



National
Consumer Law
Center

*Fighting Together
for Economic Justice*

Model Medical Debt Protection Act

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ABOUT THE NATIONAL CONSUMER LAW CENTER

Since 1969, the nonprofit National Consumer Law Center® (NCLC®) has used its expertise in consumer law and energy policy to work for consumer justice and economic security for low-income and other disadvantaged people, in the United States. NCLC's expertise includes policy analysis and advocacy; consumer law and energy publications; litigation; expert witness services; and training and advice for advocates. NCLC works with nonprofit and legal services organizations, private attorneys, policymakers, and federal and state governments and courts across the nation to stop exploitive practices, help financially stressed families build and retain wealth, and advance economic fairness.

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INTRODUCTION TO THE MODEL MEDICAL DEBT PROTECTION ACT

Medical debt affects tens of millions of consumers and is one of the most prevalent types of consumer debt. In 2021, 58% of bills in collections and on consumer credit records were medical expenses.¹ The burden of medical debt hits some communities harder than others; for example, 27.9% of Black households carry medical debt, compared to 17.2% of white non-Hispanic households.² Adults with a disability are more likely than those without a disability to report owing over \$250 in medical debt.³

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, undocumented immigrants, 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 may be further 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.⁴ 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 these rules represented a significant step forward, this consumer protection is incomplete since it applies only to nonprofit hospitals but not to for-profit hospitals⁵ and other types of large health care provider organizations. For-profit hospitals and hospital chains are widespread and in some states outnumber nonprofit hospitals.⁶

Furthermore, patients frequently receive separate medical bills from both the hospital and the physicians who treat them, since many physicians at a hospital are independent contractors rather than hospital employees.

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,
4. Insurance solutions such as reducing financial burdens on the underinsured, limits on cost-sharing, limits on out of network billing, better network adequacy standards to ensure that in-network care is available, and improving or preserving coverage standards, and
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, set 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

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 that are affiliated with any nonprofit or for-profit hospital would be covered by the hospital's FAP.
- 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 screen certain patients for FAP eligibility, 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 300% 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 301-400% FPL, the health care provider must calculate the patient's bill based on the Medicare rate, and from the starting point of the Medicare rate must offer a discount of 75%.
- In addition to these discounts, no patient with household income at or below 400% FPL would be required to pay more than \$2,300 annually per family in cumulative medical bills to large health care facilities for one year after being found eligible for financial assistance.
- If the patient's family income is 401-600% of FPL, the patient would receive the same discount as families with income below 400% FPL, 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 5% of the household's income.

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 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 an 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.
- Credit reporting of medical debt is prohibited. If a medical debt does show up on a credit report, creditors, employers and landlords are prohibited from considering it in their decisions. Health care providers must include a provision in their contracts with debt collectors and debt buyers to prohibit the reporting of medical debt to credit bureaus.
- 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 cannot exceed 2% annually.
- Health care providers and debt collectors must provide patients with detailed receipts of payments, so that consumers can keep track of their payments and, if there is a future attempt to collect the medical debt, can prove that the debt has been paid or discharged.⁹
- Family members and other third parties would be shielded from medical and nursing home debts accrued by a spouse, parent, or loved one.
- 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.

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

"Consumer" means a natural person.

"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.

"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.

"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—
 - (a) The medical debt buyer or collector is prohibited from engaging in any prohibited collection actions listed in Section 7 of this Act to obtain payment for the care;

- (b) The medical debt buyer is prohibited from charging interest on the debt in excess of that described at Section 13 of this Act;
 - (c) 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
 - (d) 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 that ensure that the individual does not pay, and has no obligation to pay, the medical debt buyer and the medical creditor together more than he or she is personally responsible for paying in compliance with this Act; or
- (2) Filing a debt collection lawsuit; or
- (3) Any Prohibited Collection Actions as defined herein.

“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
- (5) measures to widely publicize the policy within the community to be served by the covered health care provider.

“Gross charges” means a covered health care provider’s full, established price for health care services that the covered health care provider charges uninsured patients before applying any contractual allowances, discounts, or deductions. These may be referred to elsewhere as standard charges (as in 42 U.S.C.A. § 300gg-18) or chargemaster rates.

“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.

“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.

“Income” means household income.

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

“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 (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 (1) through (4), above, but bills patients independently.

“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).

“Medical debt” means an obligation or alleged obligation of a consumer to pay any amount related to the receipt of health care services, products, or devices. Medical debt does not include debt charged to a credit card or other extension of credit unless the credit card or extension of credit is offered specifically for the payment of health care services, products, or devices.

