AMENDED IN SENATE AUGUST 22, 2006

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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~~ *fair pricing* 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. Existing law also provides for the licensure and regulation of health facilities by the State Department of Health Services.

This bill would require each hospital, as a condition of licensure, to maintain written policies about discount payment and charity care for financially qualified patients, as defined. The bill would require these policies to include, among other things, a section addressing eligibility criteria, as prescribed. The bill would require each hospital to perform various functions in connection with the hospital charity care and discount pay policies, including providing patients with a written

summary of these policies 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 discount payment and charity care policies, eligibility procedures, review process, and the application for charity care or discounted payment.

The bill would authorize the Director of Health Services to levy administrative penalties for each violation by a hospital of the above provisions.

This bill would also require the director to ensure that a hospital that overcharges a patient shall reimburse that patient, as described, or if the hospital cannot locate the patient, to use those funds towards providing care to financially qualified persons.

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 all general acute care hospitals.

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~~ *Hospital Fair Pricing* 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 a patient who is both of the following:

(1) A patient who is a self-pay patient, as defined in subdivision (f) or a patient with inadequate insurance, as defined in subdivision (g).

(2) A patient who has a family income that does not exceed 350 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) "A patient with inadequate insurance" means a person whose family income does not exceed 350 percent of the federal poverty level, as defined in subdivision (c),~~ and annual deductibles that exceed 5 percent of the patient's annual income or a lower level determined in accordance with a hospital's charity care policy,~~ if that individual does not receive a discounted rate from the hospital as a result of his or her *third-party* coverage. *For these purposes, "inadequate insurance" means any of the following:*

(1) Costs incurred by the individual at the hospital that exceed 5 percent of the patient's annual income.

(2) Annual out-of-pocket expenses that exceed 5 percent of the patient's annual income, if the patient provides documentation of the patient's medical expenses in the prior 12 months.

(3) A lower level determined by the hospital in accordance with the hospital's charity care policy.

(h) "Patient's family" means the following:

(1) For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not.

(2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

127401. Each general acute care hospital licensed pursuant to subdivision (a) of Section 1250 shall comply with the provisions of this article as a condition of licensure. The State Department of Health Services shall be responsible for the enforcement of these provisions.

127405. (a) (1) Each hospital shall maintain an understandable written policy regarding discount payments for financially qualified patients as well as an understandable written charity care policy. Uninsured patients or patients with inadequate insurance who are at or below 350 percent of the federal poverty level, as defined in subdivision (c) of Section 127400, shall be eligible to apply for participation under each hospital's charity care policy or discount payment policy. Notwithstanding any other provision of this act, a hospital may choose to grant eligibility for its discount payment policy or charity care policies to patients with incomes over 350 percent of the federal poverty level. Both the charity care policy and the discount payment policy shall state the process used by the hospital to determine whether a patient is eligible for charity care or discounted payment. In the event of a dispute, a patient may seek review from the business manager, chief financial officer, or other appropriate manager as designated in the charity care policy and the discount payment policy.

(2) Rural hospitals, as defined in Section 124840, may establish eligibility levels for financial assistance and charity care at less than 350 percent of the federal poverty level as appropriate to maintain their financial and operational integrity.

(b) Each hospital's discount payment policy shall clearly state eligibility criteria based upon income consistent with the application of the federal poverty level. The discount payment policy shall also include an extended payment plan to allow payment of the discounted price over time. The policy shall provide that the hospital and the patient may negotiate the terms of the payment plan.

(c) The charity care policy shall clearly state eligibility criteria for charity care. In determining eligibility under its charity care policy, a hospital may consider income and monetary assets of the patient. For purposes of this determination, monetary assets shall not include retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans. Furthermore, the first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility.

(d) Each hospital shall limit expected payment for services it provides to any patient at or below 350 percent of the federal poverty level, as defined in subdivision (b) of Section 124700, eligible under its discount payment policy to the amount of payment the hospital would receive for providing services from Medicare, Medi-Cal, Healthy Families, or any other government-sponsored health program of health benefits in which the hospital participates, whichever is greater. If the hospital provides a service for which there is no established payment by Medicare or any other government-sponsored program of health benefits in which the hospital participates, the hospital shall establish an appropriate discounted payment.

(e) Any patient, or patient's legal representative, who requests a discounted payment, charity care, or other assistance in meeting their financial obligation to the hospital shall make every reasonable effort to provide the hospital with documentation of income.

(1) For the purpose of determining eligibility for discounted payment, documentation of income shall be limited to recent pay stubs or income tax returns.

(2) For the purpose of determining eligibility for charity care, documentation of assets may include information on all monetary assets, but shall not include statements on retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans. A hospital may require waivers or releases from the patient or the patient's family, authorizing the hospital to obtain account information from financial or commercial institutions, or other entities that hold or maintain the monetary assets to verify their

value. Information obtained pursuant to this paragraph ~~shall not be used for collections actiities.~~ *regarding the assets of the patient or the patient's family shall not be used for collections activities.*

(3) Eligibility for discounted payments or charity care may be determined at any time the hospital is in receipt of information specified in paragraph (1) or paragraph (2), respectively.

