SENATE BILL 981

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CF HB 268

By: ~~Senator Hershey~~ **Senators Hershey, Beidle, Gile, Hayes, C. Jackson, Kramer, Lam, Mautz, Ready, and A. Washington**
Introduced and read first time: January 28, 2025
Assigned to: Finance

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: February 21, 2025

CHAPTER _____

AN ACT concerning

Hospitals – Financial Assistance and Collection of Debts – Policies

FOR the purpose of excluding a civil action on a certain contract between a hospital and a consumer from a certain provision of law establishing the statute of limitations on civil actions on certain specialties; altering provisions of law related to a hospital's financial assistance and collection of debts policies; specifying the percentage by which a hospital is required to reduce a patient's out–of–pocket expenses under certain circumstances; adding to the notice requirements relating to a hospital's financial assistance policy; prohibiting a hospital from filing a civil action to collect a debt against a patient whose outstanding debt is at or below a certain amount; altering the monthly payment amount for an income–based payment plan for medical debt; increasing the number of days before interest payments on medical debt may be assessed; increasing the number of days before a hospital is authorized to commence civil action against a patient to collect a debt; and generally relating to hospital financial assistance and collection of debts policies.

BY repealing and reenacting, without amendments,
Article – Courts and Judicial Proceedings
Section 5–101 and 5–1201(a) and (e)
Annotated Code of Maryland
(2020 Replacement Volume and 2024 Supplement)

BY repealing and reenacting, with amendments,
Article – Courts and Judicial Proceedings

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.

Section 5–102
Annotated Code of Maryland
(2020 Replacement Volume and 2024 Supplement)

BY repealing and reenacting, without amendments,
Article – Health – General
Section 19–201(a) and (e) and 19–301(a) and (f)
Annotated Code of Maryland
(2023 Replacement Volume and 2024 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–214.1 and 19–214.2
Annotated Code of Maryland
(2023 Replacement Volume and 2024 Supplement)

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

Article – Courts and Judicial Proceedings

5–101.

A civil action at law shall be filed within three years from the date it accrues unless another provision of the Code provides a different period of time within which an action shall be commenced.

5–102.

(a) An action on one of the following specialties shall be filed within 12 years after the cause of action accrues, or within 12 years from the date of the death of the last to die of the principal debtor or creditor, whichever is sooner:

(1) Promissory note or other instrument under seal;

(2) Bond except a public officer's bond;

(3) Judgment;

(4) Recognizance;

(5) Contract under seal; or

(6) Any other specialty.

(b) A payment of principal or interest on a specialty suspends the operation of this section as to the specialty for three years after the date of payment.

(c) This section does not apply to:

(1) A specialty taken for the use of the State; **[**or**]**

(2) A deed of trust, mortgage, or promissory note that has been signed under seal and secures or is secured by owner–occupied residential property, as defined in § 7–105.1 of the Real Property Article**; OR**

(3) A CONTRACT, INCLUDING A CONTRACT UNDER SEAL, OR A PROMISSORY NOTE OR OTHER INSTRUMENT UNDER SEAL THAT IS:

(I) RELATED TO AN OBLIGATION OF A CONSUMER TO PAY CONSUMER DEBT, AS DEFINED IN § 5–1201 OF THIS TITLE, THAT ARISES FROM HOSPITAL SERVICES, AS DEFINED IN § 19–201 OF THE HEALTH – GENERAL ARTICLE; AND

(II) BETWEEN A CONSUMER AND A HOSPITAL, AS DEFINED IN § 19–301 OF THE HEALTH – GENERAL ARTICLE.

5–1201.

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

(e) "Consumer debt" means a secured or an unsecured debt that:

(1) Is for money owed or alleged to be owed; and

(2) Arises from a consumer transaction.

Article – Health – General

19–201.

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

(e) (1) "Hospital services" means:

(i) Inpatient hospital services as enumerated in Medicare Regulation 42 C.F.R. § 409.10, as amended;

(ii) Emergency services, including services provided at a freestanding medical facility licensed under Subtitle 3A of this title;

(iii) Outpatient services provided at a hospital;

(iv) Outpatient services, as specified by the Commission in regulation, provided at a freestanding medical facility licensed under Subtitle 3A of this title that has received:

1. A certificate of need under § 19–120(o)(1) of this title; or

2. An exemption from obtaining a certificate of need under § 19–120(o)(3) of this title; and

(v) Identified physician services for which a facility has Commission–approved rates on June 30, 1985.

