131st MAINE LEGISLATURE

FIRST SPECIAL SESSION-2023

Legislative Document	**No. 1955**
H.P. 1257	House of Representatives, May 18, 2023

An Act to Require Hospitals and Hospital-affiliated Providers to Provide Financial Assistance for Medical Care

Reference to the Committee on Health and Human Services suggested and ordered printed.

ROBERT B. HUNT
Clerk

Presented by Speaker TALBOT ROSS of Portland.
Cosponsored by Senator TIPPING of Penobscot and
Representatives: GATTINE of Westbrook, STOVER of Boothbay, Senators: BALDACCI of Penobscot, President JACKSON of Aroostook, RENY of Lincoln.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1716, as enacted by PL 1995, c. 653, Pt. B, §7 and affected by §8 and enacted by c. 696, Pt. A, §36, is repealed and the following enacted in its place:

§1716. Financial assistance

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Hospital-affiliated provider" means a provider associated with a hospital or a provider that provides medical services, treatment, procedures, tests or other billable medical services to an individual in a hospital, facility or other setting associated with a hospital.

B. "State resident" means an individual:

(1) Living in the State with the intent to remain in the State indefinitely; or

(2) Who enters the State with a permanent, temporary, seasonal or other job commitment or who is seeking employment.

2. Hospital or hospital-affiliated provider to provide care. A hospital or hospital-affiliated provider shall, in accordance with rules adopted by the department and consistent with the Hill-Burton Act established under 42 United States Code, Section 291, et seq. (1995), provide free health care services to eligible patients who are state residents in accordance with this section. Upon admission or, in cases of emergency admission, before discharge of a patient, a hospital or hospital-affiliated provider shall investigate the coverage of the patient by any insurance or state or federal programs of medical assistance. A hospital or hospital-affiliated provider shall provide free, medically necessary services for patients whose income is equal to or less than 200% of the federal poverty level. A hospital or hospital-affiliated provider shall adopt a modified adjusted gross income methodology as described in 42 Code of Federal Regulations, Section 435.603(e) in the calculation of countable income. Rules adopted pursuant to this section must be consistent with the requirements of the United States Internal Revenue Code of 1986, Section 501(r) and any federal regulations implementing those requirements. For the purposes of this section, "federal poverty level" has the same meaning as in section 3762, subsection 1, paragraph C.

3. Applications for financial assistance. A hospital or hospital-affiliated provider, in accordance with rules adopted under subsection 2:

A. Shall use a single streamlined application for all financial assistance programs;

B. May not require notarization of any application materials or of required supporting documents;

C. Shall use documentation specified by the department by rule that may be used to prove that the patient is a state resident;

D. May not solicit information from an applicant for financial assistance regarding any assets or income that are not used to calculate modified adjusted gross income as described in 42 Code of Federal Regulations, Section 435.603(e);

E. Shall provide interpretation services to a patient who is a nonnative English speaker;

F. Shall translate all written financial assistance program information and applications into the language spoken by all significant populations of nonnative English speakers served by the hospital or hospital-affiliated provider or residing in the community served by the hospital or hospital-affiliated provider;

G. Shall have an affirmative duty to investigate and determine a patient's eligibility for charity care;

H. Shall accept and process a financial assistance application submitted by a patient at any time;

I. Shall determine eligibility based upon the patient's income at the time of the application or the patient's income at the time of the provision of the health care service, whichever is less;

J. Shall determine eligibility within 15 days from the date a completed application is submitted;

K. Shall, within 10 days of receiving an application, notify the patient to clearly explain what information or documentation is needed to complete the application. The hospital or hospital-affiliated provider shall provide the patient with a reasonable amount of time and not less than 30 days to complete the application before denying the application for incompleteness;

L. Shall require any determination by the hospital or hospital-affiliated provider that a patient is eligible for charity care to remain valid for at least 12 months following the date of determination of eligibility;

M. Shall allow patients to reapply for financial assistance at any time following a denial; and

N. Shall provide to a patient who is found ineligible for charity care an opportunity for a fair hearing regarding the patient's eligibility for financial assistance.

