AMENDED IN SENATE JUNE 16, 2005

CALIFORNIA LEGISLATURE—2005–06 REGULAR SESSION

ASSEMBLY BILL No. 774

Introduced by Assembly Member Chan

February 18, 2005

An act to add Article 3 (commencing with Section 127400) to Chapter 2 of Part 2 of Division 107 of the Health and Safety Code, relating to hospitals.

LEGISLATIVE COUNSEL'S DIGEST

AB 774, as amended, Chan. Hospitals: self–pay policies.

Existing law provides for the Office of Statewide Health Planning and Development, which is charged with the administration of health policy and planning relating to health facilities, including hospitals.

This bill would require each hospital to develop a policy specifying how the hospital will determine financial liability for services rendered to both financially qualified patients and self–pay patients, as defined. The bill would require the policy to include a section addressing charity care patients that specifies the financial criteria and the procedure used by the hospital to determine whether a patient is eligible for charity care. The bill would require each hospital to perform various functions in connection with the hospital self–pay policy, including notifying patients of the policy, and attempting to determine the availability of private or public health insurance coverage for each patient. The bill would also specify billing and collection procedures to be followed by a hospital, its assignee, collection agency, or billing service.

This bill would require each hospital to submit to the office a copy of the hospital's application for financially qualified patients and a copy of its self–pay policy, eligibility procedures, review process, and

procedure for determining self–pay pricing. The bill would authorize the office to develop a uniform self–pay application to be used by all hospitals.

The bill would authorize the director of the office to levy civil penalties for violations by a hospital of the above provisions. ~~The~~ *Upon referral by the office, complaint by an individual consumer, or other information concerning violations, the* bill would authorize the Attorney General to authorize an investigation to determine whether a hospital is in compliance with the above provisions ~~and would authorize private persons to act in the capacity of the Attorney General if the Attorney General fails to determine that a violation occurred within 90 days of receiving notice of possible violation~~.

This bill would provide that to the extent that certain of the bill's requirements result in a specified federal determination relating to the hospital's established charge schedule, the requirement in question shall be inoperative with respect to a hospital that is licensed to and operated by a county or public hospital authority.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Article 3 (commencing with Section 127400) is added to Chapter 2 of Part 2 of Division 107 of the Health and Safety Code, to read:

Article 3. Self–Pay Policies

127400. As used in this article, the following terms have the following meanings:

(a) "Allowance for financially qualified patient" means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

(b) "Federal poverty level" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

(c) "Financially qualified patient" means both of the following:

(1) A patient who is a self–pay patient, as defined in subdivision (f) or an underinsured patient as defined in subdivision (g).

(2) A patient who has a family income that does not exceed 400 percent of the federal poverty level.

(d) "Hospital" means any facility that is required to be licensed under subdivision (a), (b), or (f) of Section 1250, except a facility operated by the State Department of Mental Health or the Department of Corrections.

(e) "Office" means the Office of Statewide Health Planning and Development.

(f) "Self–pay patient" means a patient who does not have third–party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital. Self–pay patients may include charity care patients.

(g) "Underinsured patient" means a person whose deductibles, copayments, medical, or hospital bills after payment by third-party payers exceed 5 percent of the patient's annual income or a lower level determined in accordance with a hospital's charity care policy.

127405. (a) Each hospital shall develop a policy specifying how the hospital will determine the financial liability for services rendered to both financially qualified patients and self–pay patients.

(b) For financially qualified patients, each hospital shall specify in its policy how the hospital will determine and apply allowances for services provided to financially qualified patients. The allowance, at a minimum, shall be equal to the difference between the charge for the services set forth in the hospital's established charge schedule and the greater of the payments the hospital would receive from the Medicare Program, the Medicaid Program, or workers' compensation.

(c) No allowance for financially qualified patients shall be required with respect to any service for which there is no coverage under the Medi–Cal program or Medicare or workers'

compensation. At the hospital's discretion, the allowance for financially qualified patients may be applied by the hospital to patients who do not meet the standards for financially qualified patients.

127407. Each hospital shall include in its policy on financially qualified and self-pay patients a section addressing charity care patients. The charity care section of the policy shall specify the financial criteria and the procedure used by the hospital to determine whether a patient is eligible for charity care. The hospital may specify that no persons are eligible for charity care under any circumstances. The policy shall include all of the following:

(a) Financial eligibility criteria.

(b) Financial information required of the patient.

(c) A review process for charity care decisions.

