

Model Medical Debt Protection Act

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By

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Introduction to the Model Medical Debt Protection Act

Medical debt affects tens of millions of consumers. It is one of the most prevalent types of consumer debt, with one in five Americans being contacted by a debt collector over an unpaid healthcare bill.¹ Twenty percent of Americans also have at least one medical debt collection item in their credit reports, and over *half* of collection items on credit reports are for medical debts.² Medical debt is different from many other types of consumer debt—people do not plan to get sick or get hurt, and health care services are not only necessary, but can be a matter of life or death. Also, medical bills often end up in collections because of insurance or billing disputes, or other problems that arise from having a third party payor involved in the payment of bills.

Despite historic reductions in the numbers of uninsured, the problem of medical debt remains. Expanded Medicaid coverage has helped many low-income people to obtain health care without the burden of medical debt. But for the remaining uninsured, including low-income residents of states that did not expand their Medicaid programs, certain immigrants who cannot enroll in insurance, and others who are in difficult financial situations, coverage may be unavailable or unaffordable. Insured consumers also face unmanageable medical debts as a result of high cost-sharing responsibilities (*i.e.*, copays and deductibles) under some plans, “surprise” out-of-network bills, or denied insurance claims. And there have been, and likely will be more, attempts in Congress to roll back the Patient Protection and Affordable Care Act (ACA) and Medicaid expansion, which if successful would lead to more uninsured patients and greater medical debt.

To help address the problem of medical debt and increase transparency, the ACA created a requirement that nonprofit hospitals adopt financial assistance policies.³ The ACA and its implementing regulations also govern the debt collection activities of nonprofit hospitals, restricting them during certain time periods until a determination is made as to whether a patient is eligible for financial assistance. While this represents a significant step forward, this consumer protection is incomplete since it applies only to nonprofit hospitals. For-profit hospitals⁴ and other types of large health care provider organizations, however, are not covered. For-profit hospitals and hospital chains are widespread, and in some states outnumber nonprofit hospitals.⁵ Furthermore, patients often receive separate medical bills from both the hospital and the physician who treated the patient, since many physicians who provide treatment at hospitals are independent contractors rather than hospital employees.

¹ Sara R. Collins *et al.*, The Commonwealth Fund, [Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act](#) 6 (Apr. 2013), available at www.commonwealthfund.org.

² Consumer Fin. Prot. Bureau, [Consumer Credit Reports: A Study of Medical and Non-Medical Collections](#) (Dec. 11, 2014), available at www.consumerfinance.gov.

³ 26 U.S.C. § 501(r)(4); 26 C.F.R. §§ 1.501(r)-1 through 1.501(r)-7.

⁴ For a discussion about non-profit and for profit hospital requirements, see Erin C. Fuse Brown, *Fair Hospital Prices Are Not Charity: Decoupling Hospital Pricing and Collection Rules from Tax Status*, 53 U. Louisville L. Rev. 509 (2016).

⁵ Kaiser Family Foundation, [State Health Facts, Hospitals by Ownership Type](#) (2014), available at www.kff.org.

While the ACA requires nonprofit hospitals to have financial assistance policies, the ACA and its implementing regulations do not specify any minimum standards that these policies must meet. And if a nonprofit hospital fails to comply with the ACA financial assistance requirements, the patient does not have a remedy to seek redress for noncompliance, as only the IRS can enforce these requirements.

States may wish to adopt statutes and regulations that parallel ACA financial assistance policies, while adding stronger protections in addition to the baseline established by the federal law. They may want to set minimum levels of financial assistance and to cover for-profit hospitals and large health care provider organizations. This Model Act and its commentary include language that could be included in state law to replicate these ACA rules, and to add protections that go beyond the ACA. The Model Act also provides language if a state wishes to adopt financial assistance and debt collection laws in the event that the ACA provisions are repealed.

Medical debt and health care affordability are multifaceted problems. The broad range of possible solutions could include:

1. More comprehensive financial assistance policies, to cover all hospitals and a broader range of health care providers.
2. Stronger consumer protection rules for medical debt collection.
3. Provider-oriented solutions such as cost control measures, limits on facility fees, and restrictions on surprise medical bills.⁶
4. Insurance solutions such as reducing financial burdens on the underinsured, limiting cost-sharing, limiting out-of-network billing, improving network adequacy standards to ensure that in-network care is available, and preserving strong coverage standards.
5. Reaching the remaining uninsured.

The Model Medical Debt Protection Act tackles the first two of these problem areas. It requires financial assistance policies that would cover more patients, sets forth specific financial guidelines for charity care and discounted care, and adds a number of procedural safeguards to protect consumers from aggressive or unfair debt collection practices.

Summary of Model Medical Debt Protection Act Provisions

Financial Assistance Policy improvements

- For-profit hospitals would be required to adopt financial assistance policies (or FAPs).
- Free-standing ambulatory surgical centers, which may provide many of the same services as hospitals, would also be required to adopt FAPs.
- Outpatient clinics or other facilities which are affiliated with any nonprofit or for-profit hospital would be covered by the hospital's FAP.

⁶ See Consumers Union, [Getting Started on Surprise Medical Bills: An Advocate's Guide](#) (Nov. 2015).

- Health care professionals who provide care in any of these settings would also be covered by the facility’s FAP, even if the individual health care provider bills patients separately.
- Large health care practice groups with revenues over \$20 million annually would be required to create FAPs.
- These entities are all “large health care facilities” under the Model Act, and may be made subject to the Model Act as a condition of their state licensure.

Required steps before billing a patient

- Consumer protections regarding billing and collections would apply to all health care providers, not just the large health care facilities that are required to establish FAPs.
- If not already doing so, large health care facilities would be required to offer to screen patients for insurance eligibility and eligibility for other programs (such as state Medical Hardship programs, state children’s catastrophic illness funds, and state agencies that assist people with certain physical or mental health conditions).⁷
- Large health care facilities would be required to give patients a copy of the FAP, post the FAP on a website, and provide copies of the application form upon request.
- The Model Act would clarify the responsibility of large health care facilities to offer language assistance as needed by patients to navigate the FAP.

Guidelines for discounts under the Financial Assistance Policy

- Under the Model Act, if a patient’s household income is at or below 200% of the federal poverty level (FPL), then the hospital or health care provider must offer free care.
- If the patient’s household income is between 201–400% FPL, the health care provider must calculate the patient’s bill based on the Medicare⁸ rate, and from the starting point of the Medicare rate must offer a discount of 50% for the first \$1,000 of medical expenses; 90% for remaining amounts between \$1,001–5,000; 95% for remaining amounts between \$5,001–10,000, and full forgiveness of any remaining charges above \$10,000.

⁷ See, e.g., Cal. Health & Safety Code § 127420 (West).

⁸ Other alternatives may include the Medicaid reimbursement rate (as used in some instances in California and New York, see Cal. Health & Safety Code § 127405(d) (West); N.Y. Pub. Health Law §2807-k(9-a) (McKinney)).

Amounts to be paid by patient with income of 201–400% FPL	Maximum for patient to pay
50% of the first \$1,000	\$ 500
10% of amounts between \$1,001–\$5,000	\$ 400
5% of amounts between \$5,001–\$10,000	\$ 250
Full forgiveness of amounts over \$10,000	----
Maximum amount for patient to pay per bill	\$1,150

- If the patient’s family income is 401–600% of FPL, the same discounts are to be provided if the patient’s total medical expenses from the current provider’s bills and all other family medical bills for the previous 12 months exceed 10% of the household’s income.
- In addition to these discounts, no patient with household income at or below 400% FPL would be required to pay more than \$2,300 in cumulative medical bills to large health care facilities for one year after being found eligible for financial assistance.

Payment plans for patients who qualify for financial assistance

- Payment plans would be spread over at least 24 months, with monthly payments not to exceed 5% of the patient’s household income.
- The patient’s first payment on a payment plan would not be due until at least 90 days after discharge or treatment, allowing the patient to address medical bills after recovering and returning to work or normal routines.

