State Hospital Billing and Collection Practices
(Formerly Fastfax #2805)

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Overview:
The collection of medical debts is often regulated at the state level, and may also be impacted by the charity care policies of hospitals, the policies state hospital associations, and the policies of the American Hospital Association. Policies may include restrictions regarding the amount of interest, and may also impact other aspects of billing and collection practices.

Summary of Analysis:
This document provides an overview of state laws regarding hospital billing and collection practices and also provides information on the policies of the American Hospital Association and some state hospital associations.

Practical Considerations:
Members should review state laws regarding medical collection, and should also be aware of the billing and charity care policies of their hospital or medical provider clients when collecting on medical debts.

Key Takeaways
• National and state hospital associations as well as some state laws impact the billing and collection practices of hospitals, which in turn may have implications for debt collectors working on behalf of medical providers.

Related SearchPoint Documents
• Medical Debts – Statutes of Limitation and Interest, #1158
• HIPAA for Business Associates: An Overview, #2065
• With whom can debt collectors discuss a medical debt under the FDCPA and HIPAA?, #2335
• Credit Reporting Medical Accounts Under HIPAA and the FCRA, #6259
In December 2003, the American Hospital Association (AHA) implemented a set of guidelines for member hospitals regarding their billing and collection practices. The guidelines were last revised in 2012, and have implications for how member hospitals handle patients’ debts for medical care. In addition to the AHA guidelines, a handful of state hospital associations have implemented guidelines for members.

**The American Hospital Association Guidelines**

The guidelines sent out by AHA, include a number of objectives member hospitals are to set into practice to better serve their patients. The guidelines include items under the following headlines:

- Communicating Effectively
- Helping Patients Qualify for Coverage
- Ensuring Hospital Policies are Applied Accurately and Consistently
- Making Care More Affordable for Patients with Limited Means
- Ensuring Fair Billing and Collection Practices.

**State Hospital Associations & State Initiatives**

In the response to the AHA guidelines, a number of state hospital associations implemented guidelines for their members to follow regarding these issues. The guidelines established by these associations are typically voluntary, but have been met with little resistance. Generally, the guidelines set forth by state associations closely mirror those of the AHA. Each Association has added their own specific language or requirements pursuant to the needs of the individual state and health system.

Additionally, a number of states have taken the initiative to enact legislation governing the billing and collection practices of the hospitals located in their state. Such guidelines and initiatives are provided below.

**CALIFORNIA State Initiative**

California’s Hospital Fair Pricing Policies Act requires each hospital in the state to establish a written policy about when and under whose authority patient debt is advanced for collection, whether the collection activity is conducted by the hospital, an affiliate or subsidiary of the hospital, or by an external collection agency. The Act also requires each hospital to establish a written policy defining standards and practices for the collection of debt, and requires each hospital to obtain a written agreement from any agency that collects hospital receivables that it will adhere to the hospital’s standards and scope of practices. This agreement must require the external collection agency of the hospital that collects the debt to comply with the hospital’s definition and application of a reasonable payment plan. The policy must not conflict with other applicable laws.

All hospitals in California must also provide a written statement to each patient concerning all services and charges as well as the patient’s rights under the Act. Hospitals may not report adverse information to consumer reporting agencies or commence civil action against patients who lack coverage or patients with high medical costs for nonpayment at any time prior to 150 days after the initial billing.

The California law also limits the ability of the hospital and its agents to use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills. Any extended payment plans offered by a hospital to assist patients eligible under the hospital's charity care policy or any other policy adopted by the hospital for assisting low-income patients with no insurance or high medical costs in settling outstanding past due hospital bills, shall be interest free. Finally, the Act also requires hospitals and their agents to make certain disclosures in debt collection notices. For more
information on required disclosures, please see ACA’s Special Text Requirements Fastfax #2008.

In addition, California’s Welfare and Institutions Code requires that hospitals who obtain notification regarding a consumer’s Medi-Cal eligibility status may not seek reimbursement or payment for the cost of covered health care services from the eligible consumer. Those who continue to pursue collection efforts may be subject to a penalty that is not to exceed three times the amount payable by the Medi-Cal program.