127410. (a) Each hospital shall provide patients with oral and written notice of the hospital's policy for financially qualified and self-pay patients at the time of admission and discharge. The notice shall also be provided to patients who receive emergency or outpatient care and who may be billed for that care, but who were not admitted. The notice shall be in the language spoken by the patient. That language shall be determined in a manner similar to that required pursuant to Section 12693.30 of the Insurance Code. All written correspondence to the patient required by this article shall also be language appropriate.

(b) Notice of the hospital's policy for financially qualified and self–pay patients shall be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to, all of the following:

(1) Emergency department, if any.

(2) Billing office.

(3) Admissions office.

(4) Any other locations that may be determined by the office, to ensure that patients are informed of the policy and how to obtain a copy of the policy and related information.

127415. Each hospital shall submit to the office a copy of the application for financially qualified patients used by the hospital, including the charity care section of that application. The office, in consultation with interested parties, may also develop a uniform self-pay application to be used by all hospitals. In

developing the application, the office shall consider whether the application used for the Medi–Cal program and the Healthy Families Program can be used as, or incorporated in, the uniform self-pay application.

127420. (a) Each hospital shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the hospital to a patient, including, but not limited to, any of the following:

(1) Private health insurance.

(2) Medicare.

(3) The Medi–Cal program, the Healthy Families Program, the California Childrens' Services Program, or other state-funded programs designed to provide health coverage.

(b) If a hospital bills a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, as a part of that billing, the hospital shall provide the patient with a clear and conspicuous notice that includes all of the following:

(1) A statement of charges for services rendered by the hospital.

(2) A request that the patient inform the hospital if the patient has health insurance coverage, Medicare, Healthy Families, Medi–Cal, or other coverage.

(3) A statement that if the consumer does not have health insurance coverage, ~~that they~~ *the consumer* may be eligible for Medicare, Healthy Families, Medi–Cal, California Childrens' Services Program, or charity care.

(4) A statement indicating how patients may obtain applications for the Medi–Cal program and the Healthy Families Program and that the hospital will provide these applications on request. If, at the time care is provided, the patient does not show proof of coverage by a third–party payer specified in subdivision (a), then the hospital shall send an application for the Medi–Cal program and the Healthy Families Program to the patient. This application may accompany the billing or may be sent separately.

(5) Information regarding the financially qualified patient and charity care application, including the following:

(A) The hospital contact for resources for additional information regarding charity care.

(B) A statement indicating how patients may obtain an application for a financially qualified patient. The statement shall provide information about the family income requirements for financially qualified patients as provided in this article.

127425. (a) In order to facilitate payment by public or private third–party payers, for at least 180 days after discharge or after the final day service is provided, a hospital, its assignee, collection agency, or billing service shall be limited to the following debt collection activities:

(1) Sending a bill to the patient in accordance with existing law.

(2) Attempting to negotiate payment of the bill or a payment plan in accordance with this article.

(3) Attempting to collect payment from any responsible third–party payer, either public or private.

(4) Providing any information that may assist the patient in obtaining coverage through the Medi–Cal program or Healthy Families Program, or any other public program for which the patient may be eligible.

(5) Attempting to make a final determination as to whether the patient may be considered a self–pay patient under the hospital's self-pay policy or is eligible for charity care under the hospital's charity care policy.

(6) Assisting a financially qualified patient in obtaining the allowance for services provided for under this article and in applying under the hospital's charity care policy, if any.

(7) Providing any notices required by state or federal law.

(b) A hospital, its assignee, collection agency, or billing service shall use reasonable efforts to negotiate a payment plan. For purposes of this section, "reasonable efforts to negotiate a payment plan" means two efforts to contact the patient by telephone and two efforts to contact the patient by mail. This requirement shall not apply if the patient has requested that the hospital, its assignee, collection agency, or agent not contact the patient.

(c) After the time period specified in subdivision (a) has elapsed, the hospital, its assignee, collection agency, or billing service may engage in any other debt collection activities

otherwise permitted by law, including, but not limited to, reporting adverse information to a consumer credit reporting agency or commencing civil action against the patient for nonpayment.

(d) Notwithstanding subdivision (c), a hospital, its agent, collection agency, or assignee shall not use wage garnishment or a lien on a primary residence as a means of debt collection from a financially qualified patient.

(e) Nothing in this section shall be construed to diminish or eliminate any protections consumers have under existing federal and state debt protection laws.

127426. (a) The period described in Section 127425 shall be extended if the patient has a pending appeal for coverage of the services.

(b) For purposes of this section, "pending appeal" includes any of the following:

(1) A grievance against a health care service plan, as described in Chapter 2.2 (commencing with Section 1340) of Division 2, or against an insurer, as described in Chapter 1 (commencing with Section 10110) of Part 2 of Division 2 of the Insurance Code.

