SPONSOR: Sen. Pinkney & Rep. Chukwuocha & Rep. Minor-Brown
Sens. Cruce, Poore, Townsend; Rep. Harris

DELAWARE STATE SENATE
153rd GENERAL ASSEMBLY

SENATE BILL NO. 13

AN ACT TO AMEND TITLE 6 AND TITLE 16 OF THE DELAWARE CODE RELATING TO HOSPITAL CHARITY CARE AND FINANCIAL ASSISTANCE.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend § 9311, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 9311. Charity care.

(a) For purposes of this section, "hospital" means as defined in § 1001 of this title.

(b) ~~Any~~ A person subject to a ~~CPR review pursuant to~~ Certificate of Public Review under this chapter shall perform and accept within this State charity ~~care~~ care, to the extent required by the ~~Board to~~ Board, for those individuals who meet the criteria for rendering charity care established by the Board, and shall continue to provide charity care in each fiscal ~~year~~ year, as determined by the Board. ~~The authority to enforce charity care requirements shall rest with the Department of Health and Social Services.~~

(c) The Department of Health and Social Services shall enforce the charity care requirement under subsection (b) of this section.

(d)(1) Except as provided under paragraph (d)(2) of this section, subsection (b) of this section does not apply to a hospital.

(2) Subsection (b) of this section applies to a hospital that provides exclusively psychiatric services, rehabilitative services, or long-term acute care services.

(e)(1) Except as provided under paragraph (e)(2) of this section, a hospital shall comply with the financial assistance requirements under subchapter VII of Chapter 99 of this title.

(2) A hospital that provides exclusively psychiatric services, rehabilitative services, or long-term acute care services is not required to comply with the financial assistance requirements under subchapter VII of Chapter 99 of this title.

Section 2. Amend Chapter 99, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

Subchapter VII. Financial Assistance

§ 9961. Definitions.

For the purposes of this subchapter:

(1) "Board" means the Diamond State Hospital Cost Review Board established by § 9902 of this title.

(2) "Department" means the Department of Health & Social Services.

(3) "Division" means the Division of Health Care Quality.

(4) "Financial assistance" means free or discounted care for medically necessary hospital services provided to a financially qualified patient, resulting in a full or partial write-off of the patient's responsibilities for the services.

(5) "Financially qualified patient" means a patient who meets all of the following:

a. Has household income at or below the applicable percentage of the federal poverty level established under this subchapter.

b. Is a resident of this State.

(6) "Facility-based provider" means a health care professional licensed under Title 24 who furnishes hospital services.

(7)a. "Hospital" means as defined in § 1001 of this title.

b. "Hospital" does not include a hospital that provides exclusively psychiatric services, rehabilitative services, or long-term acute care.

(8)a. "Hospital services" means medically necessary services provided to a patient in connection with the patient's hospital encounter, including services provided during or as part of an inpatient admission, emergency department visit, observation stay, or hospital outpatient procedure or visit.

b. "Hospital services" include services provided at the hospital, at any off-campus location operated under the hospital's license or Medicare provider agreement, or at a freestanding emergency department affiliated with the hospital, regardless of the identity of the entity billing for the service.

c. "Hospital services" do not include services provided when the patient refuses, or the medical power of attorney, legal guardian, or the patient's family refuse for the patient, to be discharged from the hospital when recommended.

c. The Board may by regulation specify categories of services that are or are not hospital services consistent with paragraph (8) of this section.

(9) “Medical hardship” means out-of-pocket hospital expenses incurred for an episode of care, including health plan deductibles and out-of-pocket hospital expenses, equal or exceed 10% of the patient's annual household income.

(10) “Medically necessary” or “medical necessity” means the provision of health-care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, disease, or the symptoms of an illness, injury, or disease in a manner that is all of the following:

a. In accordance with generally accepted standards of medical practice;

b. Consistent with the symptoms or treatment of the condition;

c. Not solely for anyone’s convenience; and

d. Not including investigational or experimental health care services.

(11) “Patient responsibility” means the amount owed by a patient for medically necessary hospital services after payment or adjustment by any insurer, health plan, Medicare, Medicaid, or other third-party payer, including copayments, coinsurance, deductibles, and any other amounts owed by the patient.

§ 9962. Minimum financial assistance standards.

(a) A hospital and a facility-based provider shall, at a minimum, provide financial assistance for the patient responsibility arising from medically necessary hospital services to financially qualified patients as follows:

(1) Full financial assistance for medically necessary hospital services for financially qualified patients with household income at or below 300% of the federal poverty level.

