

[Cal. Health & Safety Code §§ 127400 through 127446.]

§§ 127400 through 127446: Health Policy and Planning – Hospital Fair Pricing Policies

§ 127400. Definitions.

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 high medical costs, 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 a 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 State Hospitals or the Department of Corrections and Rehabilitation.

(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 high medical costs” means a person whose family income does not exceed 350 percent of the federal poverty level, as defined in subdivision (b). 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 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 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, 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.

(i) “Reasonable payment plan” means monthly payments that are not more than 10 percent of a patient’s family income for a month, excluding deductions for essential living expenses. “Essential living expenses”

means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

§ 127401. Compliance with article as condition of licensure; enforcement.

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. Hospital discount payment and charity care policies; eligibility criteria.

(a) (1) (A) 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 high medical costs who are at or below 350 percent of the federal poverty level, as defined in subdivision (b) of Section 127400, shall be eligible to apply for participation under a hospital's charity care policy or discount payment policy. Notwithstanding any other provision of this article, 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.

(B) The written policy regarding discount payments shall also include a statement that an emergency physician, as defined in Section 127450, who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital.

(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) A 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 shall negotiate the terms of the payment plan, and take into consideration the patient's family income and essential living expenses. If the hospital and the patient cannot agree on the payment plan, the hospital shall use the formula described in subdivision (i) of Section 127400 to create a reasonable payment plan.

(c) The charity care policy shall state clearly the 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) A hospital shall limit expected payment for services it provides to a patient at or below 350 percent of the federal poverty level, as defined in subdivision (b) of Section 127400, eligible under its discount payment policy to the amount of payment the hospital would expect, in good faith, to receive for providing services from Medicare, Medi-Cal, the Healthy Families Program, or another 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) A patient, or patient's legal representative, who requests a discounted payment, charity care, or other assistance in meeting his or her financial obligation to the hospital shall make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. If the person requests charity care or a discounted payment and fails to provide information that is reasonable and necessary for the hospital to make a determination, the hospital may consider that failure in making its determination.

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

(2) For purposes 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.

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

(4) 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 (2), respectively.

§ 127410. Notice to patients as to discount payment and charity care policies.

(a) Each hospital shall provide patients with a written notice that shall contain information about availability of the hospital's discount payment and charity care policies, including information about eligibility, as well as contact information for a hospital employee or office from which the person may obtain further information about these policies. This written notice shall be provided in addition to the estimate provided pursuant to Section 1339.585. 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 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.

(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. Third party coverage; billing.

(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, including coverage offered through the California Health Benefit Exchange.
- (2) Medicare.
- (3) The Medi-Cal program, the Healthy Families Program, the California Children's 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 Program, 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 Program, Medi-Cal, coverage offered through the California Health Benefit Exchange, California Children's Services program, other state- or county-funded health coverage, or charity care.
- (4) A statement indicating how patients may obtain applications for the Medi-Cal program and the Healthy Families Program, coverage offered through the California Health Benefit Exchange, or other state- or county-funded health coverage programs and that the hospital will provide these applications. The hospital shall also provide patients with a referral to a local consumer assistance center housed at legal services offices. If the patient does not indicate coverage by a third-party payer specified in subdivision (a) or requests a discounted price or charity care, then the hospital shall provide an application for the Medi-Cal program, the Healthy Families Program, or other state- or county-funded health coverage programs. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient 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.

(C) If a patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a hospital charity care or discount payment program, neither application shall preclude eligibility for the other program.

§ 127425. Debt collection policy.

(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. This agreement shall require the affiliate, subsidiary, or external collection agency of the hospital that collects the debt to comply with the hospital's definition and application of a reasonable payment plan, as defined in subdivision (i) of Section 127400. 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 high medical costs, 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 at any time prior to 150 days after initial billing.

(e) If a patient is attempting to qualify for eligibility under the hospital's charity care or 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 or other assignee, unless that entity has agreed to comply with this article.

(f) (1) The hospital or other assignee that is an affiliate or subsidiary 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.

(2) A collection agency or other assignee that is not a subsidiary or affiliate of the hospital shall not, in dealing with any patient under the hospital's charity care or discount payment policies, use as a means of collecting unpaid hospital 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 which it believes that the patient has the ability to make payments on the judgment under the wage garnishment, which 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 hospital, 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) 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 insurance or high medical costs in settling outstanding past due hospital bills, shall be interest free. The hospital 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 hospital extended payment plan no longer operative, the hospital, collection agency, or assignee shall make a reasonable attempt to contact the patient by telephone 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 hospital extended payment plan being declared inoperative, the hospital, collection agency, or assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The hospital, 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 telephone call to the patient may be made to the last known telephone 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 hospital 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).

§ 127426. Pending appeal for coverage; extension of period.

(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 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.

§ 127430. Notice required prior to commencing collection activities.

(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) 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 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. Information to be provided to Office of Statewide Health Planning and Development.

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. Patient reimbursement.

The hospital 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 hospital 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 hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars (\$5.00). The hospital shall give the patient a credit for the amount due for at least 60 days from the date the amount is due.

§ 127443. Application of article.

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. Construction of article.

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 purposes of applying any payment limit, interim payment amount, or other payment calculation based upon a hospital'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 hospital services because a hospital has waived, or will waive, collection of all or a portion of a patient's bill for hospital services in accordance with the hospital's charity care or discount payment policy, notwithstanding any contractual provision.

§ 127445. Exemption of charges from hospital's calculation of median medical charges or payment limits under Medicare or other health care program.

Notwithstanding any other provision of law, the amounts paid by parties for services resulting from reduced or waived charges under a hospital's discounted payment or charity care policy 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, and shall not be used to calculate a hospital'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.

§ 127446. Federal determination that hospital's charges or rates are not customary.

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 Public Health shall seek federal guidance regarding modifications to the requirement in question. All other requirements of this article shall remain in effect.