(2) An independent medical review, as described in Section 10145.3 or 10169 of the Insurance Code.

(3) A fair hearing for a review of a Medi–Cal claim pursuant to Section 10950 of the Welfare and Institutions Code.

(4) An appeal regarding Medicare coverage consistent with federal law and regulations.

127430. (a) Prior to commencing collection activities against a patient, the hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall provide the patient with a clear and conspicuous written notice containing both of the following:

(1) ~~(A)~~ A plain language summary of the patient's rights pursuant to this article, the Rosenthal Fair Debt Collection Practices Act (Title 1.6C (commencing with Section 1788) of Part 4 of Division 3 of the Civil Code), and the federal Fair Debt Collection Practices Act (Subchapter V (commencing with Section 1692) of Chapter 41 of Title 15 of the United States Code). The summary shall include a statement that the Federal Trade Commission enforces the federal act.

~~(B) The~~

The summary shall be sufficient if it appears in substantially the following form: "State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov."

(2) Information about nonprofit credit counseling services in the area.

(b) The notice required by subdivision (a) shall also accompany any document indicating that the commencement of collection activities may occur.

127435. Each hospital shall provide to the office in a format determined by the office a copy of its self-pay policy, eligibility procedures, review process, and procedure for determining self–pay pricing. The information shall be provided at least biennially on January 1, or when a significant change is made. If no significant change has been made by the hospital since the information was previously provided, notifying the office of the lack of change shall meet the requirements of this section. The office shall make this information available to the public.

127440. (a) For violations of this article, the director of the office may, after appropriate notice and opportunity for hearing, levy civil penalties as follows:

(1) A hospital that violates any provision of this article, except for subdivision (c) of Section 127405, shall be liable for civil penalties of not more than five hundred dollars ($500) per day per patient affected for each violation.

(2) A hospital that bills a patient for amounts in excess of those provided for in Section 127405 shall be liable for a civil penalty of three times the amount billed in error to the patient.

(3) In lieu of the civil penalty, require the hospital to provide care at no cost to financially qualified persons in a value

comparable to three times the value of the care provided in violation of Section 127405.

(4) Require the hospital to provide notice to the public in a newspaper of general distribution of its policies pursuant to this article, of any violations of this act, and of the penalties assessed.

(b) Any money that is received by the office pursuant to this section shall be paid into the General Fund.

127441. ~~The~~ *Upon referral by the office, complaint by an individual consumer or other information concerning violations of this article, the* Attorney General may authorize an investigation to determine whether a hospital is in compliance with this article. ~~If the Attorney General fails to determine that a violation of this article occurred within 90 days of receiving notice of possible violation of this article, then private persons may act in the capacity of the Attorney General.~~

127442. ~~If the Office or the Attorney General fails to make a determination that a violation of this article occurred within 90 days of receiving notice of a possible violation of this article, any person damaged by a violation of this article may bring an action~~ *The Attorney General may seek* to recover all of the following:

(a) Actual damages.

(b) Civil penalties of not more than five hundred dollars ($500) per day for each violation.

(c) For a violation of subdivision (c) of Section 127405, three times the amount billed to the patient.

(d) For intentional or willful violations of this article, exemplary damages, in an amount the court deems proper.

(e) Equitable relief as the court deems proper.

(f) Reasonable attorneys' fees and court costs.

127443. The rights, remedies, and penalties established by this article are cumulative, and shall not supersede the rights, remedies, or penalties established under other laws.

127444. Nothing in this article shall be construed to prohibit a hospital from uniformly imposing charges from its established charge schedule or published rates, nor shall this article preclude the recognition of a hospital's established charge schedule or published rates for the Medi–Cal program and the Medicare Program reimbursement charges.

127445. Notwithstanding any other provision of law, the amounts paid by patients for services resulting from the self–pay

allowances or charity care arrangements that are applied under a hospital's self–pay and charity care policies shall not constitute a hospital's uniform, published, prevailing, or customary charges, its usual fees to the general public, or its charges to non–Medi–Cal purchasers under comparable circumstances, for purposes of any payment limit under federal Medicaid law, Medi–Cal law, or any other federal or state–financed health care program.

127446. To the extent that any requirement of Section 127400 or 127405 results in a federal determination that a hospital's established charge schedule or published rates are not the hospital's customary or prevailing charges for services, the requirement in question shall be inoperative with respect to a hospital that is licensed to and operated by a county or a hospital authority established pursuant to Section 101850. The State Department of Health Services shall seek federal guidance regarding modifications to the requirement in question. All other requirements of this article shall remain in effect.

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