

Enrolled House Bill 3320

Sponsored by Representative REYNOLDS, Senator PATTERSON; Representatives BOWMAN,
FAHEY, NELSON

CHAPTER

AN ACT

Relating to financial assistance for the cost of health care services; creating new provisions; and
amending ORS 442.610, 442.618 and 646A.677.

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) As used in this section:

(a) "Financial assistance" includes:

(A) Charity care, as defined in ORS 442.601; or

(B) An adjustment to a patient's costs for care under ORS 442.614 (1)(a).

(b) "Hospital" has the meaning given that term in ORS 442.612.

(2) Using the process prescribed by the Oregon Health Authority under subsection (3) of this section, a hospital licensed under ORS 441.025 shall screen a patient for presumptive eligibility for financial assistance if the patient:

(a) Is uninsured;

(b) Is enrolled in the state medical assistance program; or

(c) Owes the hospital more than \$500.

(3) The authority shall adopt by rule the process for screening a patient for presumptive eligibility for financial assistance under subsection (2) of this section. The rules and process must:

(a) Prohibit a hospital from requiring a patient to provide documentation or other verification;

(b) Ensure that the process will not cause any negative impact on the patient's credit score;

(c) Require a hospital, before sending a bill to the patient, to conduct the screening and apply any financial assistance for which the patient qualifies to the bill; and

(d) Require the hospital to notify a patient if the patient has been screened and to explain to the patient, in language approved by the authority, how to apply for financial assistance if financial assistance was denied, or how to apply for additional financial assistance above what the patient received.

(4) A patient may apply for financial assistance:

(a) If the patient was screened for presumptive eligibility for financial assistance and was found not to be eligible or the patient disagrees with the amount of the financial assistance that was offered;

(b) If a patient was not screened for presumptive eligibility for financial assistance; or

(c) Any time up to 12 months after a patient pays for the services that the hospital provided.

(5) A hospital may require a patient who applies for financial assistance under subsection (4) of this section to provide documentation or verification of information reported as necessary for the hospital to determine the patient's eligibility for financial assistance.

(6) If a patient applies for financial assistance after having paid for the services and the patient is found to have been eligible for financial assistance when the services were provided:

(a) The hospital shall refund the amount of financial assistance for which the patient qualified;

(b) If the hospital previously determined, incorrectly, that the patient did not qualify for financial assistance for the services based on information provided by the patient at the time of the incorrect determination, the hospital shall also pay the patient interest on the amount of financial assistance at the rate set by the Federal Reserve and any other associated reasonable costs, such as legal expenses and fees, incurred by the patient in securing financial assistance; and

(c) If the hospital sold the debt to a collection agency or authorized a collection agency to collect debts on behalf of the hospital, the hospital shall notify the collection agency that the debt is invalid.

(7) If a patient applies for financial assistance and the hospital determines that the patient is eligible for financial assistance based on documentation provided by the patient, the patient's eligibility for financial assistance continues for nine months following the hospital's determination, and the patient may not be required to reapply for financial assistance for services provided during that nine-month period.

(8)(a) A hospital must have a written process that is in plain English, and in other languages as required by law, for a patient to appeal a hospital's denial of financial assistance, in whole or in part, and that allows the patient, or an individual acting on behalf of the patient, to correct any deficiencies in documentation or to request a review of the denial by the hospital's chief financial officer or the chief financial officer's designee. The authority shall prescribe by rule the requirements for the appeal process.

(b) If a hospital denies a patient's application for financial assistance, whether in whole or in part, the hospital must notify the patient of the denial and include in the notice an explanation of the hospital's appeal process.

(9) During the pendency of an appeal that is filed using a hospital's appeal process under subsection (8) of this section, if:

(a) The hospital has initiated collection activities, the hospital must suspend all collection activities; and

(b) The hospital sold the debt under appeal to a collection agency or has authorized a collection agency to collect debts on behalf of the hospital, the hospital must notify the collection agency to suspend collection activities.

SECTION 2. ORS 442.610 is amended to read:

442.610. (1) As used in this section:

(a) "Financial assistance policy" means a policy that meets the requirements of section 501(r) of the Internal Revenue Code and implementing regulations.

(b) "Hospital" has the meaning given that term in ORS 442.015.

(c) **"Nonprofit" has the meaning given that term in ORS 442.612.**

(2) A hospital shall have a written financial assistance policy that complies with the plain language standards for consumer contracts under ORS 180.545 (1).

