SB0514/447876/1

BY: Finance Committee

AMENDMENTS TO SENATE BILL 514
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in the sponsor line, strike "and Pinsky" and substitute "Pinsky, Benson, Hayes, Hershey, and Jennings"; in line 4, after "policy;" insert "requiring that the description of a hospital's financial assistance policy that is included on a certain information sheet include a certain section;"; in line 6, after "the" insert "Health Services Cost Review"; strike beginning with "requiring" in line 8 down through "bills;" in line 11 and substitute "prohibiting a hospital from charging interest or fees on certain debts incurred by certain patients;"; strike beginning with "prohibiting" in line 15 down through "period;" in line 19 and substitute "requiring the Health Services Cost Review Commission to develop certain guidelines, with input from stakeholders, for an income–based payment plan; prohibiting a hospital from seeking legal action against a patient on a debt owed until the hospital has implemented a certain payment plan;"; in line 20, after "circumstances;" insert "requiring a patient to contact the health care facility and identify a certain plan under certain circumstances; authorizing a health care facility to waive certain payments required in a payment plan under certain circumstances; providing that a health care facility may not be required to waive certain payments;"; in line 21, after "requirements" insert "and guidelines"; and in line 22, after "actions;" insert "providing that certain provisions of this Act do not prohibit a hospital from using a certain vendor for a certain purpose;".

On page 2, strike beginning with "prohibiting" in line 2 down through "amount;" in line 5; in line 6, after "patient" insert "under certain circumstances; authorizing a hospital to offer the family of a certain patient the ability to apply for financial assistance"; strike beginning with "against" in line 6 down through "or" in line 7; strike beginning with "prohibiting" in line 7 down through "debt;" in line 8; in line 16, after "the" insert "Health Services Cost Review"; in line 17, after "Commission" insert ", on or before a certain date,"; in the same line, after "to" insert "compile certain information

(Over)

and"; in the same line, strike "annual"; in line 20, after "changes;" insert "requiring the Health Services Cost Review Commission, on or before a certain date and with input from certain stakeholders, to develop certain guidelines; requiring the Health Services Cost Review Commission, on or before a certain date, to report to certain committees of the General Assembly on certain guidelines; requiring the Health Services Cost Review Commission to conduct a certain study on uncompensated care; requiring the Maryland Health Care Commission to examine the feasibility of using the State–designated Health Information Exchange for a certain purpose and to make a certain report to certain committees of the General Assembly on or before a certain date; providing for a delayed effective date;"; and in line 29, after "(ii)" insert "and (f)(1)(i)".

AMENDMENT NO. 2

On page 3, after line 11, insert:

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

(i) Describes the hospital's financial assistance policy **AND INCLUDES A SECTION THAT ALLOWS FOR A PATIENT TO INITIAL THAT THE PATIENT HAS BEEN MADE AWARE OF THE FINANCIAL ASSISTANCE POLICY**;";

in line 24, strike "**COSTS OF**" and substitute "**CHARGES FOR**"; and in line 26, after "**INSURANCE**" insert "**, INCLUDING THE OUT–OF–POCKET COSTS FOR PATIENTS COVERED BY INSURANCE,**".

AMENDMENT NO. 3

On page 4, in line 14, strike the brackets; in line 15, strike "**OR REDUCED–COST**"; strike beginning with "**MORE**" in line 15 down through "**POSTDISCHARGE**" in line 16 and substitute "**WITHIN 240 DAYS AFTER THE INITIAL**"; in line 18, strike the brackets; in line 19, strike "**OR REDUCED–COST**"; and strike beginning with "**MORE**" in line 19 down through "**POSTDISCHARGE**" in line 20 and substitute "**WITHIN 240 DAYS AFTER THE INITIAL**".

On page 5, in line 1, strike "**COST OF THE HOSPITAL SERVICE**" and substitute "**APPROVED CHARGE FOR THE HOSPITAL SERVICE AS ESTABLISHED BY THE COMMISSION**"; in line 6, strike "**OR REDUCED–COST**"; strike beginning with "**OR**" in line 10 down through "**REDUCED–COST**" in line 11; strike beginning with "**IF**" in line 17 down through "**CHARGE**" in line 21 and substitute "**A HOSPITAL MAY NOT CHARGE**"; and strike beginning with the semicolon in line 23 down through "**DISCHARGE**" in line 27.