(2) "Hospital services" includes a hospital outpatient service:

(i) Of a hospital that, on or before June 1, 2015, is under a merged asset hospital system;

(ii) That is designated as a part of another hospital under the same merged asset hospital system to make it possible for the hospital outpatient service to participate in the 340B Program under the federal Public Health Service Act; and

(iii) That complies with all federal requirements for the 340B Program and applicable provisions of 42 C.F.R. § 413.65.

(3) "Hospital services" does not include:

(i) Outpatient renal dialysis services; or

(ii) Outpatient services provided at a limited service hospital as defined in § 19–301 of this title, except for emergency services.

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**]** **INCLUDING** co–payments, coinsurance, and deductibles, for medical costs **[**billed by a hospital**]**.

(4) "MEDICALLY NECESSARY CARE" MEANS CARE THAT IS:

(I) DIRECTLY RELATED TO DIAGNOSTIC, PREVENTIVE, CURATIVE, PALLIATIVE, REHABILITATIVE, OR AMELIORATIVE TREATMENT OF AN ILLNESS, INJURY, DISABILITY, OR HEALTH CONDITION;

(II) CONSISTENT WITH ACCEPTED STANDARDS OF GOOD MEDICAL PRACTICE; AND

(III) NOT PRIMARILY FOR THE CONVENIENCE OF THE PATIENT, THE PATIENT'S FAMILY, OR THE PROVIDER.

(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 200% of the federal poverty level, 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;

(ii) Reduced–cost medically necessary care to low–income patients with family income above 200% of the federal poverty level, 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;

(iii) **[**A payment plan that is available to uninsured patients with family income between 200% and 500% of the federal poverty level**]** **A DESCRIPTION OF THE AVAILABILITY OF THE PAYMENT PLAN REQUIRED UNDER § 19–214.2(D) OF THIS SUBTITLE**; 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**]** **PARAGRAPHS** (2) **AND (4)** 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**]** **INCOME THRESHOLDS SET UNDER PARAGRAPH (3) OF THIS SUBSECTION**, 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) **(I)** If a patient is eligible for reduced–cost medically necessary care under **[**paragraphs**]** **PARAGRAPH** (2)(ii) **[**and (4)**]** of this subsection, the hospital shall **[**apply the reduction that is most favorable to the patient**], AT A MINIMUM, REDUCE THE PATIENT'S OUT–OF–POCKET EXPENSES FOR THE REGULATED HOSPITAL SERVICE:**

1. FOR A PATIENT WITH FAMILY INCOME OF AT LEAST 201% BUT NOT MORE THAN 250% OF THE FEDERAL POVERTY LEVEL, BY 75%; AND

2. FOR A PATIENT WITH FAMILY INCOME OF MORE THAN 250% BUT NOT MORE THAN 300% OF THE FEDERAL POVERTY LEVEL, BY 60%.

(II) IF A PATIENT IS ELIGIBLE FOR REDUCED–COST MEDICALLY NECESSARY CARE UNDER PARAGRAPH (4) OF THIS SUBSECTION, THE HOSPITAL SHALL, AT A MINIMUM, REDUCE THE PATIENT'S OUT–OF–POCKET EXPENSES FOR THE REGULATED HOSPITAL SERVICE:

