ASSEMBLY BILL No. 1503

Introduced by Assembly Member Lieu

February 27, 2009

An act to amend Section 1797.98c of, to amend and renumber the heading of Article 3 (commencing with Section 127400) of Chapter 2 of, to add the heading of Chapter 2.5 (commencing with Section 127400) to, and to add Article 2 (commencing with Section 127450) to Chapter 2.5 of, Part 2 of Division 107 of the Health and Safety Code, relating to emergency medical care billing.

LEGISLATIVE COUNSEL'S DIGEST

AB 1503, as introduced, Lieu. Emergency medical care: billing.

(1) Existing law establishes the Maddy Emergency Medical Services (EMS) Fund, authorizing each county to establish an emergency medical services fund and provides for deposit of certain penalties, forfeitures, and fines into the fund. Existing law requires use of the local fund for reimbursement of physicians and surgeons and hospitals for uncompensated emergency medical services pursuant to a prescribed schedule. Under this schedule, 58% of the balance in the fund is to be used for emergency medical services provided by all physicians and surgeons, except those employed in county hospitals, in general acute care hospitals that provide basic, comprehensive, or standby emergency medical services pursuant to prescribed provisions of law relating to standby emergency rooms or departments in certain small and rural hospitals and hospitals located in Los Angeles County that meet prescribed requirements, up to the time the patient is stabilized.

Existing law limits reimbursement from the local fund of claims for emergency services provided by a physician and surgeon to a patient

who does not have health insurance coverage for emergency services and care, cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, except as specified, when the several conditions are met.

This bill would revise the conditions for reimbursement to require the physician and surgeon to comply with the provisions of this bill set forth below, except as specified.

(2) Existing law also provides for the licensure and regulation of health facilities by the State Department of Public Health. Existing law requires each hospital, as a condition of licensure, to maintain written policies about discount payment and charity care for financially qualified patients, as defined. These policies are required to include, among other things, a section addressing eligibility criteria, as prescribed. Existing law requires each hospital to perform various functions in connection with the hospital charity care and discount pay policies, including providing patients with notice that contains information about the hospital's discount payment and charity care policies, including information about eligibility and attempting to determine the availability of private or public health insurance coverage for each patient. Existing law also specifies billing and collection procedures to be followed by a hospital, its assignee, collection agency, or billing service.

This bill would provide that uninsured patients or patients with high medical costs who are at or below 350% of the federal poverty level are eligible to apply to a physician and surgeon who provides emergency medical services in a general acute care hospital for a discount payment pursuant to a discount payment policy. The bill would require the physician and surgeon to limit expected payment for services provided to a patient at or below 350% of the federal poverty level and who is eligible under the physician and surgeon's discount payment policy to the amount of payment the physician and surgeon would expect, in good faith, to receive for providing services from specified government-sponsored health programs.

The bill would require the physician and surgeon to perform various functions in connection with the discount payment policy, including providing patients with notice that contains information about the physician and surgeon's discount payment policy, including information about eligibility 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 physician and surgeon, its assignee, collection agency, or billing service.

This bill would provide that a violation of the above provisions shall not constitute a violation of the terms of a physician and surgeon's licensure.

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. Section 1797.98c of the Health and Safety Code is amended to read:

1797.98c. (a) Physicians and surgeons wishing to be reimbursed shall submit their claims for emergency services provided to patients who do not make any payment for services and for whom no responsible third party makes any payment.

(b) If, after receiving payment from the fund, a physician and surgeon is reimbursed by a patient or a responsible third party, the physician and surgeon shall do one of the following:

(1) Notify the administering agency, and, after notification, the administering agency shall reduce the physician and surgeon's future payment of claims from the fund. In the event there is not a subsequent submission of a claim for reimbursement within one year, the physician and surgeon shall reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of reimbursement received from the fund.

(2) Notify the administering agency of the payment and reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of the reimbursement received from the fund for that patient's care.

(c) Reimbursement of claims for emergency services provided to patients by any physician and surgeon shall be limited to services provided to a patient who does not have health insurance coverage for emergency services and care, cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare

Prescription Drug, Improvement and Modernization Act of 2003, and where ~~all~~ *any* of the following conditions have been met:

~~(1) The physician and surgeon has inquired if there is a responsible third-party source of payment.~~

~~(2) The physician and surgeon has billed for payment of services.~~

~~(3) Either of the following~~:

~~(A) At least three months have passed from the date the physician and surgeon billed the patient or responsible third party, during which time the physician and surgeon has made two attempts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.~~

~~(B) The physician and surgeon has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician and surgeon.~~

~~(4) The physician and surgeon has stopped any current, and waives any future, collection efforts to obtain reimbursement from the patient, upon receipt of moneys from the fund~~

(1) If the physician and surgeon attempts to seek payment from a patient, the physician and surgeon shall comply with Article 2 (commencing with Section 127450) of Chapter 2.5 of Part 2 of Division 107.