Underinsured patients

- Hospitals have at times argued that they cannot forgive copayments or other patient cost sharing because to do so would violate their contracts with insurers. The Model Medical Debt Protection Act clarifies that there is no contractual violation if a health care provider forgives some or all of patient’s copay, coinsurance, or other cost sharing.
- If a patient is in the process of appealing a denial of payment by insurer, the health care provider must allow the appeals process to proceed and refrain from collections or credit reporting while the patient exercises these appeal rights.

Debt collection protections and guidelines

- The debt collection protections of the Model Medical Debt Protection Act apply to all health care providers as well as debt buyers and debt collectors that are collecting medical debts.
- If the patient qualifies for a discount and payment plan under the FAP, then no interest will be added to the medical expenses.
- For patients who do not qualify for a discount under the FAP, interest on their medical debt is limited to the rate based on U.S. Treasury yields.

- Health care providers and debt collectors must provide patients with detailed receipts of payments, allowing consumers to keep track of their payments and, if there is a future attempt to collect the medical debt, providing proof that the debt has been paid or discharged.⁹
- Family members would be shielded from medical and nursing home debts accrued by a spouse or parent.
- The Model Medical Debt Protection Act provides additional guidelines for permissible and prohibited debt collection practices.

Remedies for violations of the Model Medical Debt Protection Act

- If a health care provider or a debt collector for a health care provider violates the law, the patient would have a private right of action under state unfair and deceptive acts and practices (UDAP) law, with any associated damages or injunctive relief.
- The Attorney General or other state agency is authorized to enforce the Model Medical Debt Protection Act, and to address patient complaints when financial assistance is not provided or the law is violated.

⁹ During 2015, 26% of consumer debt collection complaints received by the Consumer Financial Protection Bureau involved continued attempts to collect debts that had already been paid. Consumer Financial Protection Bureau, [Fair Debt Collection Practices Act, CFPB Annual Report 2016](#) (Mar. 2016).

The National Consumer Law Center's Model Medical Debt Protection Act

Section 1. Purpose.

This Act shall be known and cited as the "Medical Debt Protection Act." The purpose of this Act is to reduce burdensome medical debt and to protect patients in their dealings with medical creditors, medical debt buyers, and medical debt collectors with respect to such debt. This Act is to be construed as a consumer protection statute and shall be liberally and remedially construed to effectuate its purposes.

COMMENTARY TO SECTION 1

Section 1 sets out the purpose of the Model Medical Debt Protection Act to reduce medical debt and protect vulnerable patients and families by requiring financial assistance policies to help financially eligible patients, setting forth specific financial guidelines for charity care and discounted care, and adding procedural safeguards to protect patients from aggressive or unfair debt collection practices. The section clearly announces that the legislature intends that the Act must be liberally construed and that it is a consumer protection law. These directives will give guidance to the courts when the Act's provisions are applied and interpreted.

Section 2. Definitions.

- (a) "Consumer" means a natural person.
- (b) "Consumer reporting agency" means any person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.
- (c) "External review" means a review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to an applicable state external review process as described at [insert state citation], a federal external review process as described at 42 U.S.C. § 300gg-19, a review pursuant to 29 U.S.C. § 1133, a Medicare appeals process, a Medicaid appeals process, or another applicable appeals process.
- (d) "Extraordinary collection action" means any of the following:
 - (1) Selling an individual's debt to another party, except if, prior to the sale, the medical

creditor has entered into a legally binding written agreement with the medical debt buyer of the debt pursuant to which—

- (i) The medical debt buyer or collector is prohibited from engaging in any extraordinary collection actions to obtain payment for the care;
 - (ii) The medical debt buyer is prohibited from charging interest on the debt in excess of that described at Section 13 of this Act;
 - (iii) The debt is returnable to or recallable by the medical creditor upon a determination by the medical creditor or medical debt buyer that the individual is eligible for financial assistance; and
 - (iv) If the individual is determined to be eligible for financial assistance and the debt is not returned to or recalled by the medical creditor, the medical debt buyer is required to adhere to procedures which shall be specified in the agreement. The procedures shall ensure that the individual does not pay, and has no obligation to pay either jointly or separately, the medical debt buyer and the medical creditor more than he or she is personally responsible for paying in compliance with this Act.
- (2) Reporting adverse information about the patient to a consumer reporting agency; or
 - (3) Actions that require a legal or judicial process, including but not limited to—
 - (i) Placing a lien on an individual's property;
 - (ii) Attaching or seizing an individual's bank account or any other personal property;
 - (iii) Commencing a civil action against an individual; or
 - (iv) Garnishing an individual's wages.
- (e) “Financial assistance policy” means a written financial assistance policy which includes—
- (1) Eligibility criteria for financial assistance, including when such assistance includes free or discounted care;
 - (2) The basis for calculating amounts charged to patients;
 - (3) The method for applying for financial assistance;
 - (4) The billing and collections policy, containing the actions the covered health care provider may take in the event of non-payment, including collections action and reporting to consumer reporting agencies; and
 - (5) Measures to widely publicize the policy within the community to be served by the covered health care provider.
- (f) “Gross charges” means a health care provider’s full, established price for health care services that the health care provider charges uninsured patients before applying any contractual allowances, discounts, or deductions.
- (g) “Health care services” means services for the diagnosis, prevention, treatment, cure, or relief of a physical, dental, behavioral, substance use disorder or mental health condition, illness, injury, or disease. These services include, but are not limited to, any procedures, products, devices, or medications.
- (h) “Household income” means income calculated by using the methods used to calculate Medicaid eligibility, as set forth at 42 C.F.R. § 435.603 or a comparable method designated by [state rulemaking agency] if this regulation is repealed.

(i) “Internal review or internal appeal” means review by a health insurance plan or other insurer of an adverse benefit determination.

(j) “Large health care facility” means any the following entities:

- (1) Any hospital licensed under [citation to state licensing law], whether a nonprofit subject to 26 U.S.C. § 501(c)(3); a hospital owned by a county, municipality, or state; or a for profit entity;
- (2) Any outpatient clinic or facility affiliated with a hospital or operating under the license of a hospital as defined in paragraph (1);
- (3) Any ambulatory surgical center, licensed under [citation to state licensing law];
- (4) Any practice which provides outpatient medical, behavioral, optical, radiology, laboratory, dental, or other health care services with revenues of at least \$20,000,000 annually, and is licensed under [citation to applicable state licensing laws]; or
- (5) Any licensed health care professional who provides health care services in one or more of the settings listed in paragraphs (1) through (4), above, but bills patients independently.

(k) “Medical creditor” means any entity that provides health care services and to whom the consumer owes money for health care services, or the entity that provided health care services and to whom the consumer previously owed money if the medical debt has been purchased by one or more debt buyer(s).

(l) “Medical debt” means a debt arising from the receipt of health care services.

(m) “Medical debt buyer” means a person or entity that is engaged in the business of purchasing medical debts for collection purposes, whether it collects the debt itself or hires a third party for collection or an attorney-at-law for litigation in order to collect such debt.

(n) “Medical debt collector” means any person that regularly collects or attempts to collect, directly or indirectly, medical debts originally owed or due or asserted to be owed or due another. A medical debt buyer is considered to be a medical debt collector for all purposes.

(o) “Patient” means the person who received health care services, and for the purposes of this Act shall include a parent if the patient is a minor, or a legal guardian if the patient is an adult under guardianship.

COMMENTARY TO SECTION 2

Most definitions in this section are based on those found in other state or federal laws. The definition of “consumer reporting agency” is based on the definition from the Fair Credit Reporting Act at 15 U.S.C. § 1681a(f).

The definitions of “external review” and “internal review or internal appeal” are based on the definitions used at 45 C.F.R. § 147.136(a)(2). They also reflect the requirements of 42 U.S.C. § 300gg-19 and 29 U.S.C. § 1133, which govern different types of health insurance appeals. In general, an internal review is the first step that a patient takes to challenge an insurer’s decision to deny a claim. An external review, which is a further appeal to an independent reviewer, may

be available to the patient in certain insurance disputes. The definition could be modified to be consistent with state laws regarding health insurance appeals. In addition, Medicare and Medicaid plans offer different appeal rights which are set forth in state law (for Medicaid) and federal law (for both Medicaid and Medicare). The definitions of internal and external review are needed because Section 12 of this Model Act contains a protection which pauses any collection or credit reporting activity while the patient exercises appeal rights.