1. FOR A PATIENT WITH FAMILY INCOME OF AT LEAST 201% BUT NOT MORE THAN 250% OF THE FEDERAL POVERTY LEVEL, BY 75%;

2. FOR A PATIENT WITH FAMILY INCOME OF MORE THAN 250% BUT NOT MORE THAN 300% OF THE FEDERAL POVERTY LEVEL, BY 60%;

3. FOR A PATIENT WITH FAMILY INCOME OF MORE THAN 300% BUT NOT MORE THAN 350% OF THE FEDERAL POVERTY LEVEL, BY 50%;

4. FOR A PATIENT WITH FAMILY INCOME OF MORE THAN 350% BUT NOT MORE THAN 400% OF THE FEDERAL POVERTY LEVEL, BY 45%;

5. FOR A PATIENT WITH FAMILY INCOME OF MORE THAN 400% BUT NOT MORE THAN 450% OF THE FEDERAL POVERTY LEVEL, BY 40%; AND

6. FOR A PATIENT WITH FAMILY INCOME OF MORE THAN 450% BUT NOT MORE THAN 500% OF THE FEDERAL POVERTY LEVEL, BY 35%.

(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**]** **A CHILD WHO IS** enrolled in the free and reduced–cost meal program **AND IS ELIGIBLE FOR THE PROGRAM BASED ON THE HOUSEHOLD'S INCOME**;

(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 federal Special Supplemental Food Program for Women, Infants, and Children; or

(v) Receives benefits from any other social service program as determined by the Department and the Commission.

(8) (i) A hospital may consider only household monetary assets in excess of $100,000 when determining eligibility for free and reduced–cost care under the hospital's financial assistance policy.

(ii) If a hospital considers household monetary assets under subparagraph (i) of this paragraph, 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 shall be excluded.

(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.

(10) **(I)** A hospital shall provide 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 communication to the patient regarding collection of the hospital bill.

(II) THE NOTICE REQUIRED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL STATE THAT THE PATIENT HAS UP TO 240 DAYS AFTER THE DAY THE PATIENT RECEIVES THE INITIAL HOSPITAL BILL TO APPLY FOR FINANCIAL ASSISTANCE FROM THE HOSPITAL.

(III) 1. ~~THE HOSPITAL SHALL ENSURE THAT THE PATIENT, THE PATIENT'S FAMILY, OR THE PATIENT'S AUTHORIZED REPRESENTATIVE SIGNS AND DATES THE NOTICE REQUIRED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH TO ACKNOWLEDGE THE PATIENT'S RECEIPT OF THE NOTICE BEFORE DISCHARGING THE PATIENT.~~

~~2. IF A PATIENT CHOOSES NOT TO APPLY FOR FINANCIAL ASSISTANCE, THE SIGNATURE SHALL INDICATE THAT THE PATIENT IS NOT APPLYING ON THE DAY OF THE SIGNING BUT MAY APPLY WITHIN 240 DAYS IMMEDIATELY FOLLOWING THE PATIENT'S RECEIPT OF THE INITIAL HOSPITAL BILL~~ THE HOSPITAL SHALL OBTAIN DOCUMENTATION ENSURING THAT THE PATIENT OR THE PATIENT'S AUTHORIZED REPRESENTATIVE ACKNOWLEDGES THE PATIENT'S RECEIPT OF THE NOTICE BEFORE DISCHARGING THE PATIENT.

2. IF A PATIENT CHOOSES NOT TO APPLY FOR FINANCIAL ASSISTANCE, THE PATIENT'S DOCUMENTED ACKNOWLEDGMENT SHALL INDICATE THAT THE PATIENT IS NOT APPLYING ON THE DAY OF THE ACKNOWLEDGMENT BUT MAY APPLY WITHIN 240 DAYS IMMEDIATELY FOLLOWING THE PATIENT'S RECEIPT OF THE INITIAL HOSPITAL BILL.

(11) THE HOSPITAL SHALL CONSIDER ANY CHANGE IN THE PATIENT'S FINANCIAL CIRCUMSTANCE THAT OCCURS DURING THE 240–DAY PERIOD FOLLOWING THE PATIENT'S RECEIPT OF THE INITIAL HOSPITAL BILL IF THE PATIENT INFORMS THE HOSPITAL OF THE CHANGE IN FINANCIAL CIRCUMSTANCE ON OR BEFORE THE CONCLUSION OF THE 240–DAY PERIOD.

(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 at least 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 and includes a section that allows for a patient to initial that the patient has been made aware of the 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;

(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; and

(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 at least 5% of the overall population within the city or county in which the hospital is located as measured by the most recent census.

(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;

(iii) On request; and

(iv) In each written communication to the patient regarding collection of the hospital bill.