(2) The physician and surgeon shall seek information from the hospital regarding whether the patient has provided information indicating that the patient may qualify for the hospital's charity care or discount payment policy pursuant to Article 1 (commencing with Section 127400) of Chapter 2.5 of Part 2 of Division 107 or has otherwise sought to qualify pursuant to that article. If the hospital has determined that the patient qualifies for its charity care or discount payment policy, the physician and surgeon may bill the Maddy Fund. If the physician and surgeon seeks payment from the Maddy Fund, the physician and surgeon shall cease any billing or collection activity involving the patient.

(3) If the physician and surgeon receives reimbursement from the Maddy Fund, that reimbursement shall be considered payment in full and the physician and surgeon shall not seek additional payment from the patient. If the Maddy Fund does not reimburse the physician and surgeon, the physician and surgeon may seek payment from the patient pursuant to Article 2 (commencing with Section 127450) of Chapter 2.5 of Part 2 of Division 107.

(d) A listing of patient names shall accompany a physician and surgeon's submission, and those names shall be given full confidentiality protections by the administering agency.

(e) Notwithstanding any other restriction on reimbursement, a county shall adopt a fee schedule and reimbursement methodology to establish a uniform reasonable level of reimbursement from the county's emergency medical services fund for reimbursable services.

(f) For the purposes of submission and reimbursement of physician and surgeon claims, the administering agency shall adopt and use the current version of the Physicians' Current Procedural Terminology, published by the American Medical Association, or a similar procedural terminology reference.

(g) Each administering agency of a fund under this chapter shall make all reasonable efforts to notify physicians and surgeons who provide, or are likely to provide, emergency services in the county as to the availability of the fund and the process by which to submit a claim against the fund. The administering agency may satisfy this requirement by sending materials that provide information about the fund and the process to submit a claim against the fund to local medical societies, hospitals, emergency rooms, or other organizations, including materials that are prepared to be posted in visible locations.

SEC. 2. The heading of Chapter 2.5 (commencing with Section 127400) is added to Part 2 of Division 107 of the Health and Safety Code, immediately preceding Section 127400, to read:

CHAPTER 2.5. FAIR PRICING POLICIES

SEC. 3. The heading of Article 3 (commencing with Section 127400) of Chapter 2 of Part 2 of Division 107 of the Health and Safety Code is amended and renumbered to read:

Article ~~3.~~*1*. Hospital Fair Pricing Policies

SEC. 4. Article 2 (commencing with Section 127450) is added to Chapter 2.5 of Part 2 of Division 107 of the Health and Safety Code, to read:

Article 2. Physician and Surgeon Fair Pricing Policies

127450. 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 physician and surgeon'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 or a patient with high medical costs.

(2) A patient who has a family income that does not exceed 350 percent of the federal poverty level.

(d) "Emergency care" means care provided in the emergency department of a hospital.

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

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

(g) "Physician and surgeon" means a physician and surgeon licensed pursuant to Chapter 2 (commencing with Section 2000) of the Business and Professions Code who provides emergency medical services in a hospital that provides emergency care.

(h) "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 physician and surgeon. Self-pay patients may include charity care patients.

(i) "A patient with high medical costs" means a person whose family income does not exceed 350 percent of the federal poverty level if that individual does not receive a discounted rate from the physician and surgeon as a result of his or her third-party coverage. For these purposes, "high medical costs" means any of the following:

(1) Annual out-of-pocket costs incurred by the individual at the hospital that provided emergency care that exceed 10 percent of the patient's family income in the prior 12 months.

(2) Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

(3) A lower level determined by the physician and surgeon in accordance with the physician and surgeon's discounted payment policy.

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

(1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, 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.

127451. A violation of this article shall not constitute a violation of the terms of a physician and surgeon's licensure.

127452. (a) Uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level shall be eligible to apply to a physician and surgeon for a discount payment pursuant to a discount payment policy. Notwithstanding any other provision of this article, a physician and surgeon may choose to grant eligibility for a discount payment policy to patients with incomes over 350 percent of the federal poverty level.