“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.

“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.

“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.

“Patient income” means the household income of the patient’s family.

“Prohibited Collection Actions” means the following activities when used by any medical creditor or medical debt collector to collect debts owed for health care services:

- (1) Causing or threatening an individual's arrest;
- (2) Causing or threatening an individual to be subject to a writ of body attachment [or similar term such as “capias”];
- (3) Obtaining or threatening to obtain a lien on an individual's real property;
- (4) Foreclosing or threatening to foreclose on an individual's real property;
- (5) Garnishing or threatening to garnish wages or state income tax refund(s);
- (6) State or federal tax offsets to seize tax refunds or tax credits;
- (7) Attaching, seizing, or threatening to attach or seize a consumer's bank account; or
- (8) Furnishing or threatening to furnish information about the medical debt to a consumer reporting agency.

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), which implements Section 2917 of the Public Service Health Act. They also reflect the requirements of 42 U.S.C. § 300gg-19147.136 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 activity (or credit reporting if still permitted under a state law) 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 covered 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 (6th ed. 2024), *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. Patient income means the patient's household income, not individual income.

“**Large health care facilities**” are defined to include nonprofit and for-profit hospitals, outpatient practices that are affiliated with hospitals, ambulatory surgical centers, and large outpatient practices. For the purposes of the Model Act, this definition also includes nursing homes, skilled nursing facilities, rehabilitation hospitals, and similar facilities. 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, [Hospital and Health System Financial Performance](#). We note that some states have tailored the definition of “large health care facility” in enacted consumer protection statutes, e.g., Vt. Stat. Ann. tit. 18, § 9481 (6).

Patients who are treated in hospitals may not anticipate bills that 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, subpart (5) of the definition of “Large health care facility” 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, to prevent 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 in several state medical debt credit reporting laws, including Colorado, New York, and Connecticut. It excludes lending products such as general-purpose credit cards, but includes those offered specifically to pay for health care services, products, or devices.

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. Ann. § 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.

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. Ann. § 17b-259b, and Haw. Rev. Stat. Ann. § 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 explanation of the financial assistance that is available for emergency and other medically necessary health care services offered by the covered health care provider;
 - (2) In addition to the written explanation of the financial assistance policy as required in section (b)(1), 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.
- (d) The financial assistance policy must apply to all patients who are financially eligible based on income as provided in section 4 of this Act. Patients may not be denied financial assistance on the basis of residency, health insurance coverage status, citizenship or immigration status, assets or prospective assets.

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 given the difficulty of predicting changes to or repeal of the federal law or regulations.

This section makes clear that financial assistance may not be limited to the uninsured, U.S. citizens, or local or state residents, and cannot be denied based on assets or the expectation that they patient may receive assets through a crowd-funding campaign or other sources.

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 screen all patients for eligibility for financial assistance by taking the following steps before seeking payment for any emergency or medically necessary health care services:
 - (1) Determine whether the patient has health insurance;
 - a. 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;
 - (2) 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;
 - (3) 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 0-300% of the federal poverty level shall receive free care;
 - (2) Patients with household income of 301-400% 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 25% of this recalculated bill.
 - (3) Patients with household income of 401-600% of the federal poverty level shall receive the same discounts as patients with household income of 301-400% of the federal poverty level if the patient and the patient's household have incurred medical expenses from the current large health care facility's bill and all other medical bills for medically necessary health care services received during the previous twelve (12) months which in total exceed 5% 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 FPL 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. Additional documentation other than proof of income shall not be required.
 - (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. Proof that the patient receives a means-tested benefit from the federal, state, or local government is sufficient to establish eligibility for financial assistance without additional documentation of income.
 - (4) Under subsection (a) of this section, a large health care facility shall screen a patient for presumptive eligibility for financial assistance as set forth in subsection (b). The rules and process for screening a patient for presumptive eligibility for financial assistance

must require a large health care facility inform any patient who is deemed presumptively eligible for financial assistance that the large health care facility has reduced or eliminated their medical bill, specify if any amount is currently outstanding, and explain how to apply for additional financial assistance for any remaining balance.

