Department of Legislative Services

Maryland General Assembly
2025 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

Senate Bill 981 (Senator Hershey, *et al.*)

Finance Health and Government Operations

Hospitals - Financial Assistance and Collection of Debts - Policies

This bill alters hospital financial assistance and collection of debt policies, including requiring a hospital to reduce a patient's out-of-pocket expenses for "medically necessary care" by a specified percentage based on the patient's family income. The bill prohibits a hospital from filing a civil action to collect debt against a patient under specified circumstances and increases the number of days, from 180 to 240, before interest payments on "medical debt" may be assessed or a hospital is authorized to take civil action to collect debt. The bill alters notice requirements for hospital financial assistance policies and alters the monthly payment amount for an income-based payment plan for medical debt. The bill excludes from the statute of limitations on civil actions a contract, including a contract under seal, or a promissory note or other instrument under seal that is (1) related to an obligation of a consumer to pay consumer debt that arises from hospital services and (2) between a consumer and a hospital. The bill also makes conforming changes.

Fiscal Summary

State Effect: Any additional workload for the Health Services Cost Review Commission (HSCRC) can be handled with existing budgeted resources. To the extent hospital rates increase from additional uncompensated care, Medicaid expenditures (60% federal funds, 40% general funds) and federal matching revenues increase beginning as early as FY 2026, as discussed below.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The bill alters the definition of "medical debt" to mean out-of-pocket expenses, *including* co-payments, coinsurance, and deductibles, for medical costs.

"Medically necessary care" means care that is (1) directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition; (2) consistent with accepted standards of good medical practice; and (3) not primarily for the convenience of the patient, the patient's family, or the provider.

Hospital Financial Assistance Policies

The bill specifies that, *subject to the statutory income thresholds*, a hospital financial policy must provide reduced-cost medically necessary care to patients with family income less than 500% of the federal poverty level (FPL) who have a financial hardship. The bill removes the authority for a hospital to seek (and HSCRC to approve) a family income threshold that is different than that specified under statute.

If a patient is eligible for reduced-cost medically necessary care, the hospital must, at a minimum, reduce the patient's out-of-pocket expenses for the regulated hospital service:

- for a patient with family income of 201% to 250% FPL, by 75%;
- for a patient with family income of more than 250% up to 300% FPL, by 60%;
- for a patient with family income of more than 300% up to 350% FPL, by 50%;
- for a patient with family income of more than 350% up to 400% FPL, by 45%;
- for a patient with family income of more than 400% up to 450% FPL, by 40%; and
- for a patient with family income of more than 450% up to 500% FPL, by 35%.

The financial assistance policy must provide presumptive eligibility for free medically necessary care to a patient who is not eligible for Medicaid or the Maryland Children's Health Program (MCHP) and lives in a household with *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.*

When a hospital provides notice of its financial assistance policy to a patient, the notice must state that the patient has up to 240 days after the day the patient receives the initial hospital bill to apply for financial assistance. The hospital must obtain documentation ensuring that the patient or the patient's authorized representative acknowledges the patient's receipt of the notice before discharging the patient. If a patient chooses not to apply for financial assistance, the patient's documented acknowledgement must indicate that the patient is not applying on the day of the acknowledgement but may apply within

240 days immediately following the patient's receipt of the initial hospital bill. The hospital must consider any change in the patient's financial circumstances that occurs during the 240-day period if the patient informs the hospital of the change on or before conclusion of the 240-day period.

Hospital Debt Collection

The bill alters the contents of hospital debt collection policy as follows:

- repeals the prohibition on the charging of interest on bills incurred by self-pay patients before a court judgement is obtained;
- clarifies that a hospital is prohibited from reporting *adverse information* to a consumer reporting agency;
- extends the time period before a hospital may file a civil action to collect a debt from 180 to 240 days after the initial bill is provided;
- prohibits the hospital from filing a civil action to collect a debt against a patient whose outstanding debt is at or below $500; and
- for a patient who is eligible for free or reduced-cost care under the hospital's financial assistance policy, prohibits the hospital from (1) charging interest on the debt owed on a bill for the patient before a court judgement is obtained or (2) collecting fees or any other amount that exceeds the approved charge for the hospital service as established by HSCRC.