Effective January 1, 2010, the Welfare and Institutions Code also requires when a hospital receives proof of a consumer’s Medi-Cal coverage, the provider or collector either (1) furnishes information regarding the Medi-Cal covered services or (2) fails to correct information previously furnished regarding the Medi-Cal covered services as appropriate. Note that this code does not apply to the share of cost owed by the Medi-Cal beneficiary, unless the beneficiary’s share of the cost has been met for the month in which services were rendered.

Additionally, a Medi-Cal provider or debt collector violates California’s Civil Code involving furnisher obligations if after 30 days of receiving proof of a consumer’s Medi-Cal coverage, the provider or collector fails to provide the notification to the hospital, the hospital will not be considered responsible for failing to cease collection efforts until actual notification is provided.

Additionally, a Medi-Cal provider or debt collector violates California’s Civil Code involving furnisher obligations if after 30 days of receiving proof of a consumer’s Medi-Cal coverage, the provider or collector either (1) furnishes information regarding the Medi-Cal covered services or (2) fails to correct information previously furnished regarding the Medi-Cal covered services as appropriate. Note that this code does not apply to the share of cost owed by the Medi-Cal beneficiary, unless the beneficiary’s share of the cost has been met for the month in which services were rendered.

**COLORADO**

**State Initiative**

Under Colorado statute, a healthcare provider is required to provide written notice to the last-known address of the consumer thirty days prior to commencing collection activity. Collection activity is defined as only activities provided by a licensed collection agency that uses a business name other than the healthcare provider when collecting a debt. The statute requires such notice provide “include the amount due and owing; the name, address, and telephone number of the healthcare provider; where payment may be made; the date of service; and the last date the healthcare provider will accept payment prior to the debt being submitted to a collection agency or reporting adverse information to a consumer reporting agency for the debt for which notice was provided.” Finally, a healthcare provider is prohibited from reporting any adverse information to a consumer reporting agency for which an adverse action notice was provided without providing the aforementioned notice.

**CONNECTICUT**

**State Initiative**

Connecticut’s statute relating to debt collection from uninsured patients requires that no hospital may collect from a patient more than the cost of providing the service. Additionally, the collection agent is required to give notice to the patient regarding whether the hospital deems the patient to be insured or uninsured, and the reason for such a determination.

**HAWAII**

**State Initiative**

Hawaii’s Prepaid Health Care Act requires employers to make available to all employees, healthcare insurance coverage. An employer who fails to provide such coverage for an employee could be held liable for any medical expenses that employee may incur. The purpose of this Act is to protect employees from the spiraling costs of comprehensive medical care.

**ILLINOIS**

**State Initiative**

The Illinois Hospital Fair Billing Act requires that hospitals, other than rural or Critical Access Hospitals, must provide a discount to any uninsured patient who applies for a discount and has family income of less than 600% of the federal poverty income guidelines for all medically necessary healthcare services exceeding $300 for any one inpatient or outpatient admission. Additionally,
hospitals other than rural or Critical Access Hospitals must provide a discount of 100% for a patient who applies for a discount and has family income of less than 200% of the federal poverty income guidelines for all medically necessary health care services exceeding $300 in any one inpatient or outpatient visit. 24 Similarly, rural or Critical Access hospitals must provide a discount to uninsured patients who apply for a discount and have annual family income of less than 300% of the federal poverty income guidelines for all medically necessary healthcare services exceeding $300 in any one inpatient or outpatient admission. 25 Rural hospitals or Critical Access Hospitals must also provide a charitable discount of 100% to any uninsured patient who applies for a discount and has family income of less than 125% of the federal poverty income guidelines for all medically necessary health care services exceeding $300 in any one inpatient or outpatient visit. 26 The maximum amount that can be collected in a twelve-month period on any hospital bill is 25% of the patient’s family income unless the patient has “significant assets.” 27 Additionally, every hospital bill shall include a statement that an uninsured patient who meets certain income requirements may qualify for an uninsured discount and information regarding how an uninsured patient may apply for consideration under the hospital’s financial assistance policy. 28

The availability of a discount may be contingent upon the uninsured patient first applying for coverage under public programs (e.g., Medicare, Medicaid, AllKids, the State Children’s Health Insurance Program, etc.), if there is a reasonable basis to believe that the uninsured patient may be eligible for such program. 29 Additionally, hospitals must permit an uninsured patient to apply for a discount within 60 days of the date of discharge or date of service. 30

The Hospital Uninsured Patient Discount Act is enforced by the Attorney General. 31 A civil monetary penalty not to exceed $500 may be assessed for a knowing violation of the Act. 32

Additionally, the law provides the splitting of flat fees, percentage based fees and other fees between licensed health care professionals and third-parties are expressly permitted. 33 Therefore, under the Act collection agencies are allowed to split fees with physicians. The bill further provides physicians or the physicians practice must control the fees charged and collected, and all fees collected are to be deposited in the debt collector’s trust account.