(2) Discounted financial assistance for medically necessary hospital services for financially qualified patients with household income greater than 300% and at or below 350% of the federal poverty level, in an amount that reduces the patient’s responsibility by no less than 75%.

(3) Discounted financial assistance for medically necessary hospital services for financially qualified patients with household income greater than 350% and at or below 400% of the federal poverty level, in an amount that reduces the patient’s responsibility by no less than 50%.

(b)(1) A hospital shall have a medical hardship policy that allows patients with incomes above the thresholds established in subsection (a) of this section, but who are experiencing medical hardship, to qualify for discounted financial assistance.

(2) The hospital may establish an income ceiling on eligibility under the hospital’s medical hardship policy, but the ceiling may not be lower than 500% of the federal poverty level.

(3) Under the hospital's medical hardship policy, the hospital shall discount the patient's responsibility for medically necessary hospital services by no less than 50%.

(4) A patient seeking financial assistance under this subsection shall apply for financial assistance under subsection (a) of this section.

(5) A patient previously denied financial assistance under subsection (a) of this section shall provide additional documentation supporting the medical hardship.

(6) A medical hardship determination is valid for 1 year from the date of the determination and applies to all hospital services furnished during the determination period.

(7) A facility-based provider shall honor a hospital's medical hardship determination on the same terms as an eligibility determination under subsection (f) of this section.

(c) A hospital or facility-based provider may not condition the financial assistance provided under subsection (a) of this section on prior payment, enrollment in a payment plan, or exhaustion of other remedies.

(d) Financial assistance is available to a patient regardless of insurance if the patient meets the income thresholds established in subsection (a) of this section.

(e) Notwithstanding any other provision of this subchapter, a hospital may choose to grant eligibility for the hospital's financial assistance policies to patients with incomes over 400% of the federal poverty level.

(f)(1) A patient deemed financially qualified is considered eligible for financial assistance for a minimum of 1 year from the date of the eligibility determination.

(2) On making such a determination, a hospital shall provide the patient with a written eligibility notice stating the patient's eligibility category, the household income on which the determination is based, and the dates during which the determination is effective.

(3) A facility-based provider shall accept the eligibility notice as sufficient documentation of the patient's eligibility for hospital services furnished during the eligibility period and shall apply financial assistance to the provider's bills for those services consistent with the patient's eligibility category.

(g) A hospital or a facility-based provider that receives a patient holding a valid written eligibility notice issued by another hospital under subsection (f) of this section shall rely on that notice as sufficient documentation of the patient's eligibility for financial assistance for services received during the eligibility period stated on the notice. A hospital shall provide financial assistance no less comprehensive than that reflected in subsection (a) of this section.

(h)(1) For purposes of this subsection, "pending" means an application for financial assistance or coverage has been completed by a patient and is under review by the hospital.

(2) While a determination of eligibility for financial assistance or coverage is pending, a hospital shall communicate to the patient in writing that the patient is not responsible for any bills the patient receives while the patient's application is pending.

(3) A hospital or a facility-based provider that knows or has reason to know of a patient's pending application for financial assistance or coverage may not do any of the following:

a. Refer the patient's account to a collection agency.

b. Sell or assign the patient's debt.

c. Provide information on the unpaid charges for health care services to a consumer reporting agency; or

d. Initiate a lawsuit or arbitration proceeding against the patient relative to unpaid charges for health care services.

(i) *Notice to patients.* A hospital shall do all of the following:

(1) Post visually prominent notices of financial assistance availability in all patient registration and admission areas, and in all areas where patients are billed or pay for services. The notices must be available in all languages spoken by more than 5% of the population of the hospital's service area, as determined by the most recent census data.

(2) Provide oral notice of the availability of financial assistance to each patient at the time of registration or admission. The oral notice must include information on how to apply for financial assistance and the availability of staff assistance with the application.

(3) Offer financial assistance screening and provide a financial assistance application to each patient who is uninsured, self-pays for any portion of the patient responsibility, or has a remaining balance of $500 or more after insurance.

(4) Include written notice of the availability of financial assistance and a copy of the hospital's financial assistance application with each written request for payment sent to a patient described in paragraph (i)(3) of this section.

(5) Make the hospital's financial assistance policy, application, and the written notice required under paragraph (i)(4) of this section available in all languages spoken by more than 5% of the population of the hospital's service area, as determined by the most recent census data.

(j) A hospital shall submit reports to the Board in conjunction with reports required under Chapter 93A of this title in a form, manner, and frequency set by the Board. The reports must include all of the following:

(1) The number of financial assistance applications received by the hospital.

(2) The number of applications approved, denied, or closed and the reasons for the approval, denial, or closure.