On page 6, strike in their entirety lines 7 through 23, inclusive, and substitute:

"**(3) (I) THE COMMISSION SHALL DEVELOP GUIDELINES, WITH INPUT FROM STAKEHOLDERS, FOR AN INCOME–BASED PAYMENT PLAN OFFERED UNDER THIS SUBSECTION THAT INCLUDES:**

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 LEVEL;

4. GUIDELINES FOR THE PAYMENT AMOUNT THAT:

A. MAY NOT EXCEED 5% OF THE INDIVIDUAL PATIENT'S FEDERAL OR STATE ADJUSTED GROSS MONTHLY INCOME; AND

B. SHALL CONSIDER FINANCIAL HARDSHIP, AS DEFINED IN § 19–214.1(A) OF THIS SUBTITLE;

5. GUIDELINES FOR:

A. 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

B. 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.

(II) 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 THE GUIDELINES DEVELOPED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH.";

in lines 24 and 27, strike "**(5)**" and "**(6)**", respectively, and substitute "**(4) (I)**" and "**(5) (I)**", respectively; after line 26, insert:

"**(II) IF A PATIENT MISSES A SCHEDULED MONTHLY PAYMENT, THE PATIENT SHALL CONTACT THE HEALTH CARE FACILITY AND IDENTIFY A PLAN TO MAKE UP THE MISSED PAYMENT WITHIN 1 YEAR AFTER THE DATE OF THE MISSED PAYMENT.**

(III) 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.";

in line 28, after "**SUBSECTION**" insert "**AND THE GUIDELINES DEVELOPED BY THE COMMISSION UNDER PARAGRAPH (3) OF THIS SUBSECTION**"; and in line 29, strike "**(I)**" and substitute "**1.**".

On page 7, in line 2, strike "**(II)**" and substitute "**2.**"; after line 3, insert:

"**(II) SUBPARAGRAPH (I) OF THIS PARAGRAPH DOES NOT PROHIBIT A HOSPITAL FROM USING AN ELIGIBILITY VENDOR TO PROVIDE OUTREACH TO A PATIENT FOR PURPOSES OF ASSISTING THE PATIENT IN QUALIFYING FOR FINANCIAL ASSISTANCE.**";

in line 4, strike the third set of brackets; in line 5, strike "**THE FIRST POSTDISCHARGE BILL WAS PROVIDED**"; in line 21, strike "**INFORMED**" and substitute "**NOTIFIED IN ACCORDANCE WITH FEDERAL LAW**"; in line 23, strike "**, AND UNTIL 60 DAYS AFTER THE APPEAL IS COMPLETE**" and substitute "**WITHIN THE IMMEDIATELY PRECEDING 60 DAYS**"; in line 24, strike "**UNTIL 60 DAYS AFTER**" and substitute "**IF**"; and in line 25, after "**CARE**" insert "**THAT WAS APPROPRIATELY COMPLETED BY THE PATIENT WITHIN THE IMMEDIATELY PRECEDING 60 DAYS**".

On page 8, strike beginning with "**FIRST**" in line 9 down through "**POSTDISCHARGE**" in line 10 and substitute "**INITIAL**"; strike in their entirety lines 21 and 22; in line 23, strike "**(6)**" and substitute "**(5) (I)**"; in line 24, after "**BILL**" insert "**IF THE DECEASED PATIENT WAS KNOWN BY THE HOSPITAL TO BE ELIGIBLE FOR**

FREE CARE UNDER § 19–214.1 OF THIS SUBTITLE OR IF THE VALUE OF THE ESTATE AFTER TAX OBLIGATIONS ARE FULFILLED IS LESS THAN HALF OF THE DEBT OWED.

(II) A HOSPITAL MAY OFFER THE FAMILY OF THE DECEASED PATIENT THE ABILITY TO APPLY FOR FINANCIAL ASSISTANCE";

in line 25, strike "**(7)**" and substitute "**(6)**"; and strike beginning with the colon in line 26 down through "**UNTIL**" in line 29 and substitute "**UNTIL**".