**IOWA**

**State Hospital Association**

Iowa’s Hospital Association adopted the Policy Statement on Hospital Billing and Collection Practices in October of 2004. 34 The principles require that all patients are to be treated equally, regardless of their ability to pay, and that health care services will not be denied based on such ability to pay. Additionally, hospitals are required to have clear financial aid policies and any collection practices by the hospital (including the hiring of collection agencies) will reflect the values of the hospital.

**LOUISIANA**

**State Hospital Association**

Louisiana’s Hospital Association adopted in December 2003 the Hospital Uninsured Billing and Collection Issues and Guidelines. 35 These guidelines ensure that a medical bill is not sent to a collection agency unless it is first authorized by an employee who has authority to make that decision under the hospital’s written policies. Additionally, the guidelines make certain that all medical bills are advanced to a collection agency or litigation consistently.

**MAINE**

**State Initiative**

Maine enacted a law for the purpose of protecting a consumer patient’s credit when a debt is owed to a Maine health care provider. 36 Specifically, the Act provides an agreement between a health care provider (or a debt collector acting on behalf of a health care provider) and a consumer with health care debt that accepts partial consumer payments without assessment of any interest is not considered a consumer credit transaction. 37 Maine defines a “consumer credit transaction” as a consumer credit sale, lease or loan that includes refinancing, consolidation or a deferral. 38 Additionally, a health care provider is required to notify consumers of available payment arrangements that may satisfy a debt for services rendered. 39 Such payment arrangements are required to provide consumers opportunity to reasonably satisfy the defaulted status of their debt which includes, but is not limited to, making a payment in full or timely making six consecutive monthly payments. 40 The payment arrangement may be established on the health care provider’s own terms, so long as the above requirements are adhered to. 41
MARYLAND
State Hospital Association

The Hospital Billing and Debt Collection Practices

Principles applied by the Maryland Hospital Association since October of 2003 clearly state that all patients are to be treated with dignity and respect regardless of their ability to pay. The principles require that the availability of financial assistance and charity care is clearly communicated to all patients. Also, a collection agency or attorney is not permitted to take any legal action without the hospital signing off on it first.

State Initiative

Maryland law provides that hospitals will continue incentives for hospitals to adopt “fair, efficient, and effective credit and collection policies.”

Specifically, the law provides hospitals are to develop a financial assistance policy for providing patients that lack health care by providing either free care or reduced-cost services depending on the patient’s income level. This financial assistance policy is required to be conspicuously posted throughout the hospital, including the hospital’s billing office, and must inform patients of their right to apply for financial assistance supplied with relevant contact information. Also, the hospital is required to develop an information sheet describing their financial assistance policy, which must include the patient’s rights, relevant contact information, and how to apply for the assistance.

Regarding a hospital’s debt collection policies, such policies must provide for active oversight of any contract for the collection of debts on behalf of the hospital. The policies shall also provide the hospital shall not sell any debt and is prohibited from charging interest on self-pay accounts before a judgment is obtained. The hospital’s procedures for collecting a debt and particular circumstances where a judgment will be sought against a patient are additionally required. Further, a mechanism must be provided for a patient to file a complaint against the hospital with regard to improper handling of a particular patient account.

For a period of at least 120 days after initial billing, a hospital may not furnish a negative consumer report or file suit for a patient’s non-payment unless there is specific documentation delineating the patient’s or guarantor’s lack of cooperation in providing relevant information to determine a consumer’s obligation to pay. If a negative consumer report has been filed and the patient’s payment obligation becomes fulfilled, the hospital is required to note as such in the report “within

days.” Additionally, a hospital is prohibited from forcing a sale or foreclosure on a patient’s primary residence in an effort to collect a patient debt. However, if a lien is held on the patient’s primary residence, the hospital may maintain the position as a secured creditor with regard to other creditors to whom the patient may owe a debt.