The definition of “extraordinary collection action” lists the types of collection activities that are regulated by the Model Act, and is based on those listed at 26 C.F.R. § 1.501(r)-6(b), as set forth at 79 Fed. Reg. 78953–79016 (Dec. 31, 2014), which the IRS promulgated to implement the financial assistance and debt collection provisions of the ACA.

The definition of “financial assistance policy” is closely based on 26 U.S.C. § 501(r)(4), which the IRS promulgated to implement the financial assistance and debt collection provisions of the ACA.

The definition of “gross charges” is based on the definition at 26 C.F.R. § 1.501(r)-1, which the IRS promulgated to implement the financial assistance and debt collection provisions of the ACA. Gross charges may also be referred to as chargemaster rates. While chargemaster rates are more commonly found in hospitals, this definition includes the gross charges of any health care provider. Gross charges are often several times the rates paid by third party insurers (such as Medicare or private insurers) and also several times the provider’s cost of services. See National Consumer Law Center, [Collection Actions § 9.1.3](#) (3d ed. 2014), *updated at* www.nclc.org/library (discussion of chargemaster pricing).

The definition of “health care services” is a general one, which is similar to the Massachusetts insurance law definition at Mass. Gen. Laws ch. 176O, § 1.

“Household income” is defined as income calculated by using the federal modified adjusted gross income (MAGI) method that is used to determine Medicaid eligibility. In the alternative, a state may choose to adopt a state law definition of household income.

“Large health care facilities” are defined to include nonprofit and for-profit hospitals, outpatient practices which are affiliated with hospitals, ambulatory surgical centers, and large outpatient practices. These entities and health care professionals are to be covered by the provisions of this Model Act as a condition of their licensure by the state. These covered health care providers are a subcategory of “medical creditor,” which includes large and small health care providers. The Model Act regulates the activities of all medical creditors, but places special responsibilities on large health care facilities, such as the development of financial assistance policies.

The definition of “large health care facility” includes any outpatient practice which receives at least \$20,000,000 in annual revenues. This definition would include large group practices that might not otherwise fall into any of the other categories, but does not include solo or smaller practices. The threshold of \$20 million is a sufficiently high figure to define large group practice, as it even encompasses small hospitals. For examples of the revenues received by one state’s large health care providers, see Center for Health Information and Analysis, [FY2015 Annual Report](#) (Aug. 25, 2016), *available at* www.chiamass.gov.

Patients who are treated in hospitals may not anticipate bills which are sent not by the hospital, but by health care professionals who treat patients within a hospital building or other facility but are not part of the hospital staff. Bills from anesthesiologists, surgeons, and other specialists often come as a surprise to patients who believed that only the hospital itself would bill for their care. In some instances, the specialist may not be part of the patient’s insurance network, even

though the hospital itself is within the insurer's network. The IRS regulations implementing the financial assistance provisions of the Affordable Care Act made a limited attempt to address this issue by requiring nonprofit hospitals to list any providers who were not covered by the hospital's FAP. See 26 C.F.R. §1.501(r)-4(b)(iii)(F). In addition to expanding the scope of this IRS requirement to for-profit hospitals and other large providers, the Model Medical Debt Protection Act directs that any health care professional who provides services in a large health care facility must also provide financial assistance and follow the facility's FAP. There is no requirement that such providers themselves be part of a large group, thus preventing evasion by structuring their practices to technically be solo or a small group, but in reality practicing in a hospital or large facility. High medical bills at gross charges for such providers would be financially devastating for the low- and moderate-income patients who are eligible for financial assistance.

"Medical creditor" is broadly defined as a health care provider to whom a patient owes money.

The definition of "medical debt" is based on the definition used by the Fair Credit Reporting Act at 15 U.S.C. § 1681b(g)(1)(C).

The definition of "medical debt buyer" is a modified version of the definition of debt buyer used in the North Carolina Consumer Economic Protection Act of 2009, codified at N.C. Gen. Stat. § 58-70-15(b)(4).

The definition of "medical debt collector" is a simplified version of the definition of debt collector used in the Fair Debt Collection Practices Act, at 15 U.S.C. § 1692a(6), slightly modified to make it explicit that the term covers medical debt buyers.

No definition of "medically necessary" or "medical necessity" is included, as states generally have such definitions in existing state Medicaid or insurance law. Should a state seek to adopt or modify a definition of medical necessity, examples include the following—

California medical necessity definition:

"A service is 'medically necessary' or a 'medical necessity' when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain." Cal. Welf. & Inst. Code § 14059.5 (West).

Massachusetts medical necessity definition:

"Medical Necessity or Medically Necessary means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether the service:

- (a) is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
 - (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
 - (c) for services and interventions not in widespread use, is based on scientific evidence."
- 958 Code Mass. Regs. 3.020.

For other examples, see Conn. Gen. Stat. § 17b-259b and Haw. Rev. Stat. § 432E-1.4.

Section 3. Financial Assistance Policy for Large Health Care Facilities.

- (a) All large health care facilities, as defined in this Act, are required to develop written financial assistance policies that comply with this Act and any implementing regulations. This requirement shall apply whether or not the large health care facility is required to develop a financial assistance policy under 26 U.S.C. § 501(r)(4) and implementing regulations.
- (b) The financial assistance policy must, at a minimum, contain the following:
- (1) A written financial assistance policy that applies to all emergency and other medically necessary health care services offered by the large health care facility;
 - (2) A plain language summary of the financial assistance policy, which shall not exceed two pages in length;
 - (3) The eligibility criteria for financial assistance and a summary of the type of assistance that is available as set forth in this Act;
 - (4) The method and application process that patients are to use to apply for financial assistance;
 - (5) The information and documentation the large health care facility may require an individual to provide as part of the application;
 - (6) The reasonable steps that the provider will take to determine whether a patient is eligible for financial assistance; and
 - (7) The billing and collections policy, including the actions that may be taken in the event of nonpayment, which shall comply with all applicable parts of this Act and other applicable municipal, state or federal laws.
- (c) The financial assistance policy must be approved by the owners or governing body of a health care provider. The financial assistance policy shall be reviewed and approved on an annual basis by the owners or governing board.

COMMENTARY TO SECTION 3

This section requires all large health care facilities to develop a financial assistance policy (FAP). The requirements for a FAP are based on those set forth in the Affordable Care Act provisions governing financial assistance by nonprofit hospitals at 26 U.S.C. § 501(r)(4), and implementing regulations promulgated by the U.S. Department of Treasury regarding such policies. However, the Model Act applies the FAP requirements to all large healthcare facilities and takes the additional step in Section 4 of setting forth eligibility standards and minimum levels of financial assistance. As noted earlier, the definition of FAP is also based on the language of 26 U.S.C. § 501(r)(4).

These requirements are included in the Model Act because of the difficulty of predicting changes to or repeal of the federal law or regulations.

Section 4. Implementation of the Financial Assistance Policy.

(a) In addition to any other actions required by applicable municipal, state, or federal law, large health care facilities must take the following steps before seeking payment for any emergency or medically necessary care:

- (1) Determine whether the patient has health insurance;
- (2) If the patient is uninsured, offer to screen the patient for public or private insurance eligibility and offer assistance if the patient chooses to apply for public or private insurance; however, a patient's refusal to be screened shall not be grounds for denying financial assistance;
- (3) Offer to screen the patient for other public programs which may assist with health care costs; however, a patient's refusal to be screened shall not be grounds for denying financial assistance;
- (4) If available, use information in the possession of the large health care facility to determine that the patient is qualified for free or discounted care as set forth at subsection (b);
- (5) If the patient submits an application for financial assistance, determine the patient's eligibility for the financial assistance plan within fourteen (14) days after the patient applies for financial assistance, suspending any billing or collections actions while eligibility is being determined.