- (5) If a large health care provider chooses to use credit reports or scores or similar screening tools when determining eligibility for financial assistance, the large health care provider must:
 - i. Use these tools only to make a positive eligibility determination, and not to deny financial assistance to any patient; and
 - ii. Credit reports or scores may only be obtained and used for screening if the patient consents by signing an individual standalone document granting permission for the credit check, which shall be effective for no more than 30 days.
- (d) If a large health care facility received an application for financial assistance from a patient, the facility shall notify the patient in writing within 14 days 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, 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 percent of the household's gross monthly income. Prepayment penalties, 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. The large health care facility will also be directed to refer patients to other publicly funded programs that 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 400% of the federal poverty level. Cal. Health & Safety Code §§127400, 127405.
- **Connecticut:** Discounted care for uninsured patients who do not qualify for Medicaid, Medicare, or other coverage and with income at or below 250% FPL. C.G.S.A. §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. Ann. 89/10.
- **Maine:** Free care for patients up to 150% FPL. Me. Stat. tit. 22, § 1716; 10-144 Me. Code R. ch. 150.
- **Maryland:** Free care for patients at or below 200% FPL, reduced cost care for patients with income between 200%-500% FPL. Md. Code Ann., Health-Gen. §19-214.1; Md. Code Regs. 10.37.10.26.
- **Nevada:** Free care for patients who are uninsured, ineligible for public assistance, and below a fixed income threshold for indigency. Nev. Rev. Stat. §§ 439B.300–439B.340.

- **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).
- **Rhode Island:** Patients with incomes up to 200% FPL receive free care, and patients up to 300% FPL receive discounted care. R.I. Gen. Laws § 23-17-43.
- **Washington:** Free care for uninsured patients at or below 300% FPL and discounts of 75% for patients between 301% and 350% FPL. Wash. Rev. Code Ann. § 70.170.060; Wash. Admin. Code 246-453-010; 246-453-020; 246-453-050.
- **Vermont:** Free care for uninsured patients below 250% FPL, and at least a 40% discount for uninsured patients between 250% and 400% FPL. These tiered discounts also apply to out-of-pocket costs for insured patients. If a patient's income is below 600% FPL and a medical bill exceeds 20% of their yearly income, the cost must be reduced to no more than that 20%. 18 V.S.A. §§ 9481 to 9487.

Under the Model Act, a family with income between 0%-300% of the federal poverty level would receive free care, while a family with slightly higher income between 301% and 400% that is experiencing a financial hardship as defined in this section, shall be entitled to a 75% discount for the full amount of the patient responsibility portion of charges. 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 350% of the federal poverty level without financial contribution from the patient.

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. Providing assistance for patients with family income up to 600% of the federal poverty level is an aspect of statutes in Illinois¹⁰ and Vermont,¹¹ and also reflects voluntary measures taken by some non-profit hospitals.¹²

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); N.Y. Pub. Health Law §2807-k(9-a).
- **Colorado:** Uninsured and insured patients under 250% FPL cannot be charged more than the Medicare or Medicaid rate, whichever is higher. Colo. Rev. Stat. §§ 25.5-3-503(1), 25.5-3-501(5), 25.5-3-505(2)(j). Health care facilities must also limit the amounts collected in monthly payments to 4% of the patient's family income for bills from health care facilities. Colo. Rev. Stat. § 25.5-3-503(b). After a cumulative 36 months of payments, the patient's bill is considered paid in full. Colo. Rev. Stat. § 25.5-3-503(c).
- **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. Ann. § 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. Ann. 89/5 & 89/10.
- **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.
- **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.

Examples of states that currently require financial assistance screening or screening for other insurance programs for low-income patients include the following:

- **Illinois:** The state requires that hospitals screen all uninsured patients for eligibility for public health programs or any financial assistance offered by the hospital. 210 Ill. Comp. Stat. §§ 88/16.
- **Oregon:** The state requires screening for financial assistance upon request of the patient and before sending unpaid charges to a debt collector. Oregon Revised Statutes §646A.677.
- **Colorado:** Unless the patient declines, all health care facilities must screen all uninsured patients for eligibility for public health programs, discounted care through the Colorado Indigent Care program, or required hospital discounts. Colo. Rev. Stat. § 25.5-3-502(1).

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 within 14 days that the patient's application for financial assistance was approved or denied, and in the case of a successful application 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 at least one 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, 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 household'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 all 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 medical 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 given 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 in the large health care facility's service area, as determined by U.S. Census Bureau data.
- (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 which 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, to answer 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 part (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.

Note that large health care facilities must also provide an accessible process for people with disabilities in compliance with existing state and federal laws.