When a hospital hires an outside collection agency to collect on behalf of the hospital, the hospital is required to specify the collection activity to be performed through an explicit authorization or contract with the collection agency. The hospital must also require the agency to abide by its credit and collection policy, while additionally specifying procedures the agency must follow if the patient appears to qualify for financial assistance. Specific to the actions of the collection agency, the agency must provide a mechanism for a patient to file a complaint with the hospital with regard to improper handling of a patient’s account and must forward any complaint to the hospital if a patient files the complaint with the collection agency.

Last, if a hospital knowingly violates any of these provisions, a fine may be imposed upon the hospital that is not to exceed fifty-thousand dollars ($50,000) per violation. The severity of the fine will relate to the severity of the violation, as determined by the Commission.

MASSACHUSETTS
State Initiative

The Massachusetts Health Care Reform provides increased healthcare access to the uninsured, new financial support for hospitals, and collective responsibility among businesses, providers, government and patients. The legislation provides insurance coverage for most citizens of Massachusetts. There will be an increase in subsidized private insurance, cost sharing, uncompensated care funding, and employer responsibility.

Since July 1, 2007, all residents of Massachusetts who are over the age of 18 are be required to prove they have obtained health insurance coverage. Applicable residents will be required to confirm coverage on their income tax return forms filed starting in 2008. The penalties for not confirming health insurance coverage can include loss of personal exemptions. Additionally, the penalty could be increased to an amount the individual would have paid towards half of a health insurance premium. This legislation also increases funding to the states Uncompensated Care Fund.
It is important for debt collectors collecting medical debt from consumers in Massachusetts to be aware of the state’s laws regarding health care insurance. Medical debts incurred after July 1, 2007 will need to be viewed closely to ensure that the debt was not supposed to be paid by the consumer’s insurance company.

**MINNESOTA**

**State Initiative**

In mid-2005, Minnesota Attorney General Mike Hatch announced an agreement that had been made between the Attorney General’s Office and four of Minnesota’s largest healthcare providers regarding the extension of preferred rates to those who are uninsured. This agreement was extended for an additional five years under Minnesota’s current Attorney General, Lori Swanson, in early 2007. The agreement made between the Attorney General and Minnesota healthcare providers covers issues associated with litigation practices, garnishments, collection agencies and billing the uninsured in relation to attempts to collect medical debt.

Minnesota hospitals are prohibited from giving collection agencies “blanket authorization” to take legal action against patients in an effort to collect a medical bill. Each medical bill must be individual reviewed before authorization is given to a collection agency to move forward with litigation. Each hospital must set forth a policy to determine the level of the employee who is authorized to make such determinations. Additionally, a hospital shall not subcontract or delegate the selection of any third party collection attorney or law firm. The hospital must have a written agreement directly with the attorney or law firm.

The agreement between Minnesota healthcare providers and the Attorney General also addresses garnishments. The agreement prohibits a hospital from giving a collection agency or attorney a “blanket authorization” to pursue garnishments on any patient in an attempt to collect a past due medical bill. Hospitals shall not garnish a patient’s wages or bank account unless it has first obtained a judgment in court against the patient for the amount of the debt. The hospital is also required to review the account to ensure the funds are not likely to be exempt, that the patient does in fact owe the debt, that all known third party payors have already been billed, that the patient was offered a reasonable payment plan, and that the patient was given the opportunity to submit an application for charity care.

The Attorney General’s agreement places requirements on hospitals when they forward medical bills to collection agencies or attorneys for collection. Agencies and attorneys collecting medical bills in Minnesota are required to act in a manner consistent with the agreement as well as the hospital’s mission and policies and any applicable state and federal laws. Hospitals are prohibited from sending medical debt to a collection agency or attorney if the patient has made payments on the debt in accordance with a payment plan previously agreed to by the hospital. Additionally, if a patient has submitted an application for Charity Care, the hospital is required to suspend all collection activity until the patient has been notified of the hospital’s decision. Hospitals, collection agencies and attorneys are restricted from credit reporting medical debts over $1,000 unless a legal judgment is first obtained. On debts less than $1,000, the hospital, collection agency or attorney need to first determine and certify that seven factors are considered. These seven factors were informally added to the agreement in an August 9, 2005 letter sent to the Minnesota Hospital Association by the Minnesota Attorney General’s Office. ACA has received informal guidance from the Minnesota Hospital Association that the August 9, 2005 letter is in effect. Members can obtain a copy of the August 9, 2005 letter by contacting ACA’s Compliance Department. For more information regarding credit reporting on medical debts in Minnesota, and to determine if the aforementioned conditions have been met, members should contact their hospital client.