(b) A physician and surgeon shall limit expected payment for services provided to a patient at or below 350 percent of the federal poverty level and who is eligible under the physician and surgeon's discount payment policy to the amount of payment the physician and surgeon would expect, in good faith, to receive for providing services from Medicare, Medi-Cal, Healthy Families, or another government-sponsored health program of health benefits in which

the physician and surgeon participates, whichever is greater. If the physician and surgeon provides a service for which there is no established payment by Medicare or any other government-sponsored program of health benefits in which the physician and surgeon participates, the physician and surgeon shall establish an appropriate discounted payment.

(c) (1) If a physician and surgeon seeks reimbursement from the Maddy Fund pursuant to Section 1797.98c, then the physician and surgeon shall, at that time, cease any further billing or collection activity for that patient.

(2) If the physician and surgeon does not receive reimbursement from the Maddy Fund after attempting to obtain reimbursement from the Maddy Fund, then the provisions of this article shall apply.

(3) If the physician and surgeon does not attempt to seek reimbursement from the Maddy Fund, the provisions of this article shall apply.

(d) A patient, or patient's legal representative, who requests a discounted payment or other assistance in meeting his or her financial obligation to the physician and surgeon shall make every reasonable effort to provide the physician and surgeon with documentation of income and health benefits coverage. If the person requests a discounted payment and fails to provide information that is reasonable and necessary for the physician and surgeon to make a determination, the physician and surgeon may consider that failure in making its determination.

(1) For purposes of determining eligibility for discounted payment, the physician and surgeon may rely on the determination made by the hospital at which emergency care was provided. If the physician and surgeon chooses to make a separate determination of eligibility for discounted payment, documentation of income shall be limited to recent pay stubs or income tax returns.

(2) Information obtained pursuant to paragraph (1) shall not be used for collections activities. This paragraph does not prohibit the use of information obtained by the physician and surgeon, collection agency, or assignee independently of the eligibility process for discounted payment.

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

127453. Each physician and surgeon providing emergency medical services shall provide patients with a written notice that shall contain information about availability of the physician and surgeon's discount payment policy, including information about eligibility, as well as contact information for an employee of the physician and surgeon or other entity from which the person may obtain further information about this policy. The notice shall also be provided to patients who receive emergency care and who may be billed for that care, but who were not admitted. The notice 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. Written correspondence to the patient required by this article shall also be in the language spoken by the patient, consistent with Section 12693.30 of the Insurance Code and applicable state and federal law.

127454. (a) Each physician and surgeon 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 emergency services rendered by the physician and surgeon 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 physician and surgeon 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 physician and surgeon 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 physician and surgeon.

(2) A request that the patient inform the physician and surgeon 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 discounted payment care.

(4) Information regarding the financially qualified patient and discounted payment 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.

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

127455. (a) Each physician and surgeon shall have a written policy about when and under whose authority patient debt is advanced for collection.

(b) Each physician and surgeon 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 physician and surgeon receivables that it will adhere to the physician and surgeon's standards and scope of practice. The policy shall not conflict with other applicable laws and shall not be construed to create a joint venture between the physician and surgeon and the external entity, or otherwise to allow physician and surgeon governance of an external entity that collects physician and surgeon receivables. In determining the amount of a debt a physician and surgeon may seek to recover from patients who are eligible under the physician and surgeon's charity care policy or discount payment policy, the physician and surgeon may consider only income and monetary assets as limited by Section 127452.

(c) At time of billing, if any, each physician and surgeon shall provide a written summary consistent with Section 127453, which includes the same information concerning services and charges provided to all other patients who receive care from the physician and surgeon.

(d) For a patient that lacks coverage, or for a patient that provides information that he or she may be a patient with high medical costs a physician and surgeon, any assignee of the physician and surgeon, 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 at any time prior to 150 days after initial billing.

(e) If a patient is attempting to qualify for eligibility under the physician and surgeon's discount payment policy and is attempting in good faith to settle an outstanding bill with the physician and surgeon by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the physician and surgeon shall not send the unpaid bill to any collection agency or other assignee, unless that entity has agreed to comply with this article.

(f) (1) The physician and surgeon or other assignee shall not, in dealing with patients eligible under the physician and surgeon's discount payment policies, use wage garnishments or liens on primary residences as a means of collecting unpaid physician and surgeon bills.