Section 7. Billing and Collections Rules, Limits on Creditors

- (a) Prohibited Collection Actions. Medical Creditors and Medical Debt Collector are prohibited from engaging in Prohibited Collection Actions to collect Medical Debts owed for Health Care Services.
- (b) No medical creditor or medical debt collector shall engage in any 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 permissible 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 debt 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, which date is no earlier than thirty days after the date of the notice.

- (d) A medical debt collector collecting debt for health care services provided by such a facility shall not engage in extraordinary collection actions during a state or federally declared state of emergency, or a public health emergency.
- (e) 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.
- (f) 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 permissible extraordinary collection actions or any collection activity which were previously permissible and have since become prohibited, 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 or state tax refund interception requests.
- (g) If the consumer has paid any part of the medical debt or any of the consumer's funds have been seized or levied in excess of the amount that the consumer 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 and medical debt collectors: arrest, body attachment, liens and foreclosure of a primary residence. It also prohibits wage garnishment and the interception of state tax refunds. 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 their assets to pay a judgment. Despite being ostensibly issued as a form of civil contempt, such arrest warrants are often actually used as a 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.

The model language includes a prohibition on placing a lien on the primary residence of a medical debtor. This protection is similar to a protection in New York state, which states that "[n]o property lien shall be entered or enforced against a debtor's primary residence in an action arising from a medical debt and brought by a hospital . . . or a health care professional N.Y. C.P.L.R. 5201 (McKinney). Similarly, in Maryland, hospitals may not seek liens to recover hospital debt. Md. Code Ann., Health-Gen. § 19-214.2 (West) ("A hospital may not request a lien against a patient's primary residence in an action to collect debt owed on a hospital bill.") Other states with similar prohibitions include California, Connecticut, Massachusetts, Nevada and North Carolina. Cal. Health & Safety Code § 127425(h); Conn. Gen. Stat. § 19a-673b(c);

101 Mass. Code Regs. § 613.08(1)(b); Nev. Rev. Stat. § 21.095; Nev. Rev. Stat. § 108.662(5); N.C. Gen. Stat. § 131E-91(d)(6). Several states have placed restrictions on the use of certain collection actions, including the following:

- Delaware passed legislation to prohibit wage garnishments and garnishing of bank accounts and pensions for medical debts. 2023 Delaware Senate Substitute No. 2 for Senate Bill No. 8, Delaware One Hundred Fifty-Second General Assembly - First Special Session, adopted Sept. 11, 2023.
- 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).
- 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.
- 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 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 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) creates a pause on collection activities during a state of emergency.

Paragraph (e) 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 (g) 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 their wages or bank account funds seized to pay the debt.

States should also consider broad financial protections that apply to a wider range of consumer debt. Detailed recommendations are included in the National Consumer Law Center's Model Family Financial Protection Act (available at <https://www.nclc.org/resources/model-family-financial-protection-act/>).

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; and
- (c) Use plain-language titles or descriptions of health care services that can be understood by the average consumer.

Commentary to Section 8

Gross charges, which may be referred to as standard charges or chargemaster rates, are the hospital prices for services prior to negotiated reductions for public and private insurance reimbursement. All hospitals must post standard or chargemaster prices for their health care services. 42 U.S.C.A. § 300gg-18; 83 FR 20164-01 at 20548-20549 ("Requirements for Hospitals To Make Public a List of Their Standard Charges via the Internet."). In addition, many states have similar requirements. For instance, California requires hospitals to post information about gross charges on-line. Cal. Health & Safety Code §§ 1339.51, 1339.55 & 1339.56. Colorado hospitals are prohibited from initiating or pursuing collection actions if they have not complied with federal health care price transparency laws, and patients have a private right of action to sue a hospital for noncompliance. Colo. Rev. Stat. §§ 25.5-1-901 to 25.5-1-904.

This provision augments these requirements by also requiring disclosure of Medicare rates and requiring a plain language title or description of the health care services. Information about the health care provider's gross charges and applicable Medicare reimbursement rates can help patients to address problems with medical debt that has already accrued. Patients eligible for financial assistance can see what their bill should be based on, and in some cases patients who do not qualify for financial assistance but who lack the resources to pay a large medical bill promptly may be able to use this information to negotiate reasonable discounts on a bill. The

purpose of this section is to encourage fair resolution of debt, and is not offered as a health care cost containment measure or as a mechanism to promote shopping for health care services, as there is negligible data to show that price transparency measures any benefit consumers.