Hospitals are also prohibited from billing a patient whose annual household income is less than $125,000 for any uninsured treatment in an amount greater than the amount which the provider would be reimbursed from its most favored insurer. The term “most favored insurer” means the nongovernmental third party payor that provided the most revenue to the provider during the previous calendar year.

Hospitals under the agreement must also agree to comply with all applicable state and federal laws. Finally, the agreement requires hospitals and their agents to make certain disclosures in debt collection notices. For more information on required disclosures, please see ACA’s Fastfax #2008 regarding special text requirements.

**State Law**

*Aside* from the agreement with Attorney General for the state of Minnesota, the state has also enacted a law with some requirements for charitable hospitals. Under this requirement, any patient may bring an action to enjoin
“extraordinary collection actions” taken by a nonprofit hospital if the hospital has failed to provide a plain language summary of the hospital’s financial assistance policy. A prevailing patient is entitled to reasonable attorney fees and costs.65

(b) For the purposes of this section the law defines the following terms to mean: (1) “extraordinary collection actions” means an action described in Code of Federal Regulations, title 26, section 1.501(r)–6; (2) “financial assistance policy” means a written policy that meets the requirements described in Code of Federal Regulations, title 26, section 501(r); and (4) “plain language summary” has the meaning given in Code of Federal Regulations, title 26, section 501(r)–1.66

**NEVADA**

**State Initiative**

The Nevada legislature has enacted law that has implications for Nevada hospitals. One section provides that a hospital may not proceed with efforts to collect on debts owed to the hospital for hospital care, other than co-payments and deductibles, if the person responsible for paying the account has or may be eligible for insurance benefits or public assistance, until the insurance or public program has been billed and the amount owed by the patient has been established. The statute also makes clear that collection efforts and interest may not begin sooner than 30 days after the patient has been sent notice of the amount that she is responsible to pay. Additionally, there is a limit to the amount of interest that a hospital may charge on a delinquent account to the prime rate plus 2 percent, and prohibits a hospital from imposing any other fees, including, without limitation, collection fees, attorney’s fees or any other fees or costs other than court costs and attorney’s fees awarded by a court.67

Nevada also provides a general requirement that the hospital or other person acting on its behalf to collect any debt for any amount owed to the hospital for hospital care, must do so in a professional, fair and lawful manner and in accordance with the Fair Debt Collection Practices Act (FDCPA), even if the hospital or other person acting on its behalf is otherwise not subject to the Act.68

Further, regarding the statute of limitations, the time to bring an action to enforce a debt owed to a hospital for hospital care is limited to a period of four years after the date on which any payment that is due for the services is not paid. The statute is tolled, however, during any periods in which the hospital is awaiting a determination concerning eligibility for or the amount of benefits from an insurer or public program, and during any period in which payments are being made.69

If a lien has been placed on the property of a person, a county or district hospital may not assign, sell or transfer its interest in the property.70 Finally, hospitals and their agents are required to make certain disclosures in debt collection notices.71 This new special text requirement is only applicable to Nevada hospitals. For more information on required disclosures, please see ACA’s Fastfax #2008 regarding special text requirements.

**NEW JERSEY**

**State Hospital Association**

In New Jersey, the Hospital Association Task Force developed the Compassionate Bill Collection Guidelines in 2004.72 These guidelines state that when necessary and appropriate, hospitals should work with the patient to establish a reasonable payment plan. Additionally, the guidelines also state that the Hospital should not force the sale or foreclosure of a patient’s primary residence to pay an outstanding medical bill.

**NEW MEXICO**

**State Hospital Association**

The New Mexico Hospital Association adopted the Hospital Payment and Collection Practices on February 2004.73 The principles require all patients are to be treated equally with dignity, respect, and compassion. Further, all emergency health care needs will be served, regardless of a patient’s ability to pay.

Specifically regarding collection practices, hospitals and agencies retained by hospitals to handle debt collection will do so in a matter that reflects the policies and values of the hospital. Further, any patient contacted by a collection agency on behalf of a hospital will be encouraged to discuss their bill and any need for financial assistance directly with the hospital.