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

(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) To the extent practicable, offers assistance to uninsured patients if the patient chooses to apply for public or private health insurance;

(5) 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) When a patient submits 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) Use a patient's citizenship or immigration status 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.

(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;

(iv) The total number of patients who were denied financial assistance during the immediately preceding year by race or ethnicity and gender;

(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.

19–214.2.

(a) (1) Each hospital annually shall submit to the Commission:

(i) At times prescribed by the Commission, the hospital's policy on the collection of debts owed by patients; and

(ii) A report including:

1. The total number of patients by race or ethnicity, gender, and zip code of residence against whom the hospital, or a debt collector used by the hospital, filed an action to collect a debt owed on a hospital bill;

2. The total number of patients by race or ethnicity, gender, and zip code of residence with respect to whom 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.

(2) The Commission shall post the information submitted under paragraph (1) of this subsection on its website.

(b) The policy submitted under subsection (a)(1) of this section 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)**] (4)** Prohibit the hospital from reporting **ADVERSE INFORMATION** to a consumer reporting agency **[**or**];**

(5) PROHIBIT THE HOSPITAL FROM filing a civil action to collect a debt within **[**180**] 240** days after the initial bill is provided;

(6) PROHIBIT THE HOSPITAL FROM FILING A CIVIL ACTION TO COLLECT A DEBT AGAINST A PATIENT WHOSE OUTSTANDING DEBT IS AT OR BELOW $500;

[(6)**] (7)** Describe the hospital's procedures for collecting a debt;

[(7)**] (8)** Describe the circumstances in which the hospital will seek a judgment against a patient;

[(8)**] (9)** 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 within 240 days after the initial bill was provided;

[(9)**] (10)** 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 within 240 days after the initial bill was provided 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;

[(10)**] (11)** Provide a mechanism for a patient to:

(i) Request the hospital to reconsider the denial of free or reduced–cost care;

(ii) File with the hospital a complaint against the hospital or a debt collector used by the hospital regarding the handling of the patient's bill; and

(iii) Allow the patient and the hospital to mutually agree to modify the terms of a payment plan offered under subsection **[**(e)**] (D)** of this section or entered into with the patient; and

[(11)**] (12) [**Prohibit**] FOR A PATIENT WHO IS ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY, PROHIBIT** the hospital from **[**collecting additional**]:**

(I) CHARGING INTEREST ON THE DEBT OWED ON A BILL FOR THE PATIENT BEFORE A COURT JUDGMENT IS OBTAINED; OR

(II) COLLECTING fees **[**in an**] OR ANY OTHER** amount that exceeds the approved charge for the hospital service as established by the Commission **[**for which the medical debt is owed on a bill for a patient who is eligible for free or reduced–cost care under the hospital's financial assistance policy**]** ~~**OR A PROFESSIONAL FEE**~~.

(c) (1) **(I) [**Beginning October 1, 2010, a**] 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**] WITHIN 240 DAYS AFTER THE INITIAL BILL IS PROVIDED TO THE PATIENT**.

(II) THE HOSPITAL SHALL PROVIDE THE REFUND TO THE PATIENT NOT LATER THAN 30 DAYS AFTER DETERMINING THAT THE PATIENT WAS ELIGIBLE FOR FREE CARE.

(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) 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 under § 19–214.1 of this subtitle.**]**

[(e)**] (D)** (1) Subject to paragraph (2) of this subsection, a hospital shall provide in writing to each patient who incurs medical debt information about the availability of an installment payment plan for the debt.

(2) A hospital shall provide the information under paragraph (1) of this subsection to the patient, the patient's family, the patient's authorized representative, or the patient's legal guardian:

(i) Before the patient is discharged;

(ii) With the hospital bill;

(iii) On request; and

(iv) In each written communication to the patient regarding collection of hospital debt.

(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 **HOUSEHOLD** income **THAT TAKES INTO CONSIDERATION ALL INDIVIDUALS ON THE SAME FEDERAL OR STATE TAX RETURN**; 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**]** **240** days after the **[**due date of the first payment**]** **INITIAL BILL IS PROVIDED**; and

B. A prohibition on interest payments for patients who qualify for free or reduced–cost care **AS REQUIRED UNDER SUBSECTION (B)(12) OF THIS SECTION**;

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.