(b) The following patients shall qualify for financial assistance under the financial assistance plan, which applies to any charges for health care services that are not covered by insurance and would otherwise be billed to the patient:

- (1) Patients with household income of 0–200% of the federal poverty level shall receive free care;
- (2) Patients with household income of 201–400% of the federal poverty level shall be charged no more than the amount calculated in the following manner:
 - (i) Recalculate the patient's bill using the Medicare reimbursement rate applicable on the date(s) of service;
 - (ii) The patient shall be charged no more than 50% of the first \$1,000 charged under this recalculated bill;
 - (iii) The patient shall be charged no more than 10% of any remaining amount between \$1,001–5,000;
 - (iv) The patient shall be charged no more than 5% of any remaining amount between \$5,001–10,000;
 - (v) Any amount above \$10,000 shall be provided to the patient as free care.
- (3) Patients with household income of 401–600% of the federal poverty level shall receive the same discounts as patients with household income of 201–400% of the federal poverty level if the patient and the patient's household have incurred medical expenses from the large health care facility's bill as well as all other medical bills for medically necessary health care services received during the previous twelve (12) months, the total of which exceeds 10% of the household's annual gross income.
- (4) In addition to other financial assistance provided under this Act, no patient with household income at or below 400% of the federal poverty level shall be required to pay

more than \$2,300 in cumulative medical bills to large health care facilities per year. Upon patient request and documentation, any health care services that have been delivered by one or more large health care facilities after the \$2,300 limit has been met must be provided as free care.

(c) Establishing eligibility.

- (1) Household income shall be established by the most recent tax return unless the patient chooses to submit pay stubs, documentation of public assistance, or documentation of household income which the [state regulatory agency] has identified as a valid form of documentation for the purposes of this Act. If the large health care facility requires any other documentation, it shall list such documentation requirements in its financial assistance policy as required by Section 3(b)(5).
- (2) If the large health care facility uses a consumer report, as defined in Section 603(d) of the Fair Credit Reporting Act, 15 U.S.C. § 1681a(d), or any score or rating based on consumer report information, the facility shall obtain the consumer's consent for such use, and shall comply with all applicable provisions of the Act.
- (3) A large health care facility may grant financial assistance notwithstanding a patient's failure to provide one of the required forms of documentation described in the financial assistance policy or application form and may rely on, but not require, other evidence of eligibility. A large health care facility may grant financial assistance based on a determination of presumptive eligibility relying on information in the facility's possession, but shall not presumptively deny an application based on such other evidence.

(d) If a large health care facility receives an application for financial assistance from a patient, the facility shall notify the patient in writing within three business days after making the determination of the patient's eligibility for financial assistance pursuant to Section 4(a)(5) as to whether it has approved or denied the application. The large health care facility shall provide a copy of any recalculated bill and calculation of financial assistance provided to the patient.

(e) A large health care facility shall accept and consider a patient's application for financial assistance when it is submitted within one year of the date of the first bill after the provision of the health care services. However, if the patient is the subject of collection activity by the facility or a medical debt collector, including a lawsuit to collect a medical debt or negative credit reporting regarding a medical debt, and submits an application for financial assistance, the large health care facility shall accept and process the application at any time. If the patient submits a financial assistance application to a medical debt collector, the medical debt collector shall forward the application to the large health care facility within two business days, and shall cease collection activity until notified by the large health care facility of the outcome of the application and any debt forgiven or new repayment terms.

(f) Large health care facilities and medical debt collectors shall not charge any interest or late fees to patients who qualify for financial assistance.

(g) Large health care facilities and medical debt collectors shall offer to any patient who qualifies for financial assistance a payment plan of not less than twenty-four months, and shall not require the patient to make monthly payments that exceed 5% of the patient's gross monthly income. Prepayment or early payment penalties or fees are prohibited.

(h) For a patient who has been found to be eligible for financial assistance, no initial payment on a monthly payment plan shall be due within the first 90 days after the health care services were provided.

COMMENTARY TO SECTION 4

Section 4(a)

This subsection sets forth the steps that a large health care facility must follow before billing any patient who has received health care services. In summary, the large health care facility must offer to check insurance status and offer to help uninsured patients to apply for health insurance. This type of screening is modeled on a requirement in California law. See Cal. Health & Safety Code § 127420 (West). The large health care facility will also be directed to refer patients to other publicly funded programs which may provide assistance. These programs could include Catastrophic Illness in Children Relief Funds, which operate in about 11 states, or other funds such as the Massachusetts Health Safety Net and Medical Hardship programs, which provide assistance to low-income patients for certain types of health care expenses.

A patient may choose not to be screened for insurance eligibility, and this refusal to be screened will not adversely impact the patient's eligibility for the facility's FAP.

Section 4(b)

This subsection mandates minimum levels of discounts that must be offered by large health care facilities. Several state laws have established these guidelines, although the discounts in the Model Act are more substantial than most in order to address the pervasive problem of medical debt as described in the Introduction to the Model Act.

States which currently mandate discounts for low-income patients include the following:

- California: Sets minimum eligibility criteria, discounted care for uninsured patients or patients with high medical costs who have incomes at or below 350% of the federal poverty level. Cal. Health & Safety Code §§ 127400, 127405 (West).
- Connecticut: Discounted care for uninsured patients who do not qualify for Medicaid, Medicare, or other coverage and with income at or below 250% FPL. Conn. Gen. Stat. § 19a-673.
- Illinois: Free care for most patients with a family income at or below 200% FPL (care at rural or critical access hospitals must be free for patients at or below 125% FPL); discounted care for uninsured patients with income and assets at or below 600% FPL (or 300% FPL for rural or critical access hospitals). 210 Ill. Comp. Stat. 89/10.
- Maryland: Free care for patients at or below 200% FPL, reduced cost care for patients with income between 200%–300% FPL. Md. Code Ann., Health-Gen. § 19-214.1; Md. Code Regs. 10.37.10.26.
- New Jersey: Free care for patients at or below 200% FPL, and discounts for patients with income between 200%–300% FPL. N.J. Admin. Code § 10:52-11.8.
- New York: Hospitals may charge no more than a nominal fee to patients with incomes at or below 100% FPL, and are to provide discounted care on a sliding scale basis to patients with incomes between 100%–300% FPL. N.Y. Pub. Health Law § 2807-k(9-a) (McKinney).

- Washington: Free care for uninsured patients at or below 100% FPL and discounts of 75% to 25% for patients between 100% and 200% FPL. Wash. Rev. Code Ann. § 70.170.060; Wash. Admin. Code §§ 246-453-010, 246-453-020, 246-453-050.

Under the Model Act, a family with income between 201%–400% of the federal poverty level, or a family with slightly higher income that is experiencing a financial hardship as defined in this section, could be charged no more than \$1,150 for a medical bill depending on the cost of the health care services received. This amount would be subject to a payment plan as noted below. In addition, if a family of this income level is subject to multiple medical bills, paragraph (b)(4) limits the overall cumulative amount that the family can be charged to \$2,300 in one year. Health care facilities would be free to deviate from this structure to provide additional assistance, such as providing free care for patients up to 300% of the federal poverty level without financial contribution from the patient.

The following chart describes the financial assistance which is to be made available to a patient with household income that is between 201–400% of FPL:

Amounts to be paid by patients with incomes of 201–400% FPL	Patient pays up to
50% of the first \$1,000	\$ 500
10% of amounts between \$1,001–\$5,000	\$ 400
5% of amounts between \$5,001–\$10,000	\$ 250
Full forgiveness of amounts over \$10,000	----
Maximum amount for patient to pay per bill	\$1,150

Paragraph (b)(3) includes assistance for moderate-income families with incomes between 401–600% of FPL, under certain circumstances. These families are included since they may also suffer economic harm from medical debt when large health care costs are incurred. The Act extends a discount to these families when annual out-of-pocket expenses exceed 5% of the patient’s family income. The patient must provide documentation of the patient’s medical expenses paid by the patient or the patient’s family in the prior 12 months. This 5% threshold is similar to the 10% threshold in California law, although in that state the standard is applied to families with incomes up to 350% of FPL. See Cal. Health & Safety Code § 127400 (West).