**NEW YORK STATE**

**State Initiative**

New York enforces a law that establishes a state general indigent care pool.74 In order for a general hospital to participate in the distribution of funds from the pool, a hospital must implement minimum collection policies and procedures approved by commissioner and must be in compliance with bad debt and charity care reporting requirements established by this law.75
Hospitals must establish financial aid policies and procedures for reducing charges otherwise applicable to low-income individuals without health insurance, or who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges. At the hospital's discretion, the hospital may also develop a policy for reducing or discounting the collection of copays and deductible payments from those individuals who can demonstrate an inability to pay such amounts. The law provides a formula to determine the reductions based on the income of the patient compared to the federal poverty level. The policies and procedures the hospital implements must be clear, understandable and available to patients.

The law prohibits the forced sale or foreclosure of a patient's primary residence in order to collect an outstanding medical bill and requires the hospital to refrain from sending an account to collection if the patient has submitted a completed application for financial aid, including any required supporting documentation, while the hospital determines the patient's eligibility for such aid. The law also requires any collection agency under contract with a general hospital for the collection of debts to follow the hospital's financial assistance policy, including providing information to patients on how to apply for financial assistance where appropriate. The policies of the hospital shall also prohibit collections from a patient who is determined to be eligible for medical assistance pursuant to title XIX of the federal Social Security Act at the time services were rendered and for which services Medicaid payment is available.

**NORTH CAROLINA**

**State Initiative**

North Carolina has created a Fair Billing and Collection Practices Act requiring that upon request of the patient, the hospital must present an itemized list of charges to all discharged patients detailing in language comprehensible to an ordinary layperson the specific nature of the charges or expenses incurred by the patient. Patient bills that are not itemized shall include notification to the patient of the right to request, free of charge, an itemized bill. A patient may request an itemized list of charges at any time within three years after the date of discharge or so long as the hospital or ambulatory surgical facility, a collections agency, or another assignee of the hospital or ambulatory surgical facility asserts the patient has an obligation to pay the bill. Each hospital and ambulatory surgical facility shall establish a method for patients to inquire about or dispute a bill.

The law requires that if a patient has overpaid the amount due to the hospital or ambulatory surgical facility, whether as the result of insurance coverage, patient error, health care facility billing error, or other cause, and the overpayment is not in dispute or on appeal, the hospital or ambulatory surgical facility shall provide the patient with a refund within 45 days of receiving notice of the overpayment.

The law states that hospital or ambulatory surgical facility shall not bill insured patients for charges that would have been covered by their insurance had the hospital or ambulatory surgical facility submitted the claim or other information required to process the claim within the allotted time requirements of the insurer.

The laws also states that Hospitals and ambulatory surgical facilities shall abide by the following reasonable collections practices:

- A hospital or ambulatory surgical facility shall not refer a patient's unpaid bill to a collections agency, entity, or other assignee during the pendency of a patient's application for charity care or financial assistance under the hospital's or ambulatory surgical facility's charity care or financial assistance policies.
- A hospital or ambulatory surgical facility shall provide a patient with a written notice that the patient's bill will be subject to collections activity at least 30 days prior to the referral being made.
- A hospital or ambulatory surgical facility that contracts with a collections agency, entity, or other assignee shall require the collections agency, entity, or other assignee to inform the patient of the hospital's or ambulatory surgical facility's charity care and financial assistance policies when engaging in collections activity.
- For debts arising from the provision of care by a hospital or ambulatory surgical center, the doctrine of necessaries as it existed at common law shall apply equally to both spouses, except where they are permanently living separate and apart, but shall in no event create any liability between the spouses as to each other. No lien arising out of a judgment for a debt owed a hospital or ambulatory surgical facility under this section shall attach to the judgment.
debtor's principal residence held by them as tenants by the entitites or that was held by them as tenants by the entitites prior to the death of either spouse where the tenancy terminated as a result of the death of either spouse.