On page 9, strike in their entirety the lines 1 through 3, inclusive; strike beginning with "**AS**" in line 24 down through "**COMMISSION**" in line 25.

On page 10, in line 8, strike "**NONPROFIT AND GOVERNMENT RESOURCES, INCLUDING**"; in line 12, after "**POLICY;**" insert "**AND**"; strike in their entirety lines 13 through 19, inclusive; and in line 20, strike "**8.**" and substitute "**6.**".

On page 11, in line 22, strike "**ORAL NOTICE**" and substitute "**NOTICE**"; and in line 23, after "**POLICY**" insert "**AS DOCUMENTED UNDER § 19–214.1(F) OF THIS SUBTITLE**".

On page 12, in line 12, after "**BILL;**" insert "**AND**"; and strike in their entirety lines 13 through 18, inclusive, and substitute:

"**(VI) A COPY OF THE PATIENT'S SIGNED CERTIFIED MAIL ACKNOWLEDGMENT OF RECEIPT OF THE WRITTEN NOTICE OF INTENT TO FILE AN ACTION, IF RECEIVED BY THE HOSPITAL.**".

AMENDMENT NO. 4

On page 13, in line 10, strike "**THE**" and substitute "**ON OR BEFORE FEBRUARY 1 EACH YEAR, BEGINNING IN 2023, THE**"; strike beginning with "**PREPARE**" in line 10 down through "**DEBT**" in line 12 and substitute "**COMPILE THE INFORMATION REQUIRED UNDER SUBSECTION (A) OF THIS SECTION AND PREPARE A MEDICAL DEBT COLLECTION REPORT BASED ON THE COMPILED INFORMATION**"; after line 18, insert:

"SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) On or before January 1, 2022, the Commission shall develop guidelines, with input from stakeholders, for an income–based payment plan offered under this subsection that includes:

(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 level;

(4) guidelines for the payment amount, that:

(i) may not exceed 5% of the individual patient's federal or State adjusted gross monthly income; and

(ii) shall consider financial hardship, as defined in § 19–214.1(a) of the Health – General Article;

(5) guidelines for:

(i) 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

(ii) a prohibition on interest payments for patients who qualify for free or reduced–cost care;

(6) guidelines for modification of a repayment 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.

(b) In developing the payment plan guidelines required under subsection (a) of this section, the Health Services Cost Review Commission shall seek input from stakeholders, including the Maryland Hospital Association, Maryland Insurance Administration, Office of the Attorney General, labor unions that represent the health care sector, a statewide nonprofit consumer rights group; patients' rights organizations, legal service providers who work with patients who have experienced medical debt; and patients who have experienced medical debt.

(c) On or before January 1, 2022, the Commission shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, on the guidelines required under subsection (a) of this section.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) The Health Services Cost Review Commission shall study the impact on uncompensated care of:

(1) providing for a refund of amounts collected from patients or guarantors of patients who were later found by the hospital 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 by the hospital to be eligible for reduced–cost care.

(b) (1) In conducting the study required under subsection (a) of this section, if the Health Services Cost Review Commission determines that additional hospital data is required, the Commission shall notify the hospital of the data that is required.

(2) Not later than 30 days after receiving notification from the Commission under paragraph (1) of this subsection, a hospital shall submit the required data to the Commission.

(c) On or before January 1, 2022, the Health Services Cost Review Commission shall report the findings of the study required under subsection (a) of this section to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article.

SECTION 4. AND BE IT FURTHER ENACTED, That the Maryland Health Care Commission shall:

(1) examine the feasibility of using the State–designated Health Information Exchange 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; and

(2) on or before December 1, 2021, report the findings from the examination required under item (1) of this section to the Senate Finance Committee

and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article.";

in line 19, strike "2." and substitute "5."; and strike beginning with "this" in line 19 down through "2021" in line 20 and substitute "Sections 2, 3, and 4 of this Act shall take effect June 1, 2021.

SECTION 6. AND BE IT FURTHER ENACTED, That, except as provided in Section 5 of this Act, this Act shall take effect January 1, 2022".