A critical question for any medical debt or charity care law is how to set the reimbursement rate from which financial assistance is calculated. Financial assistance should not be calculated from gross or chargemaster rates, which are highly inflated. The Model Act uses the Medicare reimbursement rate to determine the amount that can be charged for care, and then applies the appropriate discount to the Medicare amount. Existing state laws and the federal regulations use different methods to calculate this amount. Alternatives include:

- California and New York: The Medicaid reimbursement rate is used in some instances in California and New York. Cal. Health & Safety Code § 127405(d) (West); N.Y. Pub. Health Law § 2807-k(9-a) (McKinney).
- New Jersey: New Jersey limits charges to “an amount no greater than 115% of the applicable payment rate under the federal Medicare program” for uninsured patients with a family income below 500% of the federal poverty level (FPL). N.J. Stat. Ann. § 26:2H-12.52 (West).
- Connecticut: Connecticut limits charges for uninsured patients at or below 250% FPL to the “cost of providing services,” although this cost is calculated using a formula based upon charges that the hospitals must publish and file with the state. Conn. Gen. Stat. § 19a-673.
- Illinois: This state requires discounted care for those with incomes between 201%–600% FPL, limiting allowable charges to no more than the hospital’s costs plus 35%, and limiting

billing to no more than 25% of the patient's family income over a 12 month period, for bills exceeding \$300. 210 Ill. Comp. Stat. 89/5, 89/10.

- Colorado: Charges to uninsured patients with income at or below 250% FPL are limited to "not more than the lowest negotiated rate from a private health plan." Colo. Rev. Stat. § 25-3-112.
- IRS regulations: Patients eligible for financial assistance cannot be charged more than "amounts generally billed," or AGB, which can be calculated using one of two methods: a "look back" method based on what the hospital was actually paid for such care, using Medicare, Medicaid, and private insurance rates; or a "prospective" method using Medicaid or Medicare rates. 26 C.F.R. § 1.501(r)-5(b)(3), (4).

Section 4(c)

This subsection sets out the documentation requirements to be used for financial assistance determinations. It allows large health care facilities to grant assistance even if there is missing documentation. It also permits a large health care facility to grant financial assistance based on a determination of presumptive eligibility based on other information, such as the fact that the patient receives public benefits or is eligible for another income-based program, but prohibits the facility from denying financial assistance using a presumptive determination.

If a large health care facility uses credit scores or other scoring models when determining eligibility, the Model Act requires patient consent and that the facility be in compliance with the federal Fair Credit Reporting Act, 15 U.S.C. § 1681 *et seq.*

Section 4(d)

This subsection requires the large health care facility to give the patient written notice of its financial assistance eligibility decision within three business days after making its decision whether to approve or deny the patient's application, a decision which Section 4(a)(5) requires to be made within 14 days of the application. In the case of a successful application, the large health care facility is to issue a revised bill explaining how much the patient is expected to pay. This notice is to provide clear information to the patient about their financial obligations after the receipt of financial assistance.

Section 4(e)

This subsection requires that any large health care facility must accept and process applications for financial assistance for a full year after the first bill for the health care services that generated the medical debt. In addition, if the large health care facility or medical debt collector (including medical debt buyers) engages in collection activity over the debt, including suing the patient for the debt or reporting it to a credit reporting agency, then the patient may submit the financial assistance application at any time, and the large health care facility must determine if the patient is eligible. If the patient is eligible based on the most recent financial information, then the large health care facility must provide financial assistance. Note that in the state of Washington, there is no deadline and an application for financial assistance may be submitted at any time. Wash. Admin. Code § 246-453-020(10).

Section 4(f) and Section 4(g)

The Act establishes minimum requirements for payment plans. It also prohibits the charging of interest, late fees, and prepayment penalty fees for FAP-eligible patients and ensures that payments do not exceed 5% of the patient's gross monthly income.

Section 5. Financial Assistance Policy: Public Education and Information.

- (a) A large health care facility must publicize its financial assistance policy widely, by:
- (1) Making the financial assistance policy and the financial assistance application form easily accessible online, through the large health care facility's website and through any patient portal, or other online communication portal used by patients of the health care provider;
 - (2) In addition to any other requirements in this Act, making paper copies of the financial assistance policy and application form available upon request and without charge, both by mail and in the large health care facility's office. For hospitals, copies should be available, at a minimum, in the emergency room (if any) and admissions areas;
 - (3) Notifying and informing members of the community served by the large health care facility about the financial assistance policy in a manner reasonably calculated to reach those members who are most likely to require financial assistance with such efforts commensurate to the size and income of the provider; and
 - (4) Notifying and informing individuals who receive care from the large health care facility about the financial assistance policy by—
 - (i) Offering a paper copy of the financial assistance policy to patients as part of the patient's first visit, or in the case of a hospital facility, during the intake and discharge process;
 - (ii) Including a conspicuous written notice on billing statements, whether sent by the large health care facility or a medical debt collector, that notifies and informs recipients about the availability of financial assistance and includes the telephone number of the large health care facility's office or department that can provide information about the financial assistance policy and application process and the direct website address where copies of the financial assistance policy and application may be obtained; and
 - (iii) Setting up conspicuous public displays (or other measures reasonably calculated to attract patients' attention) that notify and inform patients about the financial assistance policy in public locations in the large health care facility's office. For hospitals, displays should be posted in the emergency room (if any) and admissions areas, at a minimum.
- (b) In all attempts, whether written or oral, by a medical creditor or debt collector to collect a medical debt for health care services provided by a large health care facility, the patient must be informed of any financial assistance policy available through the large health care facilities.

COMMENTARY TO SECTION 5

This subsection lists the notice and publicity requirements for the financial assistance policy, and is based on the regulations at 26 C.F.R. § 1.501(r)-4. These requirements are included in the Act because of the difficulty of predicting changes to or repeal of the federal regulations. States may opt to use their own state law requirements or state guidelines for the format of notices from health care providers to patients.

With any attempt to collect the debt by the large health care facility or a medical creditor or debt collector, the patient must be notified again of the large health care facility's FAP. This sample notice language, or something similar, may be included with bills or collections notices: "Need help paying your bill? You may be eligible for financial assistance. Call [insert large health care facility's phone number] or visit [insert large health care facility's web page address] for more information."

Section 6. Financial Assistance Policies: Language Access.

(a) A financial assistance policy shall include a notice that states "This document contains important information about financial assistance for your bill. Contact [insert name and phone number of large health care facility] for translation assistance," translated in the ten (10) languages most frequently spoken by limited English proficient households as determined by U.S. Census Bureau data in the large health care facility's service area.

(b) A large health care facility must accommodate all significant populations that have limited English proficiency by translating the financial assistance policy and application form into the primary language(s) spoken by such populations. A large health care facility will satisfy this translation requirement if it makes available translations of its financial assistance policy and application form in the language spoken by each limited English proficiency language group that constitutes the lesser of 1,000 individuals or 5% of the community served by the large health care facility or the population likely to be affected or encountered by the large health care facility. A large health care facility may determine the percentage or number of limited English proficiency individuals in the large health care facility's community or likely to be affected or encountered by the hospital facility using any reasonable method.

(c) A large health care facility must accommodate any patient with limited English proficiency and who is part of a population that falls below the numerical thresholds established in Section 6(b) by providing oral interpretation services to the patient upon request and at no cost to the patient to explain the financial assistance policy and its application.

(d) A large health care facility must accommodate any patient with limited English proficiency by answering questions from the patient regarding the financial assistance policy, the application form, any written determination of eligibility, and any other communication regarding financial assistance from the large health care facility. A large health care facility may accommodate these patients by providing oral interpretation services to the patient upon request and at no cost to the patient.