(3) The number of presumptive eligibility screenings completed and the number of patients determined presumptively eligible.

(4) The average and median length of time to determine eligibility for completed financial assistance applications.

(5) The amount of financial assistance provided, measured at cost.

(6) The amount of financial assistance provided, measured as a percentage of hospital operating expenses.

§ 9963. Duties of the Board.

(a) The Board may adopt regulations to administer, enforce, or implement this subchapter.

(b) The Board shall establish by regulation, with input from the Delaware Healthcare Association, all of the following:

(1) Categories of information and documentation that hospitals may request from patients when determining eligibility for financial assistance. The categories may not exceed what is reasonably necessary to verify income and household size. A hospital may not request information or documentation outside the categories established under this subsection.

(2) Categories of presumptive eligibility for financial assistance, which may include enrollment in or eligibility for income-based public benefits, residency in publicly subsidized housing, current or recent receipt of services in homeless services systems, or other indicators of household income reasonably available to the hospital.

(3) Methodologies for identifying presumptively eligible patients, including standards governing the use of historical data, predictive modeling, and any other approaches the Board permits hospitals to use. The Board may require, permit, or restrict the use of specific methodologies.

(c) The Board shall prescribe all of the following:

(1) A standard financial assistance application consistent with the categories established under subsection (b) of this section, which hospitals shall use when determining eligibility for financial assistance.

a. A hospital may request Board approval to use a modified application in lieu of the standard application.

b. The Board shall approve a modified application that reduces applicant burden.

c. The Board may not approve a modified application that requires information or documentation beyond the categories established under subsection (b) of this section.

(2) A standardized list of acceptable forms of income verification consistent with the categories established under subsection (b) of this section.

(3) A list of income-based public assistance programs established by the Board under § 9964(a)(1) of this title and associated forms of verification.

(c) The Board shall maintain a website and shall publicly post on the website all of the following:

(1) The financial assistance policies and reports submitted by a hospital under § 9962(j) of this title within 30 days of receipt.

(2) Information on financial assistance rights, hospital financial assistance policies required under § 9964 of this title, and items prescribed by the Board under § 9963(b) of this title.

(3) The documents the Board is required to prescribe under subsection (b) of this section.

(d) The Board may initiate reviews for hospital compliance with this subchapter on the occurrence of any of the following:

(1) A credible complaint alleging noncompliance.

(2) Outlier patterns in reporting under this section, including unusually high denial or closure rates, unusually long determination times, or unusually low presumptive eligibility usage.

(3) Evidence of lack of written communication about financial assistance eligibility during billing or collection activity taken during a pending determination.

(4) Any other risk indicators as the Board may establish by regulation.

§ 9964. Hospital financial assistance policies.

(a) In accordance with federal and state guidelines, a hospital shall publish the hospital's financial assistance policy and application on the hospital's website. In addition to other information required under this subchapter, a hospital shall include all of the following in the hospital's financial assistance policy:

(1) *Presumptive eligibility program.* The criteria the hospital uses to presumptively determine an individual's eligibility for financial assistance, which at a minimum must do all of the following:

a. Apply categories of presumptive eligibility established by regulation of the Board, and apply categories no more restrictive in scope than those established by the Board.

b. Use methodologies for identifying presumptively eligibility patients consistent with regulations of the Board, which may include historical data from individuals approved through the hospital's full application process, predictive modeling using publicly available data, or other methodologies the Board permits.

c. Not impose documentation or verification requirements beyond those required by the Board.

d. Publish information on the presumptive program and the basis for presumptive eligibility.

e. A statement that presumptive financial assistance determination are valid for no less than 180 days.

(2) Patient application rights following presumptive determination. A patient may not be required to submit a full application for financial assistance if the patient qualifies for presumptive eligibility. A patient may choose to apply for financial assistance to extend the approval time period to 1 year.

(3) *Application process.* Requirements for hospitals screening a patient for financial assistance, which must include all of the following:

a. Allowances for a patient to apply for financial assistance, which must include all of the following:

1. The patient was screened for presumptive eligibility and was found not to be eligible.

2. Patients may apply for financial assistance at any time during the collections process, including after the patient account has been sold, referred to, or assigned to another entity. If the patient is determined eligible after the patient's account has been sold, referred, or assigned to another entity, the hospital shall notify the entity that the debt is invalid.