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 held personally liable for the medical debt or nursing home debt of any other person age 18 or older, or other damages related to the collection of the patient's bill.
- (c) Any admission agreement shall comply with applicable federal and state laws including the Nursing Home Reform Law, 42 U.S.C. §§ 1395i-3.

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.

Special federal protections for nursing home residents are codified in the Nursing Home Reform Act, which created a set of rights for nursing home residents, and banned third-party financial guarantees (co-signers) as a condition of admission to a nursing home. 42 U.S.C. § 1395i-3. Under this law, a skilled nursing facility must “not request or require a third-party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility.” 42 U.S.C. § 1395i-3(c)(5)(A)(ii). The Nursing Home Reform Act’s prohibition on guarantees does not prevent nursing homes from requiring an individual “who has *legal* access to a resident’s income or resources available to pay for care in the facility, to sign a contract (*without incurring personal financial liability*) to provide payment *from the resident’s income* or resources for such care.” 42 U.S.C. § 1395i-3(c)(5)(B)(ii). These are sometimes

referred to as “responsible party clauses.” The Nursing Home Reform Act clearly states that these third parties cannot incur personal financial liability in signing these contracts, yet nursing homes frequently seek collection from third parties in violation of the law.

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. Itemized bills can help a consumer to understand what their health care costs are, whether some or all of the charges are covered by insurance, and whether the provider made errors in billing. Texas recently passed a state law requiring itemized medical billing, prohibiting a provider from pursuing debt collection unless the provider has complied with the requirements of the itemized billing law. 2023 Tex. Sess. Law Serv. Ch. 271 (S.B. 490), amending Tex. Health & Safety Code, Title 2, Subtitle J, §§ 185.001-185.003.

Section 11. Medical Debt and Consumer Reporting Agencies

(a) A consumer reporting agency is prohibited from making a consumer report containing an item of information that the consumer reporting agency knows or should know concerns medical debt.

(b) No person may communicate with or report any information to any consumer reporting agency regarding a medical debt.

(c) A person who uses a consumer report shall not use a medical debt listed on the report as a negative factor when making a credit, employment or housing decision.

(d) A medical creditor shall include a provision in any contract entered into with a medical debt collector for the purchase or collection of medical debt that prohibits the reporting of any portion of such medical debt to a consumer reporting agency

Commentary to Section 11

This section prohibits consumer reporting agencies (CRA) from reporting medical debts, and medical creditors, medical debt collectors, or any other person from furnishing medical debt to a CRA. It also prohibits lenders, employers and landlords from using medical debts in their decisions and requires medical creditors to include a provision in their contracts with medical debt collectors to prohibit reporting of medical debt to CRAs. The latter two provisions are included because they are less likely to face preemption challenges under the federal Fair Credit Reporting Act. States should make sure to include the severability language in Section 21 so that if one provision is preempted, the remaining provisions survive.

At least nine states have adopted laws that prohibit or restrict the reporting of medical debt on credit reports, including:

- California: Cal. Civ. Code §§ 1785.13(a)(7), 1785.20.6, 1785.27, 1786.18(a)(9), 1371.56(C)(1)(A);
- Colorado: Colo. Rev. Stat. § 5–18–109;
- Connecticut: Conn. Gen. Stat., §§ 19a-673b, 20-7i;
- Illinois: 815 Ill. Comp. Stat. Ann. 505/2EEEE;
- Minnesota: Minn. Stat. Ann. ch. 332C.;
- New Jersey: N.J. Stat. Ann. § 56:11-56;
- New York: N.Y. Pub. Health Law art. 49–A;
- Rhode Island; R.I. Gen. L. §§ 6-60-1 to 6-60-5;
- Virginia: Va. Code Ann. §§59.1-200(A)(79), 59.1-444.1..

In January 7, 2025, the CFPB issued a regulation that banned lenders from considering medical debt, and banned CRAs from including such debts in credit reports sent to lenders. Prohibition on Creditors and Consumer Reporting Banking Regulators Concerning Medical Information (Regulation V), 90 Fed. Reg. 3276 (Jan. 14, 2025). However, the fate of that rule is uncertain, given that it faces two lawsuits by the credit reporting and debt collection industry, Cornerstone Credit Union League v. CFPB, No. 4:25-cv- 00016 (E.D. Tex.) and ACA International v. CFPB, No. 4:25-cv-0009 (S.D. Tex.), as well as a Congressional Review Act challenge, S.J. Res.36 (Rounds)/H.J. Res.74 (Norman.) There is also a significant risk that the CFPB under the Trump Administration will move to rescind or withdraw the rule.