- For debts arising from the provision of care by a hospital or ambulatory surgical center to a minor, there shall be no execution on or otherwise forced sale of the principal residence of the custodial parent or parents for a judgment obtained for the outstanding debt until such time as the minor is either no longer residing with the custodial parent or parents or until the minor reaches the age of majority, whichever occurs first.82

**NORTH DAKOTA**

**State Initiative**

North Dakota has enacted legislation relating to late payment charges on medical debts. The law stipulates that accounts for medical services of a licensed nursing care facility or basic care facility do not become delinquent for a period of 45 days following the billing of medical services.83 Accounts for services that are not of a licensed nursing care facility or basic care facility do not become delinquent for a period of 90 days following the receipt of the billed medical services.84

The law also stipulates that a hospital or other health care facility may not charge a late fee in excess one percent per month, not to exceed twenty-five dollars per month.85 Additionally, the law provides that healthcare providers may not assess a late payment charge unless they provide consumers with monthly billing statements for each month in which there is an unpaid balance.86

**OKLAHOMA**

**State Initiative**

One particular section of the Oklahoma Crime Victims Compensation Act has implications for hospitals and collection agencies. When a person files a claim under the Oklahoma Crime Victims Compensation Act, all healthcare providers that have been given notice of a pending claim shall refrain from all debt collection activities relating to medical treatment received by the person in connection with such claim until an award is made on the claim, or until a claim is determined to be noncompensable.87 The law also tolls the statute of limitations for civil actions to recover the debt while the claim is pending.88

**OREGON**

**State Hospital Association**

The Oregon Financial Assistance Guidelines for members of the Association of Hospitals and Health Systems focuses greatly on financial assistance and charity care for those under the Federal Poverty Guidelines and the uninsured.89 There are a number of actions a hospital needs to take to ensure that all patients are made aware of the availability of financial assistance and charity care. These actions include, business cards with telephone numbers for them to call regarding assistance, interpreter services, signage, and brochures outlining the application process.

**PENNSYLVANIA**

**State Hospital Association**

In Pennsylvania, the Hospital and Healthsystem Association developed the Charity Care and Financial Guidelines in 2004.90 These guidelines recommend that hospitals work with each patient to establish reasonable payment plans. They also require that legal action not be taken unless there is evidence that the patient or responsible party has income and/or assets to pay the bill. The Pennsylvania Association also states that a Hospital shall not force the sale or foreclosure of a patient’s primary residence to pay an outstanding medical bill. Additionally, Hospitals should not employ a third-party to use physical or legal means to compel the patient or responsible party to appear in court.

**SOUTH CAROLINA**

**State Initiative**

South Carolina requires that when a health care provider receives a written notice of a pending claim from a consumer, the provider is prohibited from any debt collection activity related to medical and psychological treatments under the claim until (1) an award is made on the claim (2) the claim is determined to be noncompensable and is denied, or (3) ninety days have passed after receiving the pending claim notice.91 The statute of limitations for collecting such debt is suspended during the period a provider is restricted from debt collection activity.92

For purposes of the above requirement, “debt collection activity” includes making repeated calls to the consumer and sending notices to the consumer that threaten the account will be turned over to a debt collector or attorney for purposes of collection, enforcement or filing of other processes.93 “Debt collection activity” does not include researching billing or inquiries as to the status of the claim.94
Healthcare Claims Practices

Effective Date of Amendments: 60 days following adjournment of legislature

(4) (a) Except as provided in Subsection (4)(c), a health care provider may not make any report to a credit bureau or use the services of a collection agency, or use methods other than routine billing or notification until the later of unless the health care provider:

(i) (A) after the expiration of the time afforded to an insurer under Section 31A-26-301.6 to determine its the insurer's obligation to pay or deny the claim without penalty; or, sends a notice described in Subsection (4)(b) to the insured by certified mail with return receipt requested, priority mail, or text message; and

(B) makes the report to a credit bureau or uses the services of a collection agency after the date stated in the notice in accordance with Subsection (4)(b)(ii)(A); or

(ii) (A) in the case of a Medicare beneficiaries or retirees beneficiary or retiree 65 years of age or older, 60 days from after the date Medicare determines its Medicare's liability for the claim, sends a notice described in Subsection (4)(b) to the insured by certified mail with return receipt requested, priority mail, or text message; and

(B) makes the report to a credit bureau or uses the services of a collection agency after the date stated in the notice in accordance with Subsection (4)(b)(ii)(B).

(b) A notice described in Subsection (4)(a) shall state:

(i) the amount that the insured owes;

(ii) the date by which the insured must pay the amount owed that is:

(A) at least 45 days after the day on which the health care provider sends the notice; or

(B) if the insured is a Medicare beneficiary or retiree 65 years of age or older, at least 60 days after the day on which the health care provider sends the notice;

(iii) that if the insured fails to timely pay the amount owed, the health care provider may make a report to a credit bureau or use the services of a collection agency; and

(iv) that each action described in Subsection (4)(b)(iii) may negatively impact the insured's credit score.