3. A patient previously denied financial assistance may apply again for financial assistance if financial circumstances have changed or the patient incurred additional medical expenses.

b. The availability of staff assistance for a patient completing an application for financial assistance.

c. The ability for a patient to submit the patient's financial assistant application in a variety of methods including electronically, by mail, or in person.

d. A determination and written notification to the patient on eligibility for financial assistance within 21 days of the completed application submission, including notification of the denial and the opportunity to appeal.

e. An appeals process for a patient deemed ineligible for financial assistance in accordance with the process prescribed by the Board. A patient must have the ability to provide additional documentation supporting the patient's appeal.

f. Practices the hospitals may not employ when administering the financial assistance process, including all of the following:

1. Requiring documentation or verification not included on the standardized list created by the Board.

2. Requiring documentation not reasonably available to the patient or not necessary to determine eligibility for financial assistance.

3. Deeming applications incomplete without providing written notice of missing information and a reasonable opportunity to complete the form.

4. Closing or denying an application due to missed internal deadlines where the hospital possesses sufficient information to determine eligibility.

5. Engaging in any other practice, policy, or pattern of conduct that has the purpose or effect of delaying, deterring, or discouraging access to financial assistance.

(4) Requirements for Medicaid coordination when screening. When reliable information reasonably available to the hospital indicates that a patient is reasonably likely to be eligible for Medicaid coverage for the date of service, the hospital may initiate the Medicaid coordination process concurrently with financial assistance screening.

a. A hospital may not deny or delay financial assistance on the basis that a patient may be eligible for Medicaid or other public coverage unless the hospital has screened the patient for such coverage using information reasonably available to the hospital, has made reasonable efforts to assist the patient with enrollment in Medicaid or other public coverage, and has documented the results of that screening in the patient's medical record.

b. Hospitals shall only document whether the patient appears to be eligible for Medicaid or other public coverage and not the reasons for eligibility or ineligibility.

c. A patient who is not eligible for Medicaid or other public coverage as a matter of federal or state law may not be required to undergo screening for Medicaid or other public coverage as a condition of financial assistance eligibility.

d. Nothing in this subchapter prohibits a hospital from assisting a patient with enrollment in Medicaid or other coverage, if the hospital's assistance does not delay the application of financial assistance.

(5) Requirements if hospitals choose to permit provisional financial assistance pending determination of Medicaid or other public coverage, including all of the following:

a. That a hospital may not treat financial assistance as provisional for more than 180 days after the date of the eligibility determination unless the patient has a pending coverage application and the hospital documents that status in the patient's medical record.

b. That any reconciliation must occur no later than 30 days after the hospital receives notice of coverage approval or denial, and the hospital must provide the patient a written reconciliation notice describing any adjustments.

c. That a patient may not be billed or sent to collections for any amount covered by financial assistance while reconciliation is pending, and any overpayment must be refunded within 30 days.

(6) Procedures for the refund of hospital service costs to a patient if the hospital failed to screen the patient for presumptive eligibility for financial assistance as required or previously determined, incorrectly, that the patient did not qualify for financial assistance based on information provided by the patient at the time of the incorrect determination.

a. The hospital shall refund the amount paid by the patient of financial assistance for which the patient qualified and other reasonable costs incurred by the patient in securing financial assistance. The interest rate must mirror the rate set by the Federal Reserve.

b. 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.

§ 9965. Licensure and penalties.

(a) On finding that a hospital is not in compliance with the financial assistance requirements under this subchapter, the Board shall notify the Division of Health Care Quality.

(b) The Division of Health Care Quality may use the Division's authority under § 1007(b)(3) of this title.

(c) The Attorney General may bring a civil action on behalf of a patient or class of patients harmed by violations of §§ 9962 through 9964 of this title.

§ 9966. Successor liability.

The obligations imposed by this subchapter run with the hospital license and apply to any successor owner or operator of a hospital licensed under Chapter 10 of this title.

Section 3. Amend § 1007, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 1007. Enforcement.

(b) The Department may impose civil money penalties for the violation of provisions of this ~~chapter~~ chapter, or the regulations adopted ~~pursuant to it.~~ under this chapter, or subchapter VII of Chapter 99 of this title.

Section 4. Amend § 2505J, Title 6 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 2505J. Billing and collections rules; limits on creditors.

(h) A medical creditor or medical debt collector may not take any extraordinary collection action against a patient who qualifies for financial assistance under subchapter VII of Chapter 99 of Title 16 or against a patient whom the medical creditor has reason to know likely qualifies for financial assistance under subchapter VII of Chapter 99 of Title 16.

Section 5. Amend § 2508J, Title 6 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 2508J. Prohibition against collection of medical debt during health insurance appeals.