(3) A hospital shall:

(a) Provide a paper copy of the financial assistance policy **and an application form to apply for financial assistance** to a patient upon request;

(b) Include on each billing statement, **on the hospital's website home page and on any website where the patient pays a bill or accesses information about the patient's account, a prominently displayed** notice of:

(A) The availability of financial assistance;

(B) The contact information for the office or department of the hospital that can provide information about obtaining financial assistance; and

(C) The *[direct]* Internet address for the financial assistance policy **and the Internet address where an application for financial assistance may be accessed, completed and submitted online, including on a mobile device; *[and]***

(c) Accept an application for financial assistance that is submitted:

(A) In an online application; or

(B) Sent by mail to or submitted in person at the hospital's address as shown on the application; and

[(c)] **(d)** Maintain public displays in locations in the hospital that are accessible to the public that notify and inform patients about the financial assistance policy. Locations that are accessible to the public include but are not limited to the emergency department, if any, and the areas where patient admissions are processed.

[(4) The Oregon Health Authority shall make available to hospitals and the general public a uniform application for financial assistance, created by a trade association representing hospitals, that may be used in any hospital in this state to request financial assistance.]

(4)(a) A nonprofit hospital's application for financial assistance, when completed by a resident of this state:

(A) May require the resident to provide only:

(i) The patient's household income, for purposes of ORS 442.614; and

(ii) Information about any third party that may be liable for the cost of the services, as permitted by ORS 646A.677.

(B) Must clearly mark as optional any other information, including information about the patient's assets.

(b) A nonprofit hospital may not use information other than information listed in paragraph (a) of this subsection to deny financial assistance to a resident of this state.

(c) This subsection does not prohibit:

(A) A hospital from requiring a patient to respond to requests from the patient's insurer as needed for the insurer to adjudicate the hospital's claim for reimbursement, as permitted by ORS 646A.677; or

(B) A nonprofit hospital from requiring a patient to provide information that the Centers for Medicare and Medicaid Services requires the hospital to collect for the purpose of cost reporting.

SECTION 3. ORS 442.618 is amended to read:

442.618. (1) As used in this section[,];

(a) "Extraordinary collection action" means actions referenced in section 501(r)(6) of the Internal Revenue Code or implementing regulations.

(b) "Health care facility" has the meaning given that term in ORS 442.015, excluding long term care facilities.

(c) "Payer type" means one or more of the following persons legally responsible for all or part of the cost of hospital services:

(A) A commercial insurer;

(B) Medicare;

(C) The state medical assistance program;

(D) A patient who is uninsured or otherwise personally responsible for the cost of hospital services; or

(E) Another payer type prescribed by the Oregon Health Authority by rule.

(2) A hospital shall report annually to the [*Oregon Health*] authority the following information regarding all health care facilities and affiliated clinics that are owned in part or in full by the hospital or operating under the same brand as the hospital:

(a) The address of each health care facility and affiliated clinic;

(b) Whether the hospital's financial assistance policy, developed under ORS 442.614, [*is posted in the health care facility and affiliated clinic and available to patients of the facility and affiliated clinic*] **complies with ORS 442.610 (3); [and]**

(c) Whether the hospital is a nonprofit entity and whether the hospital's nonprofit status applies to the hospital's affiliated clinics[.];

(d) During the reporting period:

(A) How many applications for financial assistance the hospital received and of the applications received, the number of applications that were approved;

(B) Of the patients who received financial assistance, the number of patients who received financial assistance without completing the hospital's financial assistance application process; and

(C) Reported by payer type, the number of patients who received financial assistance and the number of patients who were denied financial assistance;

(e) During the reporting period, the number of accounts that were:

(A) Referred to a debt collector or collection agency during the reporting period; and

(B) Transferred for extraordinary collection actions during the reporting period, listed by type of action; and

(f) The average, median and total amount of debt, owed to the hospital by patients, that was placed in collections during the reporting period.

(3) The authority shall prescribe the form and manner for reporting the information described in subsection (2) of this section.

(4) A hospital that fails to file a timely report, as prescribed by the authority, may be subject to a civil penalty not to exceed \$500 per day. Civil penalties shall be imposed as provided in ORS 183.745.

SECTION 4. ORS 646A.677 is amended to read:

646A.677. (1) As used in this section:

(a) "Debt collector" has the meaning given that term in ORS 646.639.