COMMENTARY TO SECTION 6

The Model Act includes language accessibility requirements for the FAP, which are based on similar requirements found in the IRS regulations, at 26 C.F.R. § 1.501(r)-4(b)(5)(ii). The FAP must also include a "Babel notice," or a tagline notice written in different languages to inform the patient that the document is important and the patient may seek translation assistance. Since

this notice is relatively easy to implement and can take the form of a short insert, a somewhat longer list of languages is specified.

A large health care facility must provide a written translation of its FAP to patients described in paragraph (b). In addition, the health care facility must provide oral translation services to other patients who speak less common languages about the FAP, and to any patients who have questions about the FAP and its application. The large health care facility may provide oral translation services by using a telephone language line service. States may wish to create a model FAP and translation into frequently-spoken languages and offer this model to large health care facilities. States may also adopt more detailed regulations regarding language access to provide any other needed guidance to large health care providers.

Section 7. Billing and Collections Rules, Limits on Creditors.

(a) The following prohibited collection actions may not be used by any medical creditor or medical debt collector to collect debts owed for health care services:

- (1) Causing an individual's arrest;
- (2) Causing an individual to be subject to a writ of body attachment [or similar term such as "*capias*"];
- (3) Foreclosing on an individual's real property; or
- (4) Garnishing the wages or state income tax refund(s) of a patient who is eligible for financial assistance pursuant to Section 4(b) of this Act.

(b) No medical creditor or medical debt collector shall engage in any permissible extraordinary collection actions until 180 days after the first bill for a medical debt has been sent.

(c) At least thirty days before taking any extraordinary collection actions, a medical creditor or medical debt collector must provide to the patient a notice containing the following:

- (1) In the case of large health care facilities and medical debt collectors collecting debts for health care services provided by such facilities, stating that financial assistance is available for eligible individuals and providing a plain-language summary of the financial assistance policy;
- (2) Identifying the extraordinary collection actions that will be initiated in order to obtain payment; and
- (3) Providing a deadline after which such extraordinary collection actions will be initiated and that deadline shall be no earlier than thirty days after the date of the notice.

(d) A large health care facility or a medical debt collector collecting debt for health care services provided by such a facility shall not use any extraordinary collection actions unless these actions are described in the large health care facility's billing and collections policy.

(e) If a large health care facility or a medical debt collector collecting debt for health care services provided by such a facility bills or initiates collection activities and the patient is later found eligible for financial assistance, the large health care facility or medical debt collector shall reverse any extraordinary collection actions, including:

- (1) Deleting any negative reports to consumer reporting agencies;
- (2) Dismissing or vacating any collection lawsuits over the medical debt; and

(3) Removing any wage garnishment orders.

If the patient has paid any part of the medical debt or any of the patient's funds have been seized or levied in excess of the amount that the patient owes after application of financial assistance, the large health care facility or medical debt collector shall refund any excess amount to the patient.

COMMENTARY TO SECTION 7

This section prohibits certain collection actions by medical creditors or debt collectors: arrest, body attachment, and foreclosure. It also prohibits them from garnishing the wages or state tax refunds of patients eligible for financial assistance. With respect to arrests and body attachments, also sometimes called a "*capias*," this usually occurs because the consumer supposedly has failed to show up to a court-mandated hearing, such as the debtor's examination in which the debtor is required to reveal his or her assets to pay a judgment. Despite being ostensibly issued as a form of civil contempt, such arrest warrants are often actually used as an *in terrorem* tactic by collectors to coerce payment. The Act prohibits medical creditors or debt collectors from seeking an arrest or body attachment; however, the court always has the inherent authority to issue them. As for foreclosures, a medical creditor or debt collector has the ability to place a lien on a home, but cannot foreclose on that lien under this section. Instead, they must wait until the home is sold to collect the amount.

Several states have placed restrictions on the use of certain collection actions. For instance, Kansas forbids wage garnishments for two months after the return to employment of a debtor after an illness of the debtor or of a family member which has kept the debtor out of work for two or more weeks. Kan. Stat. Ann. § 60-2310(c). Ohio forbids execution on the primary residence for health care debts during the lifetime of the debtor and certain specified dependents. Ohio Rev. Code Ann. §§ 2329.66(A)(1)(a), 2329.661 (West). Louisiana provides a homestead exemption for the full value of the home for debts arising from catastrophic or terminal illness or injury. La. Rev. Stat. Ann. § 20:1. West Virginia provides a larger homestead exemption for debts resulting from "catastrophic illness or injury." W. Va. Code § 38-9-3.

Of the remaining permissible extraordinary collection actions, a medical creditor or medical debt collector (including a medical debt buyer) may take these allowable extraordinary collection actions only after 180 days have passed since sending the first bill for a medical debt. This protection is based on a similar prohibition (albeit only 120 days) in the Internal Revenue Service regulations at 26 C.F.R. § 1.501(r)-6. The purpose of this 180-day period is to give the patient time to resolve billing disputes and questions, or insurance documentation requests and appeals, before being subject to extraordinary collection actions.

The section also requires that, for large health care facilities, the billing and collection policy include any extraordinary collection actions that the provider will take.

Paragraph (c), requires medical creditors, medical debt buyers, and medical debt collectors to notify the patient 30 days before taking any of the permissible extraordinary collection actions. This notice requirement is based on the 30-day notice that is provided in the Internal Revenue Service regulations at 26 C.F.R. § 1.501(r)-6(c)(4)(i)(A). If the debt originates from a large health care facility, this notice informs the patient about the availability of financial assistance, including a plain language summary of the FAP.

Paragraph (d) prohibits a large health care facility or a medical debt collector collecting its debts from taking an extraordinary collection action unless it is listed in the large health care facility's financial assistance policy.

Paragraph (e) directs a large health care facility or a medical debt collector collecting its debts to make refunds to the patient in some circumstances if the patient is found to qualify for financial assistance. A refund to the patient may be needed to resolve the patient's debt where the patient has paid the medical debt with a credit card, has borrowed other funds to pay the medical debt, or has had his or her wages or bank account funds seized to pay the debt.

Section 8. Price Information.

All large health care facilities must post price information on their Internet websites. This information must be accessible via a link from the website's homepage, and at a minimum must include the following:

- (a) List gross charges for all health care services; and
- (b) List the amount that Medicare would reimburse for the health care service, next to the relevant gross charge.

COMMENTARY TO SECTION 8

Information about the health care provider's gross charges and applicable Medicare reimbursement rates will provide valuable information to a patient. Patients eligible for financial assistance can see what their bill should be based on. Patients who do not qualify for financial assistance but who lack the resources to pay a large medical bill promptly would be able to use this information to negotiate reasonable discounts on a bill. Although the purpose of this section is to encourage fair resolution of debt (rather than health care cost containment or shopping), this section is also consistent with the growing attention to price transparency as a tool to help individuals and to slow the growth of health care costs. For instance, California requires hospitals to post information about gross charges on-line. Cal. Health & Safety Code §§ 1339.51, 1339.55, 1339.56 (West). For a summary of existing state price transparency laws, see National Conference of State Legislatures, Transparency and Disclosure of Health Costs and Provider Payments: State Actions (updated Mar. 2017).

Section 9. Liability for Medical Debt.

(a) Parents and legal guardians are jointly liable for any medical debt(s) incurred by children under the age of 18.

(b) No spouse or other person shall be liable for the medical debt or nursing home debt of any other person age 18 or older. A person may voluntarily consent to assume liability, but such consent:

- (1) Shall be on a separate standalone document signed by the person;
- (2) Shall not be solicited in an emergency room or during an emergency situation; and
- (3) Shall not be required as a condition of providing any emergency or non-emergency health care services.