4. Notice and publication requirements. In accordance with rules adopted by the department, a hospital or hospital-affiliated provider shall widely publicize its financial assistance programs within the community served by the hospital or hospital-affiliated provider, including by:

A. Publishing a summary of the programs written in plain language;

B. Providing physical copies of the summary, application and any application instructions in conspicuous locations within the hospital or hospital-affiliated provider, including admission, registration and waiting areas;

C. Posting a full, accessible and downloadable version of the application on the hospital's or hospital-affiliated provider's publicly accessible website;

D. Including on all summaries and notices regarding the hospital's or hospital-affiliated provider's financial assistance program information regarding the availability of no-cost assistance with applying for financial assistance and the health coverage program through the Health Insurance Consumer Assistance Program as established in Title 24-A, section 4326; and

E. Providing information on the availability of financial assistance on all billing statements sent to a patient, including, how to apply, a publicly accessible website

where an individual may download a copy of the application and a phone number that an individual may call to request a paper copy of the application.

5. Noncovered services. In accordance with rules adopted by the department, if a patient is not eligible for charity care, a hospital or hospital-affiliated provider shall inform patients who are determined to be eligible for financial assistance if any part of a medical service, treatment, procedure or test provided or administered to the patient in the hospital or hospital-affiliated provider will not be covered by the hospital's or hospital-affiliated provider's financial assistance programs. A hospital or hospital-affiliated provider may not bill patients for services if the hospital or hospital-affiliated provider failed to provide the patient with advance notice and a good faith estimate of the cost of a medical service, treatment, procedure or test that is not covered under the hospital's or hospital-affiliated provider's financial assistance programs.

6. Reasonable payment plans; maximum out-of-pocket payments. In accordance with rules adopted by the department, a hospital or hospital-affiliated provider shall offer patients reasonable payment plan options with terms of at least 2 years, with monthly payments not to exceed 3% of the patient's monthly gross income.

7. Limitations on billing and collections actions. This subsection governs limitations on a hospital's or hospital-affiliated provider's ability to undertake collections actions on medical debt. A hospital or hospital-affiliated provider:

A. May not withhold medically necessary care to a patient prior to the collection of debt;

B. May not bill or attempt to collect any charge from a patient until the hospital or hospital-affiliated provider has made all reasonable efforts to determine the patient's eligibility for charity care under this section and rules adopted pursuant to this section, including resolving an appeal filed by the patient challenging a denial of eligibility for charity care;

C. May not undertake extraordinary collections actions, as defined by the department by rule, for at least 240 days, beginning on the date the hospital or hospital-affiliated provider provides a billing statement to the patient who has received medical care and left the hospital or hospital-affiliated provider. Extraordinary collections actions include the sale of a patient's medical debt to a collection agency or any action against a patient that requires a legal or judicial process with the intent of collecting a debt for services rendered;

D. Shall, before assigning patient debt to collections:

(1) Screen the patient for eligibility for financial assistance;

(2) Apply all required discounts, including charity care and any applicable hospital or hospital-affiliated provider financial assistance;

(3) Provide a plain language explanation of the fees billed and notify the patient of potential collections actions; and

(4) Give the patient an opportunity to request a reasonable payment plan;

E. Shall refund a patient any excess amount paid by the patient if the patient who was eligible for charity care was not properly screened by the hospital or hospital-affiliated

provider. This paragraph also applies to a creditor other than a hospital or hospital-affiliated provider;

F. May not report information on unpaid debt to a credit reporting agency or bureau and may not sell a patient's medical debt to a debt collector or collection agency unless the hospital or hospital-affiliated provider has entered into a legally binding written agreement with the medical debt buyer that expressly prohibits the medical debt buyer from reporting adverse information about the patient to a credit reporting agency or bureau; and

G. Shall, before initiating a legal action to collect a medical debt:

(1) Notify the patient at least 30 days before the potential collections action;

(2) Provide information to the patient on the availability of financial assistance, how to apply for financial assistance and an application for financial assistance; and

(3) Provide information to the patient on the availability of a reasonable payment plan and how to request a reasonable payment plan.