(b) "Financial assistance" means the written financial assistance policy described in ORS 442.610.

(c) "Hospital" has the meaning given that term in ORS 442.612.

(d) "Hospital-affiliated clinic" has the meaning give that term in ORS 442.612.

(e) "Medical debt" means an amount owed by a patient to a hospital or a nonprofit hospital-affiliated clinic for medically necessary services or supplies.

(f) "Medically necessary" has the meaning given that term in ORS 442.612.

(g) "Nonprofit" has the meaning given that term in ORS 442.612.

(2) A hospital and a nonprofit hospital-affiliated clinic shall post the hospital's financial assistance policy in the manner described in ORS 442.610 [(3)(c)] **(3)(d)**.

(3) Upon the request of a patient or an individual who is authorized to act on behalf of a patient, a hospital or hospital-affiliated clinic shall conduct a screening to determine if the patient qualifies for:

(a) Financial assistance under the hospital's financial assistance policy; or

(b) The state medical assistance program.

(4) Before transferring an unpaid charge for services to a debt collector or referring an unpaid charge for collection, a hospital or hospital-affiliated clinic shall:

(a) Conduct a screening to determine if the patient qualifies for financial assistance as described in ORS 442.614 (1)(a)(A), if applicable; and

(b) Provide a copy of its financial assistance policy to the patient along with an application for financial assistance.

(5) A hospital or nonprofit hospital-affiliated clinic may conduct the screening described in subsections (3) and (4) of this section using commercially available services, software or online tools.

(6) As a condition for providing financial assistance, a hospital may require a patient to:

(a) Respond to requests from the patient's primary insurer as necessary for the insurer to adjudicate a claim for reimbursement of the cost of services; and

(b) Provide information concerning any potential third party liability for the cost of services including but not limited to:

(A) Information about the coordination of benefits between insurers that cover the patient's care;

(B) Accident reports; and

(C) The patient's workers' compensation claims or benefits.

(7) If a patient qualifies for financial assistance under ORS 442.614 (1)(a)(A), a hospital, nonprofit hospital-affiliated clinic or other debt collector may not charge interest on the patient's medical debt.

(8)(a) Except as provided in paragraph (b) of this subsection, the interest that a hospital, nonprofit hospital-affiliated clinic or other debt collector may charge on a medical debt owed by a patient who does not qualify for financial assistance under ORS 442.614 (1)(a)(A) may not exceed the weekly average one-year constant maturity Treasury yield, as published by the Board of Governors of the Federal Reserve System, for the week preceding the date when the patient was first billed, except that the interest may not be less than two percent per annum or more than five percent per annum.

(b) Upon entry of a judgment against a patient described in paragraph (a) of this subsection, a hospital, nonprofit hospital-affiliated clinic or other debt collector may increase the interest charged on a medical debt up to the amount specified in ORS 82.010.

(9) A hospital, hospital-affiliated clinic or other debt collector may not attempt to collect a medical debt from a patient's child or other family member who is not financially responsible for the debt under ORS chapter 108.

(10) It is an unlawful collection practice under ORS 646.639 for a hospital, hospital-affiliated clinic or other debt collector to collect or attempt to collect a medical debt in a manner that the hospital, hospital-affiliated clinic or other debt collector knows, or after exercising reasonable diligence would know, is in violation of this section.

SECTION 5. A hospital is not required to have in place an appeals process described in section 1 (8) of this 2023 Act before January 1, 2025.

SECTION 6. (1) Section 1 of this 2023 Act and the amendments to ORS 442.610 and 646A.677 by sections 2 and 4 of this 2023 Act become operative on July 1, 2024.

(2) The amendments to ORS 442.618 by section 3 of this 2023 Act become operative on January 1, 2025.

(3) The Oregon Health Authority shall take any action before the operative dates specified in this section that is necessary to carry out section 1 of this 2023 Act and the amendments to ORS 442.610, 442.618 and 646A.677 by sections 2 to 4 of this 2023 Act on and after the operative dates specified in this section.

Passed by House April 18, 2023

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Timothy G. Sekerak, Chief Clerk of House

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Dan Rayfield, Speaker of House

Passed by Senate June 22, 2023

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Rob Wagner, President of Senate

Received by Governor:

.....M,....., 2023

Approved:

.....M,....., 2023

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Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M,....., 2023

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Secretary of State