(d) No medical creditor or medical debt collector that knows or should know that a determination of eligibility for financial assistance under subchapter VII of Chapter 99 of Title 16 is pending, or that a patient has appealed a denial of such financial assistance, may do any of the following:

(1) Communicate with the consumer regarding unpaid charges for health-care services for the purpose of seeking to collect the charges unless the creditor communicates in writing that the patient is not responsible for the charges during the time period that the application is pending.

(2) Initiate a lawsuit or arbitration proceeding against the consumer relative to unpaid charges for health-care services.

(e) No medical creditor that knows or should know that a determination of eligibility for financial assistance under subchapter VII of Chapter 99 of Title 16 is pending, or that a patient has appealed a denial of such financial assistance, may 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.

Section 5. Amend § 2511J, Title 6 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 2511J. Remedies.

(f) In any civil action to collect medical debt from a patient, it is a complete defense that the ho-spital or the facility-based provider, as defined in § 9961 of Title 16, did not comply with subchapter VII of Chapter 99 of Title 16 or that the patient is eligible for financial assistance under subchapter VII of Chapter 99 of Title 16.

(g) A hospital, facility-based provider, or medical debt collector may not be granted a default judgment in any civil action to collect medical debt without filing with the court an affidavit from a responsible officer of the hospital attesting that the hospital offered the patient screening for financial assistance under subchapter VII of Chapter 99 of Title 16 before initiating the action and that the patient was determined ineligible or did not respond to the screening offer.

Section 8. Effective date.

(a) Section 9962(a) and § 9962(b) of Title 16, as contained in Section 2 of this Act, establishing minimum financial assistance standards based on the federal poverty level, take effect on January 1, 2027.

(b) All other provisions of this Act take effect on the earlier of the following:

(1) Notice by the Diamond State Hospital Cost Review Board published in the Register of Regulations that final regulations to implement this Act have been adopted.

(2) July 1, 2027.

SYNOPSIS

This Act amends Title 16 and Title 6 of the Delaware Code relating to hospital charity care and financial assistance. Among other things, the Act does the following:

(1) Section 1 of the Act amends § 9311 of Title 16 to exempt certain hospitals from the existing charity care requirement and require these hospitals to comply with the new financial assistance requirements under Section 2 of this Act. A hospital that provides exclusively psychiatric services, rehabilitative services, or long-term acute care services remains subject to the charity care requirement.

(2) Section 2 of the Act creates a new Subchapter VII of Chapter 99 of Title 16, §§ 9961 through 9966, establishing minimum financial assistance standards for hospitals and facility-based providers. The subchapter requires full financial assistance for Delaware residents with household income at or below 300% of the federal poverty level, a 75% discount above 300% and at or below 350%, and a 50% discount above 350% and at or below 400%, and requires each hospital to maintain a medical hardship policy providing a 50% minimum discount with an income ceiling of at least 500% of the federal poverty level. Eligibility determinations are valid for at least 1 year, transfer among hospitals and facility-based providers, and suspend collection activity while an application or appeal is pending. Hospitals must provide notice in languages spoken by more than 5% of the hospital's service area, screen patients for financial assistance, report annually to the Diamond State Hospital Cost Review Board ("Board"), and publish a financial assistance policy addressing presumptive eligibility, the application process, Medicaid coordination, and patient refunds. The Board administers the subchapter and conducts compliance reviews, the Division of Health Care Quality may take licensure action on a finding of noncompliance, the Attorney General may bring a civil action on behalf of patients harmed by a violation, and the obligations run with the hospital license.

(3) Section 3 of the Act amends § 1007 of Title 16 to extend the Department of Health and Social Services' civil money penalty authority to violations of Subchapter VII of Chapter 99.

(4) Section 4 of the Act amends § 2505J of Title 6 to prohibit a medical creditor or medical debt collector from taking extraordinary collection action against a patient who qualifies, or whom the creditor has reason to know likely qualifies, for financial assistance.

(5) Section 5 of the Act amends § 2508J of Title 6 to prohibit collection communications, litigation, and debt referrals or sales by a medical creditor or medical debt collector that knows or should know that a patient's financial assistance application or appeal is pending.

(6) Section 6 of the Act amends § 2511J of Title 6 to make noncompliance with the new subchapter, or a patient's eligibility for financial assistance, a complete defense in a civil action to collect medical debt, and to bar entry of a default judgment in any such action without an affidavit from a responsible officer of the hospital attesting that the patient was offered financial assistance screening.

(7) Section 7 of the Act provides that the minimum financial assistance standards under § 9962(a) and (b) of Title 16 take effect on January 1, 2027, and that all other provisions take effect on the earlier of notice by the Diamond State Hospital Cost Review Board, published in the Register of Regulations, that final implementing regulations have been adopted, or July 1, 2027.

Author: Senator Pinkney