(4) (i) A patient shall be deemed to be compliant with a payment plan if the patient makes at least 11 scheduled monthly payments within a 12–month period.

(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.

(5) (i) A hospital shall demonstrate that it attempted in good faith to meet the requirements of this subsection and the guidelines developed by the Commission under paragraph (3) of this subsection before the hospital:

1. Files an action to collect a debt owed on a hospital bill by a patient; or

2. Delegates collection activity to a debt collector for a debt owed on a hospital bill by a patient.

(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.

[(f)**] (E)** (1) For at least **[**180**] 240** days after **[**issuing an**] THE** initial patient bill **WAS PROVIDED**, a hospital may not report adverse information about a patient to a consumer reporting agency or commence civil action against a patient for nonpayment.

(2) A hospital 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.

(3) A hospital may not report adverse information to a consumer reporting agency regarding a patient who at the time of service was uninsured or eligible for free or reduced–cost care under § 19–214.1 of this subtitle.

(4) 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:

(i) If the hospital was notified in accordance with federal law by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days; or

(ii) If the hospital **[**has completed**] IS PROCESSING** a requested reconsideration of the denial of free or reduced–cost care that was appropriately completed by the patient **OR HAS COMPLETED THE RECONSIDERATION** within the immediately preceding 60 days.

(5) If a hospital has reported adverse information about a patient to a consumer reporting agency, the hospital shall instruct the consumer reporting agency to delete the adverse information about the patient:

(i) If the hospital was informed by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending, and until 60 days after the appeal is complete; or

(ii) Until 60 days after the hospital has completed a requested reconsideration of the denial of free or reduced–cost care.

[(g)**] (F)** (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) A hospital may not request a lien against a patient's primary residence in an action to collect debt owed on a hospital bill.

(3) (i) A hospital may not **[**file an action against a patient to collect a debt owed on a hospital bill or**]** give notice to a patient under subsection **[**(i)**] (H)** of this section until after **[**180**] 240** days after the initial bill was provided.

(ii) If a hospital files an action to collect the debt owed on a hospital bill, the hospital may not request the issuance of or otherwise knowingly take action that would cause a court to issue:

1. A body attachment against a patient; or

2. An arrest warrant against a patient.

(4) A hospital may not request a writ of garnishment of wages or file an action that would result in an attachment of wages against a patient to collect debt owed on a hospital bill if the patient is eligible for free or reduced–cost care under § 19–214.1 of this subtitle.

(5) (i) A hospital may not make a claim against the estate of a deceased patient to collect a debt owed on a hospital bill 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.

(6) A hospital may not file an action to collect a debt owed on a hospital bill by a patient until the hospital determines whether the patient is eligible for free or reduced–cost care under § 19–214.1 of this subtitle.

[(h)**] (G)** (1) Except as provided in paragraph (2) of this subsection, 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.

(2) An individual may voluntarily consent to assume liability for the debt owed on a hospital bill of any other individual if the consent is:

(i) Made on a separate document signed by the individual;

(ii) Not solicited in an emergency room or during an emergency situation; and

(iii) Not required as a condition of providing any emergency or nonemergency health care services.

[(i)**] (H)** (1) Subject to paragraph (2) of this subsection, at least 45 days before filing an action against a patient to collect on the debt owed on a hospital bill, a hospital shall send written notice of the intent to file an action to the patient.

(2) The notice required under paragraph (1) of this subsection shall:

(i) Be sent to the patient by certified mail and first–class mail;

(ii) Be in simplified language and in at least 10 point type;

(iii) Include:

1. The name and telephone number of:

A. The hospital;

B. If applicable, the debt collector; and

C. An agent of the hospital authorized to modify the terms of the payment plan, if any;

2. The amount required to cure the nonpayment of debt, including past due payments, **INTEREST,** penalties, and fees;

3. A statement recommending that the patient seek debt counseling services;

4. Telephone numbers and Internet addresses of the Health Education Advocacy Unit in the Office of the Attorney General, available to assist patients experiencing medical debt;

5. An explanation of the hospital's financial assistance policy; and

6. Any other relevant information prescribed by the Commission; and

(iv) 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 at least 5% of the population within the jurisdiction in which the hospital is located as measured by the most recent federal census.