This paragraph also applies to a creditor other than a hospital or hospital-affiliated provider.

8. Enforcement. This subsection governs enforcement of this section.

A. The department shall:

(1) Establish a process for a patient to submit a complaint of noncompliance with this section;

(2) Conduct a review within 30 days of receiving a complaint under paragraph A; and

(3) Require a corrective action of a hospital or hospital-affiliated provider, if the department determines that the hospital or hospital-affiliated provider is not in compliance, that may include:

(a) Measures to inform the patient about the noncompliance; and

(b) Financial correction.

B. If the department determines that a hospital or hospital-affiliated provider knowingly or willfully violated this section or engaged in a pattern of noncompliance with this section, the hospital or hospital-affiliated provider is subject to a civil penalty not to exceed $1,000 payable to the department. This penalty is recoverable in a civil action.

Sec. 2. 22 MRSA §1718-H is enacted to read:

§1718-H. Hospital price transparency

A hospital shall comply with the price transparency requirements established in 45 Code of Federal Regulations, Part 180. A hospital may not initiate or pursue a collections action against a patient for services provided on a date on which the hospital was not in compliance with the price transparency requirements.

SUMMARY

This bill does the following.

1. It directs the Department of Health and Human Services to adopt rules, consistent with the federal Hill-Burton Act, for the provision of free health care services to patients who are state residents and meet certain income requirements.

2. It requires hospitals and hospital-affiliated providers to adopt a modified adjusted gross income methodology in determining a patient's eligibility for financial assistance.

3. It requires that hospitals and hospital-affiliated providers use a single streamlined application for all financial assistance programs and provides for other resources relating to applications and for the determination of a patient's financial assistance.

4. It requires that hospitals and hospital-affiliated providers widely publicize their financial assistance programs within the community served by the hospital or hospital-affiliated provider, including by publishing a summary of the programs written in plain language; by providing physical copies of the summary, application and application instructions in conspicuous locations within the hospital or hospital-affiliated provider; and by posting a full, accessible and downloadable version of the application on the hospital's or hospital-affiliated provider's publicly accessible website.

5. It requires that hospitals and hospital-affiliated providers inform patients eligible for financial assistance if any service, treatment, procedure or test is not covered by the hospital's or hospital-affiliated provider's financial assistance program.

6. It provides that a hospital and a hospital-affiliated provider must offer patients payment plan options with terms of at least 2 years, with monthly payments not to exceed 3% of the patient's monthly gross income.

7. It prohibits certain collections actions by hospitals and hospital-affiliated providers for at least 240 days beginning on the date the hospital or hospital-affiliated provider provides a billing statement to the patient who has received medical care and left the hospital or hospital-affiliated provider. Prohibited collections actions include the sale of a patient's medical debt to a collection agency, legal action against a patient with the intent of collecting a debt for services rendered or withholding medically necessary care to a patient prior to the collection of debt.

8. It prohibits other billing or collections actions by a hospital or a hospital-affiliated provider until the hospital or hospital-affiliated provider fully determines a patient's eligibility for charity care, including by resolving an appeal filed by the patient.

9. It provides that the Department of Health and Human Services enforce the provisions of this law and establishes a civil penalty for hospitals or hospital-affiliated providers that knowingly or willfully violate these provisions or engage in a pattern of noncompliance.

10. It requires hospitals to comply with the price transparency requirements established in 45 Code of Federal Regulations, Part 180. A hospital is prohibited from initiating or pursuing a collections action against a patient for services provided on a date on which the hospital was not in compliance with the price transparency requirements.