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 180 days shall:
 - (1) communicate with the consumer regarding the unpaid charges for health care services for the purpose of seeking to collect the charges; or
 - (2) initiate a lawsuit or arbitration proceeding against the consumer relative to unpaid charges for health care services.
- (b) 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 180 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 medical creditors shall refrain from 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; Mass. Gen. Laws ch. 176O, § 14(f). As a practical matter, a patient may need to inform the medical creditor or medical debt collector of an appeal to invoke the protections of this section, since they 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 not exceed 2 percent 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 of no more than 2% per annum. New York state has capped interest on all consumer debt at 2%. N.Y. C.P.L.R. 5004.

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 commence a civil action against the patient or responsible party for nonpayment until at least 90 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.

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 date of service, when the health care services were provided;
- (b) the amount paid;
- (c) the date payment was received;
- (d) the account's balance before the most recent payment;
- (e) the new balance after application of the payment;
- (f) the interest rate and interest accrued since the consumer's last payment;
- (g) the consumer's account number;
- (h) the name of the current owner of the debt and, if different, the name of the medical creditor; and
- (i) 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 co-pays 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 large health care provider, 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 by a medical creditor or medical debt collector 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 consumer and a large health care provider 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.
- (e) Any provision in a financial assistance policy or other written agreement violating (d) 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. This section makes any violation of the Model Act subject to private enforcement through the state's UDAP law.

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. 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.

States may add additional consumer protections for a broader range of consumer debts. For suggested language, please see the NCLC Model Family Financial Protection Act, available at nclc.org.

Section 18. Prohibition of Waiver of Rights

Any waiver by any 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.

A large health care provider may not circumvent the responsibilities and protections of this Act by requiring pre-payment for medical care.

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 as it believes are necessary or appropriate to effectuate the purpose of this Act, to provide for the protection of consumers, 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 consumer or any member of the public may file a complaint against a medical creditor or medical debt collector who violates any provision of this Act. All complaints shall be considered public records pursuant to [cite for 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 large health care provider shall file its financial assistance policy and an annual report with the state legislature and [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 of that 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 number of patients who were denied financial assistance

- (4) De-identified demographic information for patients who received financial assistance, including zip code, race, language, gender, and disability status, to the extent that such data is available from the large health care provider
- (5) The total amount of financial assistance provided to patients
- (6) The types of collection practices used
- (7) The amounts of money collected with each of these collection practices, in dollars and by percentage of the large health care provider's annual revenue.

Commentary to Section 20

Large health care providers 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 and whether there are racial or other disparities among patients who receive financial assistance. See, Md. Code Ann., Health-Gen. § 19-214.2, section 1.

States may consider addition additional reporting requirements to assess the effectiveness of the Act and whether there is any financial impact on hospitals and other large health care providers. See, e.g., 2020 Law of Maryland, Chapter 470, Section 2 (codified at Md. Code Ann., Health-Gen. §§ 19-214.1 & 19-214.2).

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.

ENDNOTES

¹ Consumer Financial Protection Bureau, Medical Debt Burden in the United States (Feb. 2022).

² Berneta L. Haynes, [The Racial Health and Wealth Gap: Impact of Medical Debt on Black Families](#), *National Consumer Law Center* (2022).

³ Kaiser Family Foundation, *Health Tracker: The burden of medical debt in the United States* (March 10, 2022), available at <https://www.kff.org/health-costs/press-release/1-in-10-adults-owe-medical-debt-with-millions-owing-more-than-10000/>.

⁴ 26 U.S.C. § 501(r)(4); 26 CFR § 1-501(r).

⁵ 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).

⁶ Kaiser Family Foundation, State Health Facts, [Hospitals by Ownership Type](#) (2021).

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

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); N.Y. Pub. Health Law §2807-k(9-a)).

⁹ Since its inception in 2013, 56% of debt collection complaints to the CFPB involved attempts to collect a debt not owed. Consumer Financial Protection Bureau, *Fair Debt Collection Practices Act, CFPB Annual Report 2022* (March 2022).

¹⁰ 210 Ill. Comp. Stat. §§ 89/1 to 89/20.

¹¹ 18 V.S.A. §§ 9481 to 9487.

¹² E.g., UMass Memorial Medical Center Financial Assistance and Credit and Collection Policy, December 21, 2020, available at <https://www.ummhealth.org/umass-memorial-medical-center/patients-visitors/patient-resources/financial-assistance-and-credit-and-collection-policy>.