COMMENTARY TO SECTION 9

This section clarifies the financial responsibility for medical debt. It also removes application of the common law “doctrine of necessities” to medical debt. That doctrine makes spouses liable for each other’s “necessaries,” which almost always includes medical bills. The doctrine originated as a way to require a husband to pay for certain necessary expenses incurred by his wife back when married women were not permitted to own property. The doctrine has been abolished in some states. See, e.g., Ark. Code Ann. § 9-11-516 (abolishing doctrine of necessities); *Connor v. Sw. Florida Reg'l Med. Ctr., Inc.*, 668 So. 2d 175, 177 (Fla. 1995) (abrogating the doctrine of necessities on equal protection grounds). However, many other states retain the doctrine in some form and have expanded it to include both spouses, and sometimes other family members. See, e.g., *S. New Hampshire Med. Ctr. v. Hayes*, 159 N.H. 711, 992 A.2d 596 (2010); S.C. Code Ann. § 20-5-60. In states that continue to follow the doctrine of necessities, the language at Section 9(b) of this Model Act would exempt medical bills from the doctrine. This would provide protection for the non-debtor spouse, and may help to prevent situations in which the spouse is burdened with overwhelming medical debt for the patient’s medical care, including expensive end-of-life treatment, resulting in severe financial hardship to elderly widows and widowers.

Section 10. Verification.

Upon written or oral request and without fee, a medical creditor or medical debt collector shall provide an itemized bill to the patient within 60 days of the request. The itemized bill shall state:

- (a) The name and address of the medical creditor;
- (b) The date(s) of service;
- (c) The date(s) the medical debt(s) were incurred, if different from the date(s) of service;
- (d) A detailed list of the specific health care services provided to the patient;
- (e) A list of all health care professionals who treated the patient;
- (f) The amount of principal for any medical debt(s) incurred;
- (g) Any adjustment to the bill (e.g., negotiated insurance rates or other discounts);
- (h) The amount of any payments received, whether from the patient or any other party;
- (i) Any interest or fees;
- (j) Whether the patient was screened for financial assistance; and

- (k) Whether the patient was found eligible for financial assistance, and if so, the amount due after all financial assistance has been applied to the itemized bill.

COMMENTARY TO SECTION 10

The information that must be provided pursuant to this section will help patients and creditors resolve disputes around the amounts that are owed.

Section 11. Medical Debt and Consumer Reporting Agencies.

(a) During the 180-day period beginning on the date when the consumer was first given a bill for the medical debt, no medical creditor or medical debt collector may communicate with or report any information to any consumer reporting agency regarding such medical debt.

(b) After the 180-day period described in paragraph (a), medical creditors and medical debt collectors must give consumers at least one additional bill before reporting a medical debt to any consumer reporting agency. The amount reported to the consumer reporting agency must be the same as the amount stated in this bill, and such bill shall state that the debt is being reported to a consumer reporting agency. Medical debt collectors shall also provide the notice required by 15 U.S.C. § 1692g before reporting a debt to a consumer reporting agency.

COMMENTARY TO SECTION 11

These consumer protections would allow for a six-month period between the initial billing of a patient and when the debt could be reported to a consumer reporting agency. This six-month period allows “breathing room” to resolve insurance issues (appeals, disputes), billing errors, and other complications that arise from having a third party payor (the insurer) involved in financial transactions.

This section would codify one of the protections for medical debt in the 2015 settlement reached between thirty-one state attorneys general and the three major credit bureaus, which also included a six-month period before a medical debt could appear on a credit report. A similar provision was included in H.R. 2362, the Medical Debt Relief Act, a bill introduced during the 114th Congress.

In addition, this section mandates that medical debt collectors (including medical debt buyers) must provide the notice of the right to validate a debt, which is required under the Fair Debt Collection Practices Act, before reporting a medical debt to a consumer reporting agency. This prevents the practice of passive collection or “parking,” in which a medical debt collector will not actively dun a consumer for a debt, but will simply report it on the consumer’s credit report and then wait until the consumer applies for credit and then must address the debt urgently. See Consumer Fin. Prot. Bureau, [Consumer Credit Reports: A Study of Medical and Non-Medical Collections](#) 35–36 (Dec. 11, 2014) (discussing passive collection).

Section 12. Prohibition Against Collection of Medical Debt During Health Insurance Appeals.

(a) No medical creditor or medical debt collector that knows or should have known about an internal review, external review, or other appeal of a health insurance decision that is pending now or was pending within the previous 60 days shall:

- (1) Provide information relative to unpaid charges for health care services to a consumer reporting agency;
- (2) Communicate with the consumer regarding the unpaid charges for health care services for the purpose of seeking to collect the charges; or
- (3) Initiate a lawsuit or arbitration proceeding against the consumer relative to unpaid charges for health care services.

(b) If a medical debt has already been reported to a consumer reporting agency and the medical creditor or medical debt collector who reported the information learns of an internal review, external review, or other appeal of a health insurance decision that is pending now or was pending within the previous 60 days, that person shall instruct the consumer reporting agency to delete the information about the debt.

(c) No medical creditor that knows or should have known about an internal review, external review, or other appeal of a health insurance decision that is pending now or was pending within the previous 60 days shall refer, place, or send the unpaid charges for health care services to a medical debt collector, including by selling the debt to a medical debt buyer.

COMMENTARY TO SECTION 12

This section requires that all health care providers, whether required to have a financial assistance policy or not, shall refrain from any credit reporting, debt collection activities, or selling medical debt to a debt buyer while a patient appeals the denial of coverage by a health insurance payor. Both Massachusetts and California have similar protections. See Cal. Health & Safety Code § 127426 (West); Mass. Gen. Laws ch. 176O, § 14(f). This section also requires the medical creditor or medical debt collector that has reported a medical debt to a consumer reporting agency to remove that information if it learns of an appeal. As a practical matter, a patient may need to inform the health care provider of an appeal to invoke the protections of this section, since the health care provider may not otherwise be aware of the appeal.

Section 13. Interest on Medical Debt.

(a) Unless a patient is eligible for financial assistance under Section 4(b), and notwithstanding any agreement to the contrary, interest on medical debt shall be limited to the rate of interest equal to the weekly average 1-year constant maturity Treasury yield, but not less than 2% per annum nor more than 5% per annum, as published by the Board of Governors of the Federal Reserve System, for the calendar week preceding the date when the consumer was first provided with a bill. If the Board of Governors of the Federal Reserve System ceases to publish this interest rate, then [state regulatory agency] shall substitute another measure that

will result in a reasonable interest rate of no more than 5% per annum. Patients eligible for financial assistance shall not be charged any interest or late fees.

(b) The rate of interest provided in paragraph (a) shall also apply to any judgments on medical debt, notwithstanding any agreement to the contrary.

COMMENTARY TO SECTION 13

This section ensures that interest on medical debts is charged at a reasonable rate. It allows medical creditors and debt collectors an interest rate that is the same as permitted under federal law for civil judgments, 28 U.S.C. § 1961, but with a floor of 2% and ceiling of 5% per annum. This section is necessary because in some states, post-judgment interest laws were passed during times of high inflation, and can be as high as 12%, which essentially doubles the amount of the debt after five years.

This section also provides that patients who are eligible for financial assistance under Section 4(b) of the Model Act will not be required to pay interest on their debts.

Reasonable interest rates will also apply to any judgments obtained in court.

Section 14. Medical Debt Payment Plans.

(a) Any medical creditor or medical debt collector that agrees to a payment plan for a medical debt shall provide a written copy of the payment plan to the consumer within five (5) business days of entering into the payment plan. This plan shall prominently disclose the rate of any interest being applied to the debt in compliance with Section 13 of this Act, and the date by which the account will be paid off in full, assuming the payments set by the schedule are made without interruption.

(b) A consumer need not make a payment on the payment plan until the written copy has been provided.

(c) A medical debt payment plan may be accelerated or declared in default or no longer operative due to nonpayment only after the patient fails to make scheduled payments on the payment plan for at least three consecutive months. Before declaring the payment plan no longer operative, the medical creditor or medical debt collector shall make at least three reasonable attempts to contact the patient by telephone or other method preferred by the patient. Additionally, notice must be provided in writing that the payment plan may become inoperative, and informing the patient of the opportunity to renegotiate the payment plan. Prior to the payment plan being declared inoperative, the medical creditor shall attempt to renegotiate the terms of the defaulted payment plan, if requested by the patient. The medical creditor shall not report adverse information to a consumer reporting agency or commence a civil action against the patient or responsible party for nonpayment until at least 60 days after the payment plan is declared to be no longer operative. For purposes of this section, the notice and telephone call to the patient may be made to the last known telephone number and address of the patient.