127410. (a) Each hospital shall provide patients with a written summary of the hospital's policy for financially qualified patients at the time of admission. The written summary shall be consistent with the summary provided pursuant to Section 1339.585, and shall contain information about availability of the hospital's discount payment and charity care policies, including eligibility criteria, as well as contact information for a hospital employee or office from which the person may obtain further information about these policies. This written summary shall be provided in addition to the estimate provided pursuant to Section 1339.585. The summary 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 summary shall be provided in English, and in languages other than English. The languages to be provided 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 in the language spoken by the patient, consistent with this section.

(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) Other outpatient settings.

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, 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~~ *provide* an application for the Medi-Cal program and the Healthy Families Program to the patient. This application may accompany the billing, *or may be provided at the time of care*.

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

(A) A statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or charity care.

(B) The name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's discount payment and charity care policies, and how to apply for that assistance.

127425. (a) Each hospital shall have 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.

(b) Each hospital shall establish a written policy defining standards and practices for the collection of debt, and shall obtain a written agreement from any agency that collects hospital receivables that it will adhere to the hospital's standards and scope of practices. *The policy shall not conflict with other applicable laws and shall not be construed to create a joint venture between the hospital and the external entity, or otherwise to allow hospital governance of an external entity that collects hospital receivables.* In determining the amount of a debt a hospital may seek to recover from patients who are eligible under the hospital's charity care policy or discount payment policy, the hospital may consider only income and monetary assets as limited by Section 127405.

(c) At time of billing, each hospital shall provide a written summary consistent with Section 127410, which includes the same information concerning services and charges provided to all other patients who receive care at the hospital.

(d) For a patient that lacks coverage, or for a patient that provides information that he or she may be a patient with inadequate insurance, as defined in this article, a hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for ~~nonpayment,~~ *nonpayment at any time* prior to 150 days after initial billing. For purposes of this subdivision, a hospital may sell or assign debt to another entity if that entity does not report adverse information to a consumer credit agency.

(e) If a patient ~~qualifies~~ *is attempting to qualify* for eligibility under the hospital's charity care of discount payment policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the hospital shall not send the unpaid bill ~~to any collection agency if doing so may negatively impact a patient's credit~~ *to any collection agency or other assignee, unless that entity has agreed to comply with this article*.

(f) ~~The hospital or collection agency operating on behalf of the~~ *The hospital, collecting agency, or other assignee of the* hospital shall not, in dealing with patients eligible under the hospital's charity care or discount payment policies, use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills. This requirement does not preclude a hospital from pursuing reimbursement from third-party liability settlements, tortfeasors, or other legally responsible parties.

(g) Any extended payment plans offered by a hospital to assist patients eligible under the hospital's charity care policy, discount payment policy, or any other policy adopted by the hospital for assisting low-income patients with no or inadequate insurance in settling outstanding past due hospital bills, shall be interest free.

(h) Nothing in this section shall be construed to diminish or eliminate any protections consumers have under existing federal and state debt collection laws, or any other consumer protections available under state or federal law. *This subdivision does not limit or alter the obligation of the patient to make payments from the first date due on the obligation owing to the hospital pursuant to any contract or applicable statute, in the event that the patient fails to make payments for 90 days, or to renegotiate the payment plan.*

127426. (a) The period described in Section 127425 shall be extended if the patient has a pending appeal for coverage of the services, until a final determination of that appeal is made, if the patient makes a reasonable effort to communicate with the hospital about the progress of any pending appeals.

(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 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.

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.

(c) The requirements of this section shall apply to the entity engaged in the collection activities. If a hospital assigns or sells the debt to another entity, the obligations shall apply to the entity, including a collection agency, engaged in the debt collection activity.

127435. Each hospital shall provide to the office a copy of its discount payment policy, charity care policy, eligibility procedures for those policies, review process, and the application

for charity care or discounted payment programs. The office may determine whether the information is to be provided electronically or in some other manner. 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 Health Services may, after appropriate notice and opportunity for hearing, levy administrative penalties. When assessing administrative penalties against a health facility, the director shall determine the appropriate amount of the penalty for each violation. In making that determination, the director may consider the following factors:

(1) The nature, scope, and gravity of the violation.

(2) The facility's history of violations.

(3) The demonstrated willfulness of the violation.

(4) The behavior of the facility with respect to violations, including whether the facility mitigated any damage or injury from the violations.

(b) In lieu of an administrative penalty, the director may 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.

127441. The director shall order the hospital to reimburse the patient or patients that were overcharged the amount of actual financial damages, including interest. If the hospital is unable to locate a patient or patients, the hospital shall use the remaining funds to provide care at no cost to financially qualified persons.

127442. A hospital may appeal an administrative penalty within 30 days, as consistent with section 100171. The facility may also seek to adjudicate the validity of the violation or the penalty.

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, 127401, 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 for all general acute care hospitals, including, but not limited 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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