(3) The notice required under this subsection shall be accompanied by:

(i) An application for financial assistance under the hospital's financial assistance policy, along with instructions for completing the application for financial assistance, and the telephone number to call to confirm receipt of the application;

(ii) The availability of **[**a**]** **AN INCOME–BASED** payment plan to satisfy the medical debt that is the subject of the hospital debt collection action; and

(iii) The information sheet required under § 19–214.1(f) of this subtitle.

[(j)**] (I)** A complaint by a hospital in an action to collect a debt owed on a hospital bill by a patient shall:

(1) Include an affidavit stating:

(i) The date on which the **[**180–day**]** **240–DAY** period required under subsection **[**(g)(3)**] (F)(3)** of this section elapsed and the nature of the nonpayment;

(ii) That a notice of intent to file an action under subsection **[**(i)**] (H)** of this section:

1. Was sent to the patient and the date on which the notice was sent; and

2. Accurately reflected the contents required to be included in the notice;

(iii) That the hospital provided:

1. The patient with a copy of the information sheet on the financial assistance policy in accordance with subsection **[**(i)(3)(ii)**] (H)(3)(II)** of this section; and

2. Notice of the financial assistance policy as documented under § 19–214.1(f) of this subtitle;

(iv) That the hospital made a determination regarding whether the patient is eligible for the hospital's financial assistance policy in accordance with § 19–214.1 of this subtitle; and

(v) That the hospital made a good–faith effort to meet the requirements of subsection **[**(e)**] (D)** of this section; and

(2) Be accompanied by:

(i) The original or a certified copy of the hospital bill;

(ii) A statement of the remaining due and payable debt supported by an affidavit of the plaintiff, the hospital, or the agent or attorney of the plaintiff or hospital;

(iii) A copy of the most recent hospital bill sent to the patient;

(iv) If the defendant is eligible for federal Service Members Civil Relief Act benefits, an affidavit that the hospital is in compliance with the Act;

(v) A copy of the notice of intent to file an action on a hospital bill; and

(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.

[(k)**] (J)** If a hospital delegates collection activity to a debt collector, the hospital shall:

(1) Specify the collection activity to be performed by the debt collector through an explicit authorization or contract;

(2) Require the debt collector to abide by the hospital's credit and collection policy;

(3) Specify procedures the debt collector must follow if a patient appears to qualify for financial assistance; and

(4) Require the debt collector 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 debt collector regarding the handling of the patient's bill;

(ii) Forward the complaint to the hospital if a patient files a complaint with the debt collector; and

(iii) Along with the hospital, be jointly and severally responsible for meeting the requirements of this section.

[(l)**] (K)** (1) The board of directors of each hospital shall review and approve the **HOSPITAL'S** financial assistance **POLICY REQUIRED UNDER § 19–214.1 OF THIS SUBTITLE** and debt collection **[**policies of the hospital**] POLICY REQUIRED UNDER THIS SECTION** at least every 2 years.

(2) A hospital may not alter its financial assistance or debt collection policies without approval by the board of directors.

[(m)**] (L)** The Commission shall review each hospital's implementation of and compliance with the hospital's policies and the requirements of this section.

[(n)**] (M)** (1) On or before February 1 each year, beginning in 2023, the Commission shall compile the information required under subsection (a) of this section and prepare a medical debt collection report based on the compiled information.

(2) The report required under paragraph (1) of this subsection shall be:

(i) Made available to the public free of charge; and

(ii) Submitted to the Senate Finance Committee and the House Health and Government Operations Committee in accordance with § 2–1257 of the State Government Article.

19–301.

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

(f) "Hospital" means an institution that:

(1) Has a group of at least 5 physicians who are organized as a medical staff for the institution;

(2) Maintains facilities to provide, under the supervision of the medical staff, diagnostic and treatment services for 2 or more unrelated individuals; and

(3) Admits or retains the individuals for overnight care.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2025.

Approved:

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Governor.

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President of the Senate.

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Speaker of the House of Delegates.