COMMENTARY TO SECTION 14

This section sets forth requirements for payment plans to resolve medical debt, requiring the medical creditor or medical debt collector (including a medical debt buyer) to provide a copy of the plan in writing to the patient.

Section 14(c) recognizes that financial hardships may interfere with a patient's ability to make every payment on schedule, and allows a patient who has missed payments during a 90-day period to renegotiate the payment plan. A similar protection is found in California law, Cal. Health & Safety Code § 127425 (West).

Section 15. Receipts for Payments.

Within 10 business days of receipt of a payment on a medical debt, the medical creditor or medical debt collector, or any of their agents receiving the payment shall furnish a receipt to the person that made the payment. All receipts shall show:

- (a) The amount paid;
- (b) The date payment was received;
- (c) The account's balance before the most recent payment;
- (d) The new balance after application of the payment;
- (e) The interest rate and interest accrued since the consumer's last payment;
- (f) The consumer's account number;
- (g) The name of the current owner of the debt and, if different, the name of the medical creditor; and
- (h) Whether the payment is accepted as payment in full of the debt.

COMMENTARY TO SECTION 15

This section directs medical creditors and debt collectors to provide receipts to patients who have made payments on medical debts. In addition to confirming that payment was received, the receipts will be helpful to patients if they are later dunned or charged for a debt that was already paid.

Section 16. Debt Forgiven by Medical Creditor.

Forgiveness of any part of an insured patient's copayment, coinsurance, deductible, facility fees, out of network charges, or other cost sharing shall not be a breach of contract or other violation of an agreement between the medical creditor and the insurer or payor.

COMMENTARY TO SECTION 16

This section addresses a concern that had been raised by health care providers in the past. Some hospitals and health care providers were concerned that their contracts with insurance companies prevented them from waiving or reducing patient copayments or other patient cost-sharing. This section clarifies that forgiveness of copayments and other cost sharing will be permitted and will not be construed to violate insurance contracts. New York has adopted a similar state law, and directs hospitals that receive funds from the hospital indigent care pool to establish financial aid policies which allow for "... reducing or discounting the collection of copays and deductible payments from those individuals who can demonstrate an inability to pay such amounts." N.Y. Pub. Health Law § 2807-k (McKinney). This section is also consistent with principles of medical ethics that encourage the waiver of patient copayments for financial hardship. AMA Principles of Medical Ethics, Ch. 11, § 11.1.4 *Financial Barriers to Health Care Access* (June 2016).

Section 17. Private Remedy.

(a) Collection activity against a consumer who the medical creditor or medical debt collector knew or should have known was or should have been eligible for financial assistance shall be a violation of [insert citation to State UDAP law]. Any other violation of this Act shall also be a violation of [insert citation to State UDAP law].

(b) Any consumer may sue for injunctive or other appropriate equitable relief to enforce this Act.

(c) The remedies provided in this section are not intended to be the exclusive remedies available to a consumer nor must the consumer exhaust any administrative remedies provided under this Act or any other applicable law.

(d) No financial assistance policy or agreement between the patient and a large health care facility or medical debt collector shall contain a provision that, prior to a dispute arising, waives or has the practical effect of waiving the rights of a patient to resolve that dispute by obtaining:

- (1) Injunctive, declaratory, or other equitable relief;
- (2) Multiple or minimum damages as specified by statute;
- (3) Attorney's fees and costs as specified by statute or as available at common law; or
- (4) A hearing at which that party can present evidence in person.

Any provision in a financial assistance policy or other written agreement violating this subsection shall be void and unenforceable. A court may refuse to enforce other provisions of the financial assistance policy or other written agreement as equity may require.

COMMENTARY TO SECTION 17

All states have adopted laws to protect consumers from unfair or deceptive acts or practices. See National Consumer Law Center, [Unfair and Deceptive Acts and Practices § 1.1](#) (9th ed. 2016), *updated online at* www.nclc.org/library. This section makes any violation of the Model Act subject to private enforcement through the state's UDAP law, in addition to any other applicable consumer protections law, such as a state equivalent of the Fair Debt Collection Practices Act.

Some state UDAP statutes exclude all or some medical providers, or have been construed not to apply to debt collectors. See National Consumer Law Center, [Unfair and Deceptive Acts and Practices §§ 2.2.2, 2.3.10](#) (9th ed. 2016), *updated online at* www.nclc.org/library. If there is any question about whether the scope of the UDAP statute extends to medical creditors and medical debt collectors, a provision such as “Medical creditors and medical debt collectors shall be subject to [the State UDAP statute] and its private cause of action notwithstanding any other provision of law” should be added at the end of Section 17(a). A few state UDAP statutes have been interpreted to allow consumers to bring suit only if they show that the defendant's practice has a significant impact on the public interest. See *id.* § 11.4.2. This is a proof hurdle that makes it extremely difficult for small individual claims to proceed. In these states, a provision should be crafted for the end of Section 17(a) providing that “there shall be no [public interest requirement/public impact requirement] as a condition of suit.”

Part (e) of this section prevents waiver of certain individual rights whose preservation is important for the operation of the justice system, whether the dispute is resolved in court, in arbitration, or otherwise.

Section 18. Prohibition of Waiver of Rights.

Any waiver by any patient or other consumer of any protection provided by or any right of the patient or other consumer under this Act is void and may not be enforced by any court or any other person.

COMMENTARY TO SECTION 18

This section is included to preserve the rights established in this Model Act.

Section 19. Enforcement.

(a) The [Office of the Attorney General/other applicable state agency] shall have the authority to enforce this Act, and may adopt any regulation or rules it believes are necessary or appropriate to effectuate the purpose of this Act, to provide for the protection of patients and their families, and to assist market participants in interpreting this Act.

(b) Complaint Process. The [Office of the Attorney General/other applicable state agency] shall establish a complaint process whereby an aggrieved patient or any member of the public may file a complaint against a medical creditor or debt collector who violates any provision of this Act. All complaints shall be considered public records pursuant to [citation to state public records law] with the exception of the complainant's name, address, or other personal identifying information.

COMMENTARY TO SECTION 19

This section designates the Office of the Attorney General or other state agency, such as a state health care regulator, to enforce the Act. Such enforcement activities would include promulgating regulations, receiving and resolving complaints, public reporting of complaints, litigation, and other enforcement actions.

Section 20. Annual Reports and Database.

(a) On or before July 1 of each year, beginning July ____, each hospital shall file its financial assistance policy and an annual report with the [Office of the Attorney General/other applicable state agency] pursuant to procedures that the [Office of the Attorney General/other applicable state agency] shall establish.

(b) [The Office of the Attorney General/other applicable state agency] shall post each report and financial assistance policy in a searchable database accessible on the Internet.

(c) An annual consolidated report shall be prepared by the [Office of the Attorney General/other applicable state agency] and made available to the public. These reports shall include the following information for the time period of July 1 of the prior year to July 1 of the following year:

- (1) The total number of patients who applied for financial assistance.
- (2) The total number of patients who received financial assistance.
- (3) The total amount of financial assistance provided to patients.

COMMENTARY TO SECTION 20

Hospitals must file an annual report in which they provide a copy of their FAP and provide data on, among other things, the number of patients who applied for and were approved for financial assistance, and the amount of financial assistance they provided. This information will be compiled by the Office of the Attorney General/other applicable state agency and made available to the public, the governor, and the legislature. This information is critical in determining if the Act serves the purposes for which it is intended.

Section 21. Severability.

Should a court decide that any provision of this Act is unconstitutional, preempted, or otherwise invalid, that provision shall be severed and such decision shall not affect the validity of the Act other than the part severed.

COMMENTARY TO SECTION 21

Where not implied by state law canons of construction or directed by other state law, a severability clause may be needed to protect the rights established in this Model Act even if one or more sections are found to be invalid.

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