Chapter 770

(House Bill 565)

AN ACT concerning

Health Facilities – Hospitals – Medical Debt Protection

FOR the purpose of specifying the method for calculating family income to be used for certain purposes under a certain hospital financial assistance policy; requiring that the description of a hospital's financial assistance policy that is included on a certain information sheet include a certain section; requiring a hospital to submit annually a certain report to the Health Services Cost Review Commission at a certain time; requiring the Health Services Cost Review Commission to post certain information on its website; altering the required contents of a hospital's policy on the collection of debts owed by patients; ~~requiring a hospital to provide a refund of certain amounts collected from a patient or the guarantor of a patient who was found eligible for reduced–cost care on the date of service; establishing certain prohibitions on hospitals that charge interest fees on hospital bills;~~ prohibiting a hospital from charging interest or fees on certain debts incurred by certain patients; requiring a hospital to provide in writing to certain patients information about the availability of a certain installment payment plan; requiring a hospital to provide certain information to a patient, the patient's family, an authorized representative, or the patient's legal guardian at certain times; ~~prohibiting a certain payment plan from requiring a patient to make certain monthly payments and imposing certain penalties; requiring a hospital to determine certain adjusted monthly income in a certain manner under certain circumstances; requiring a certain payment plan to have a certain repayment period;~~ 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; establishing that certain patients are deemed to be compliant with a certain payment plan under certain circumstances; 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; requiring a hospital to demonstrate that it attempted in good faith to meet certain requirements and guidelines before the hospital takes certain actions; providing that certain provisions of this Act do not prohibit a hospital from using a certain vendor for a certain purpose; altering and specifying certain time periods during which and the circumstances under which a hospital is prohibited from taking a certain action; prohibiting a hospital from reporting certain information about certain patients to a consumer reporting agency; prohibiting a hospital from taking certain actions against certain patients under certain circumstances; requiring a hospital to provide certain instructions to a consumer reporting agency under certain circumstances; repealing a certain authorization for a hospital to hold a certain lien; prohibiting a hospital from requesting a certain lien

in a certain action; prohibiting a hospital from filing an action or giving a certain notice to a patient for nonpayment of debt until after a certain time period; prohibiting a hospital from taking certain actions if the hospital files a certain action; prohibiting a hospital from requesting a certain writ to garnish certain wages or filing a certain action under certain circumstances; ~~prohibiting a hospital from filing a certain action if a certain debt is below a certain amount;~~ prohibiting a hospital from making a certain claim against an estate of a deceased patient under certain circumstances; authorizing a hospital to offer the family of a certain patient the ability to apply for financial assistance; prohibiting a hospital from filing a certain action ~~against a certain patient or~~ until certain conditions are met; ~~prohibiting a hospital from delegating certain collection activity to a debt collector to collect a certain amount of debt;~~ prohibiting certain individuals from being held liable for a certain debt; authorizing a certain individual to consent to assume a certain liability under certain circumstances; requiring a hospital to send a certain written notice of intent at least a certain period of time before filing a certain action; providing for the manner of delivery, content, and structure of a certain notice of intent; requiring a certain complaint to include a certain affidavit and be accompanied by certain documents; requiring that a hospital require a debt collector to have certain responsibility for meeting certain requirements under certain circumstances; requiring the Health Services Cost Review Commission, on or before a certain date, to compile certain information and prepare a certain ~~annual~~ report; requiring that a certain report be made available to the public in a certain manner and submitted to certain committees of the General Assembly; altering certain references by changing "outside collection agency" to "debt collector"; making conforming changes; 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 generally relating to hospital debt collection policies.

BY repealing and reenacting, without amendments,
Article – Health – General
Section 19–214.1(b)(1)
Annotated Code of Maryland
(2019 Replacement Volume and 2020 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–214.1(b)(2)(i) and (ii) and (f)(1)(i) and 19–214.2
Annotated Code of Maryland
(2019 Replacement Volume and 2020 Supplement)

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.

(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,** in accordance with the mission and service area of the hospital;

(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**;

19–214.2.