(2) A collection agency or other assignee shall not, in dealing with any patient under the physician and surgeon's discount payment policy, use as a means of collecting unpaid physician and surgeon bills, any of the following:

(A) A wage garnishment, except by order of the court upon noticed motion, supported by a declaration filed by the movant identifying the basis for that it believes that the patient has the ability to make payments on the judgment under the wage garnishment, that the court shall consider in light of the size of the judgment and additional information provided by the patient prior to, or at, the hearing concerning the patient's ability to pay, including information about probable future medical expenses based on the current condition of the patient and other obligations of the patient.

(B) Notice or conduct a sale of the patient's primary residence during the life of the patient or his or her spouse, or during the period a child of the patient is a minor, or a child of the patient who has attained the age of majority is unable to take care of himself or herself and resides in the dwelling as his or her primary residence. In the event a person protected by this paragraph owns more than one dwelling, the primary residence shall be the dwelling that is the patient's current homestead, as defined in Section 704.710 of the Code of Civil Procedure or was the patient's homestead at the time of the death of a person other than the patient who is asserting the protections of this paragraph.

(3) This requirement does not preclude a physician and surgeon, collection agency, or other assignee from pursuing reimbursement and any enforcement remedy or remedies from third-party liability settlements, tortfeasors, or other legally responsible parties.

(g) Any extended payment plans offered by a physician and surgeon to assist patients eligible under the physician and surgeon's discount payment policy or any other policy adopted by the physician and surgeon for assisting low-income patients with no insurance or high medical costs in settling outstanding past due physician and surgeon bills, shall be interest free. The physician and surgeon's extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during a 90-day period. Before declaring the physician and surgeon's extended payment plan no longer operative, the physician and surgeon, collection agency, or assignee shall make a reasonable attempt to contact the patient by phone and to give notice in writing that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. Prior to the physician and surgeon's extended payment plan being declared inoperative, the physician and surgeon, collection agency, or assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The physician and surgeon, collection agency, or assignee shall not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment prior to the time the extended payment plan is declared to be no longer operative. For purposes of this section, the notice and phone call to the patient may be made to the last known phone number and address of the patient.

(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. If the patient fails to make all consecutive payments for 90 days and fails to renegotiate a payment plan, this subdivision does not limit or alter the obligation of the patient to make payments on the obligation owing to the physician and surgeon pursuant to any contract or applicable statute from the date that the extended payment plan is declared no longer operative, as set forth in subdivision (g).

127456. (a) The period described in Section 127455 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 physician and surgeon 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 contracting 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.

127457. (a) Prior to commencing collection activities against a patient, the physician and surgeon, any assignee of the physician and surgeon, 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) A statement that nonprofit credit counseling services may be available 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 physician and surgeon 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.

127458. The physician and surgeon shall reimburse the patient or patients any amount actually paid in excess of the amount due under this article, including interest. Interest owed by the physician and surgeon to the patient shall accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date payment by the patient is received by the hospital. However, a physician and surgeon is not required to reimburse the patient or pay interest if the amount due is less than five dollars ($5). The physician and surgeon shall give the patient a credit for the amount due for at least 60 days from the date the amount is due.

127459. The rights, remedies, and penalties established by this article are cumulative, and shall not supersede the rights, remedies, or penalties established under other laws.

127460. Nothing in this article shall be construed to prohibit a physician and surgeon from uniformly imposing charges from its established charge schedule or published rates, nor shall this article preclude the recognition of a physician and surgeon's established charge schedule or published rates for purposes of applying any payment limit, interim payment amount, or other payment calculation based upon a physician and surgeon's rates or charges under the Medi-Cal program, the Medicare Program, workers' compensation, or other federal, state, or local public program of health benefits. No health care service plan, insurer, or any other person shall reduce the amount it would otherwise reimburse a claim for physician and surgeon services because a physician and surgeon has waived, or will waive, collection of all

or a portion of a patient's bill for physician and surgeon services in accordance with the physician and surgeon's discount payment policy, notwithstanding any contractual provision.

127461. Notwithstanding any other provision of law, the amounts paid by parties for services resulting from reduced or waived charges under a physician and surgeon's discounted payment policy shall not constitute a physician and surgeon'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, and shall not be used to calculate a physician and surgeon's median non-Medicare or Medi-Cal charges, for purposes of any payment limit under the federal Medicare Program, the Medi-Cal program, or any other federal or state-financed health care program.

127462. To the extent that any requirement of this article results in a federal determination that a physician and surgeon's established charge schedule or published rates are not the physician and surgeon's customary or prevailing charges for services, the requirement in question shall be inoperative for all physician and surgeons. The State Department of Public Health 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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