORMED BY THE OUTSIDE COLLECTION AGENCY THROUGH AN EXPLICIT AUTHORIZATION OR CONTRACT;

(2) REQUIRE THE OUTSIDE COLLECTION AGENCY TO ABIDE BY THE HOSPITAL'S CREDIT AND COLLECTION POLICY;

(3) SPECIFY PROCEDURES THE OUTSIDE COLLECTION AGENCY MUST FOLLOW IF A PATIENT APPEARS TO QUALIFY FOR FINANCIAL ASSISTANCE; AND

(4) REQUIRE THE OUTSIDE COLLECTION AGENCY TO:

(I) IN ACCORDANCE WITH THE HOSPITAL'S POLICY, PROVIDE A MECHANISM FOR A PATIENT TO FILE WITH THE HOSPITAL A COMPLAINT AGAINST THE HOSPITAL OR THE OUTSIDE COLLECTION AGENCY REGARDING THE HANDLING OF THE PATIENT'S BILL; AND

(II) IF A PATIENT FILES A COMPLAINT WITH THE COLLECTION AGENCY, FORWARD THE COMPLAINT TO THE HOSPITAL.

(G) (1) THE BOARD OF DIRECTORS OF EACH HOSPITAL SHALL REVIEW AND APPROVE THE FINANCIAL ASSISTANCE AND DEBT COLLECTION POLICIES OF THE HOSPITAL AT LEAST EVERY ~~3~~ 2 YEARS.

(2) A HOSPITAL MAY NOT ALTER ITS FINANCIAL ASSISTANCE OR DEBT COLLECTION POLICIES WITHOUT APPROVAL BY THE BOARD OF DIRECTORS.

[(c)**] (H)** The Commission shall review each hospital's implementation of and compliance with the hospital's **[**policy**] POLICIES** and the requirements of **[**subsection (b) of**]** this section.

19–350.

(b) **(1) (I) ON REQUEST OF A PATIENT MADE BEFORE OR DURING TREATMENT, A HOSPITAL SHALL PROVIDE TO THE PATIENT A WRITTEN ESTIMATE OF THE TOTAL CHARGES FOR THE HOSPITAL SERVICES, PROCEDURES, AND SUPPLIES THAT REASONABLY ARE EXPECTED TO BE PROVIDED AND BILLED TO THE PATIENT BY THE HOSPITAL.**

(II) THE WRITTEN ESTIMATE SHALL STATE CLEARLY THAT IT IS ONLY AN ESTIMATE AND ACTUAL CHARGES COULD VARY.

(III) A HOSPITAL MAY RESTRICT THE AVAILABILITY OF A WRITTEN ESTIMATE TO NORMAL BUSINESS OFFICE HOURS.

(IV) THIS PARAGRAPH DOES NOT APPLY TO EMERGENCY SERVICES.

[(1)**] (2)** Within 30 days after discharge of an individual from a hospital, the hospital shall give the individual a summary financial statement that clearly describes:

(i) The total charges incurred;

(ii) If readily ascertainable, a summary of the total charges under the major services categories, including:

1. Room and board;

2. Diagnostic services;

3. Therapeutic services;

4. Emergency room services;

5. Drugs and IV solutions; and

6. Miscellaneous other supplies and services;

(iii) If applicable, the name of the primary and secondary insurer to which a claim has been or will be filed on the individual's behalf;

(iv) That charges for services provided by a physician are not included in the total hospital charges and are billed separately; and

(v) The individual's right to request an itemized statement of the account within 1 year of receipt of the summary statement.

[(2)**] (3)** Within 30 days after an individual's request as provided under paragraph **[**(1)(v)**] (2)(V)** of this subsection, the hospital shall provide the individual a statement of the account that:

(i) Is itemized; and

(ii) Describes briefly but clearly each item and the amount charged for it.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2010.

Approved:

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Governor.

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President of the Senate.

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Speaker of the House of Delegates.