(a) **(1)** Each hospital **ANNUALLY** shall submit to the Commission**[**, at**]:**

(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 ~~COSTS OF~~ 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) PROHIBIT THE HOSPITAL FROM REPORTING TO A CONSUMER REPORTING AGENCY OR FILING A CIVIL ACTION TO COLLECT A DEBT WITHIN 180 DAYS AFTER THE INITIAL BILL IS PROVIDED;

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

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

[(7)**] (8)** 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 ~~OR REDUCED–COST~~ care **[**on the date of service**]** ~~MORE THAN 240 DAYS AFTER THE FIRST POSTDISCHARGE~~ **WITHIN 240 DAYS AFTER THE INITIAL BILL WAS PROVIDED**;

[(8)**]** **(9)** 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 ~~OR REDUCED–COST~~ care **[**on the date of the service**]** ~~MORE THAN 180 DAYS AFTER THE FIRST POSTDISCHARGE~~ **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; **[**and**]**

[(9)**]** **(10)** 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**]** **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) OF THIS SECTION OR ENTERED INTO WITH THE PATIENT; AND

(11) PROHIBIT THE HOSPITAL FROM COLLECTING ADDITIONAL FEES IN AN AMOUNT THAT EXCEEDS THE ~~COST OF THE HOSPITAL SERVICE~~ 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.

(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 ~~OR REDUCED–COST~~ 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 ~~OR REDUCED–COST~~ 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) ~~**IF A HOSPITAL CHARGES INTEREST FEES ON A HOSPITAL BILL, THE HOSPITAL MAY NOT:**~~

~~**(1) CHARGE INTEREST IN EXCESS OF AN EFFECTIVE RATE OF SIMPLE INTEREST OF 1.5% PER ANNUM ON THE UNPAID PORTION OF A HOSPITAL BILL;**~~

~~**(2) CHARGE**~~ **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**~~**; OR**~~

~~**(3) BEGIN ACCRUAL OF INTEREST OR LATE PAYMENT CHARGES UNTIL 180 DAYS AFTER THE DATE OF THE LATER OF:**~~

~~**(I) THE END OF EACH REGULAR BILLING PERIOD; OR**~~

~~**(II) THE PATIENT'S DISCHARGE**~~**.**

(E) (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) A PAYMENT PLAN OFFERED UNDER THIS SUBSECTION MAY NOT:**~~

~~**1. REQUIRE THE PATIENT TO MAKE MONTHLY PAYMENTS THAT EXCEED 5% OF THE INDIVIDUAL PATIENT'S FEDERAL OR STATE ADJUSTED GROSS MONTHLY INCOME; OR**~~

~~2. IMPOSE PENALTIES OR FEES FOR PREPAYMENT OR EARLY PAYMENT.~~

~~(II) IF THE PATIENT DOES NOT SUBMIT TAX DOCUMENTATION TO BE USED FOR DETERMINING A PAYMENT PLAN, A HOSPITAL SHALL DETERMINE A PATIENT'S ADJUSTED GROSS MONTHLY INCOME BY FOLLOWING STANDARDS FOR THE DETERMINATION OF INCOME THAT ARE DEVELOPED BY THE COMMISSION IN REGULATIONS.~~

~~(4) A PAYMENT PLAN UNDER THIS SUBSECTION SHALL HAVE A REPAYMENT PERIOD THAT IS NOT LESS THAN THE LONGER OF:~~

~~(I) 36 MONTHS; OR~~

~~(II) A TIME PERIOD THAT WOULD ENSURE THAT PAYMENTS ARE GREATER THAN ACCRUED INTEREST.~~

(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.

~~(5)~~ (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.

~~(6)~~ (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:

~~(I)~~ 1. FILES AN ACTION TO COLLECT A DEBT OWED ON A HOSPITAL BILL BY A PATIENT; OR

~~(II)~~ 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.

[(d)**] (F)** (1) For at least **[**120**] 180** days after ~~[~~issuing an initial patient bill~~]~~ ~~THE FIRST POSTDISCHARGE 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 **[**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 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 ~~INFORMED~~ 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~~, AND UNTIL 60 DAYS AFTER THE APPEAL IS COMPLETE~~ WITHIN THE IMMEDIATELY PRECEDING 60 DAYS; OR

(II) ~~UNTIL 60 DAYS AFTER~~ IF 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.

(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.

[(e)**] (G)** (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**] 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) OF THIS SECTION UNTIL AFTER 180 DAYS AFTER THE ~~FIRST POSTDISCHARGE~~ 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) A HOSPITAL MAY NOT FILE AN ACTION AGAINST A PATIENT TO COLLECT A DEBT OWED ON A HOSPITAL BILL IN AN AMOUNT OF $1,000 OR LESS.**~~

~~**(6)**~~ **(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.