The bill also specifies that a hospital must provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who was found to be eligible for free care *within 240 days after the initial bill is provided to the patient*. The hospital must provide the refund to the patient not later than 30 days after determining that the patient was eligible for free care.

The bill repeals the prohibition on a hospital charging 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.

The guidelines developed by HSCRC for an income-based payment plan, among several existing requirements, must include:

- guidelines for the payment amount that may not exceed 5% of the 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
- 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 240 days after the initial bill is provided.

The bill clarifies that 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 the hospital *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.

A hospital may not give notice to a patient until *240* (rather than 180) days after the initial bill was provided. Notice must, among other things, include the amount required to cure the nonpayment of debt, including *interest,* and be accompanied by the availability of an *income-based* payment plan to satisfy the medical debt.

Current Law: "Hospital" means an institution that (1) has a group of at least five 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 two or more unrelated individuals; and (3) admits or retains the individuals for overnight care.

"Hospital services" means (1) inpatient hospital services specified in Medicare regulations; (2) emergency services, including services provided at a freestanding medical facility; (3) outpatient services provided at the hospital; (4) outpatient services, as specified by HSCRC in regulation, provided at a specified licensed freestanding medical facility; and (5) identified physician services for which a facility has HSCRC-approved rates. "Hospital services" includes a hospital outpatient service (1) of a hospital that, on or before June 1, 2015, is under a merged asset hospital system; (2) 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 federal 340B Program; and (3) that complies with specified federal requirements. "Hospital services" does not include (1) outpatient renal dialysis services or (2) outpatient services provided at a limited service hospital, except for emergency services.

"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.

Hospital Financial Assistance Policies

Each hospital, or related institution, under the jurisdiction of HSCRC must develop a financial assistance policy for providing free and reduced cost medically necessary 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. The financial assistance policy must provide, at a minimum:

- free medically necessary care to patients with family income at or below 200% FPL;
- reduced-cost medically necessary care to patients with family income above 200% FPL;
- a payment plan that is available to uninsured patients with family income between 200% and 500% FPL; and
- a mechanism for a patient to request the hospital reconsider the denial of free or reduced-cost care that includes specified information regarding the Health Education and Advocacy Unit.

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. A hospital may seek (and HSCRC may approve) a different family income threshold. HSCRC must 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. 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.

The financial assistance policy must provide presumptive eligibility for free medically necessary care to a patient who is not eligible for Medicaid or MCHP and lives in a household with children enrolled in the free and reduced-cost meal program and receives benefits through the federal Supplemental Nutrition Assistance Program, the State's Energy Assistance Program, the federal Special Supplemental Food Program for Women, Infants, and Children, or any other social service program as determined by the Maryland Department of Health (MDH) and HSCRC.

Hospital Debt Collection Policies

Each hospital's debt collection policy must 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.

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.

Civil Actions

A civil action must be filed within 3 years from the date it accrues, unless otherwise provided by State law. State law provides a longer statute of limitations for filing civil actions for specialties, including a promissory note or other instrument under seal; a bond, except a public officer's bond; a judgment; a recognizance; and a contract under seal. With the exception of a specialty taken for the use of the State or a deed of trust, mortgage, or promissory note that has been signed under the seal and secures or is secured by owner-occupied residential property, a civil action for a specialty must 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.

Health Services Cost Review Commission

HSCRC is an independent commission within MDH 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.

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.

Uncompensated Care

Uncompensated care is care provided for which no compensation is received, typically a combination of charity care, financial assistance, and bad debt. The uncompensated care fund maintains access to care in communities with higher uncompensated care by limiting the financial strain on hospitals. 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.

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 (60% federal funds, 40% 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 October 1, 2025, these impacts may be observed as early as fiscal 2026; otherwise, they are likely delayed to fiscal 2027 and beyond.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: HB 268 (Delegate Charkoudian, *et al.*) - Health and Government Operations.

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

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