(c) A health care provider satisfies the requirements described in Subsections (4)(a) and (b) if the health care provider complies with the provisions of 26 C.F.R. Sec. 1.501(r)-6.


Conclusion

Debt collection agencies need to ensure when they are attempting to collect medical debt from a consumer, they are in compliance with state law or any applicable healthcare system agreement. In response to federal investigations regarding hospital billing and collection practices, more states may jump on the band wagon by enacting laws or creating agreements to regulate healthcare providers.

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1 Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association (Revised May 5, 2012) at http://www.aha.org/content/12/120505-bill-collec-prac-statement.pdf (last visited on Mar. 11, 2015).
3 Id. at § 127425(b).
4 Id. For the definition of “reasonable payment plan” see Cal. Health & Safety Code § 127400(i)
5 Id. at § 127425(c).
6 Id. at § 127425(d).
7 Id. at § 127425(f).
8 Id. at § 127425(g).
9 Id. at § 127430.
11 Id. at § 14019.4(c).
12 Id. at § 14019.4(d).
13 Id. at § 14019.4(e).
14 Id. at § 14019.4(f).
15 Id. at § 14019.4(g).
17 Id. at § 6-20-201(1).
18 Id. at § 6-20-202(1)(b).
Id. at § 6-20-202(2)(a).
22 Id. at § 393-2.
23 210 ILCS § 89/10(a)(1) (West, WESTLAW through P.A. 98-1174 of the 2014 Reg. Sess.).
24 Id. at § 89/10(a)(2).
25 Id. at § 89/10(a)(3).
26 Id. at § 89/10(a)(4).
27 Id. at § 89/10(c)(1).
28 Id. at § 89/10(d).
29 Id. at § 89/15(a).
30 Id. at § 89/15(b).
31 Id. at § 89/25.
32 Id. at § 89/25(g).
33 225 Ill. Comp. Stat. § 60/22.2(d) (West, WESTLAW through the 54th Leg. (2014)).
37 Id. at § 5-116-A(2).
38 Me. Rev. Stat. Ann. tit. 9-A § 1-301 (West, WESTLAW through.).
40 Id. at § 5-116-A(4).
41 Id.
45 Id. at § 19-214.1(c).
46 Id. at § 19-214.1(f).
47 Id. at § 19-214.2(b)(1).
48 Id. at § 19-214.2(b)(2)-(3).
49 Id. at § 19-214.2(b)(5)-(6).
50 Id. at § 19-214.2(b)(9)(ii).
51 Id. at § 19-214.2(d)(1).
52 Id. at § 19-214.2(d)(2).
53 Id. at § 19-214.2(e)(1).
54 Id. at § 19-214.2(e)(2).
55 Id. at § 19-214.2(f)(1).
56 Id. at § 19-214.2(f)(2)-(3).
57 Id. at § 19-214.2(f)(4).
58 Id. at § 19-214.3(a).
59 Id. at § 19-214.3(b).
61 Id.
62 Id.
63 Id.
65 See Minnesota S.F. 1741 (Minn. 2015) to be codified at Minn. Stat. § 604.175 (West, WESTLAW through laws of the 2015 Reg. Sess.).
66 Id.
68 Id. at § 449.759.
69 Id. at § 11.2095.
70 Id. at § 108.662.
71 Id. at § 649.332.
74 N.Y. Pub. Health § 2807-k (West, WESTLAW through L.2015, chapters 1 to 4.).
75 Id. at § 2807-k(9).
76 Id. at § 2807-k(9-a)(b).
77 Id. at § 2807-k(9-a)(c).
78 Id. at § 2807-k(9-a)(h).
84 Id. at § 13-01-14.1(2)(a).
85 Id. at § 13-01-14.1(5)(b).
86 Id. at § 13-01-15(1).
87 Okla. Stat. tit. 21 § 142.9(H) (West, WESTLAW current Ch.430 of the 2nd Sess. of the 54th Leg. (2014)).
88 Id.


91 S.C. Code Ann. § 16-3-1360(A) (West, WESTLAW through end of 2014 Reg. Sess.).

92 Id.

93 Id. at § 16-3-1360(B).

94 Id.