~~(7)~~ (6) A HOSPITAL MAY NOT FILE AN ACTION TO COLLECT A DEBT OWED ON A HOSPITAL BILL BY A PATIENT:

~~(I) WHO WAS UNINSURED AT THE TIME SERVICE WAS PROVIDED; OR~~

~~(II)~~ ~~UNTIL~~ UNTIL THE HOSPITAL DETERMINES WHETHER THE PATIENT IS ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER § 19–214.1 OF THIS SUBTITLE.

~~(8) A HOSPITAL MAY NOT DELEGATE COLLECTION ACTIVITY TO A DEBT COLLECTOR FOR DEBT OWED ON A HOSPITAL BILL BY A PATIENT THAT IS $1,000 OR LESS.~~

(H) (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) (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 ~~AS DETERMINED IN REGULATIONS ADOPTED BY THE COMMISSION~~ 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, PENALTIES, AND FEES;

3. A STATEMENT RECOMMENDING THAT THE PATIENT SEEK DEBT COUNSELING SERVICES;

4. TELEPHONE NUMBERS AND INTERNET ADDRESSES OF ~~NONPROFIT AND GOVERNMENT RESOURCES, INCLUDING~~ 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. AN EXPLANATION OF THE STATE MEDICAL DEBT COLLECTION PROCESS AND TIMELINE;~~

~~7. AN EXPLANATION OF THE PATIENT'S RIGHT TO APPEAL TO THE PATIENT'S INSURANCE CARRIER, THE MARYLAND INSURANCE ADMINISTRATION, OR THE HOSPITAL FOR ANY DENIED REIMBURSEMENT OR ACCESS TO FREE OR REDUCED-COST CARE, AND THE NEED TO INFORM THE HOSPITAL IF AN APPEAL IS IN PROCESS; AND~~

~~8.~~ 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 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 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) 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 PERIOD REQUIRED UNDER SUBSECTION (G)(3) OF THIS SECTION ELAPSED AND THE NATURE OF THE NONPAYMENT;

(II) THAT A NOTICE OF INTENT TO FILE AN ACTION UNDER SUBSECTION (I) 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) OF THIS SECTION; AND

2. ~~ORAL NOTICE~~ 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) 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) DOCUMENTATION THAT THE PATIENT HAS ACKNOWLEDGED RECEIPT OF A COPY OF THE INFORMATION REQUIRED TO BE PROVIDED BY THE HOSPITAL UNDER SUBSECTION (I)(3) OF THIS SECTION; AND**~~

~~**(VII) DOCUMENTATION THAT THE HOSPITAL HAS PROVIDED WRITTEN AND ORAL NOTICE OF THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY TO THE PATIENT.**~~

(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.

[(f)**] (K)** If a hospital delegates collection activity to **[**an outside collection agency**] A DEBT COLLECTOR**, the hospital shall:

(1) Specify the collection activity to be performed by the **[**outside collection agency**]** **DEBT COLLECTOR** through an explicit authorization or contract;

(2) Require the **[**outside collection agency**]** **DEBT COLLECTOR** to abide by the hospital's credit and collection policy;

(3) Specify procedures the **[**outside collection agency**]** **DEBT COLLECTOR** must follow if a patient appears to qualify for financial assistance; and

(4) Require the **[**outside collection agency**]** **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 **[**outside collection agency**]** **DEBT COLLECTOR** regarding the handling of the patient's bill; **[**and**]**

(ii) Forward the complaint to the hospital if a patient files a complaint with the **[**collection agency**]** **DEBT COLLECTOR; AND**

(III) ALONG WITH THE HOSPITAL, BE JOINTLY AND SEVERALLY RESPONSIBLE FOR MEETING THE REQUIREMENTS OF THIS SECTION.

[(g)**]** **(L)** (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 2 years.

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

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

(N) (1) ~~**THE**~~ **ON OR BEFORE FEBRUARY 1 EACH YEAR, BEGINNING IN 2023, THE COMMISSION SHALL** ~~**PREPARE AN ANNUAL MEDICAL DEBT COLLECTION REPORT THAT IS BASED ON SPECIAL AUDIT PROCEDURE REQUIREMENTS FOR HOSPITALS RELATED TO MEDICAL DEBT**~~ **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.

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.

SECTION ~~2.~~ 5. AND BE IT FURTHER ENACTED, That ~~this Act shall take effect October 1, 2021~~ 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.

Enacted under Article II, § 17(c) of the Maryland Constitution, May 30, 2021.