Assembly Bill No. 1020

Passed the Assembly September 7, 2021

_____

Chief Clerk of the Assembly

Passed the Senate September 2, 2021

_____

Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2021, at _____ o'clock ___M.

_____

Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 1788.14, 1788.52, and 1788.58 of, and to add Section 1788.185 to, the Civil Code, and to amend Sections 127400, 127401, 127405, 127410, 127420, 127425, 127435, 127440, and 127444 of, and to add Section 127436 to, the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 1020, Friedman. Health care debt and fair billing.

Existing law requires a hospital to maintain an understandable written policy regarding discount payments for financially qualified patients and an understandable written charity care policy. Existing law requires that uninsured patients or patients with high medical costs who are at or below 350% of the federal poverty level be eligible for charity care or discount payments from a hospital. Existing law defines "high medical costs" to mean, among other things, annual out-of-pocket costs at the hospital that exceed 10% of the patient's family income in the prior 12 months. Existing law authorizes a hospital to grant eligibility for charity care or discount payments to patients with incomes over 350% of the federal poverty level. Existing law requires a hospital to provide the Department of Health Care Access and Information with a copy of its discount payment policy and charity care policy, and requires the department to make the information public. Existing law requires a hospital to post notice of its policy for financially qualified and self-pay patients in designated locations that are visible to the public.

This bill would instead require that uninsured patients or patients with high medical costs who are at or below 400% of the federal poverty level be eligible for charity care or discount payments from a hospital, and would authorize a hospital to grant eligibility for charity care or discount payments to patients with incomes over 400% of the federal poverty level. The bill would redefine "high medical costs" to include annual out-of-pocket costs at the hospital that exceed the lesser of 10% of the patient's current family income or family income in the prior 12 months. The bill would require a hospital to prominently display a notice of the

hospital's policy for financially qualified and self-pay patients on the hospital's internet website with a link to the policy itself. The bill would also make related technical changes.

Existing law requires a hospital to have a written policy about the advancing of patient debt to collection. Existing law requires the hospital, its assignee, or other owner of the patient debt to provide a patient with a clear and conspicuous notice with specified information about the debt before beginning collection activities against a patient, and prohibits a collection action before 150 days after the initial billing if the patient lacks coverage or may have high medical costs. Existing law requires a hospital to reimburse a patient for overpayments in excess of the amount due, including interest, and to give a patient a credit for the amount due at least 60 days from the date the amount is due.

Existing law, the Rosenthal Fair Debt Collection Practices Act, prohibits debt collectors from engaging in unfair or deceptive acts or practices in the collection of consumer debts and to require debtors to act fairly in entering into and honoring those debts. A debt collector who violates the act is liable for specified damages and penalties to be paid to the debtor. Existing law prohibits a debt buyer from making a written statement to a debtor in an attempt to collect a consumer debt unless the debt buyer possesses specified information, including the date of default or the date of the last payment, and requires the debt buyer to include specified information in the written statement to the debtor. Existing law defines "debt buyer" to mean a person or entity that is regularly engaged in the business of purchasing charged-off consumer debt for collection purposes, whether it collects the debt itself, hires a third party for collection, or hires an attorney at law for collection litigation.

This bill would prohibit a hospital from selling patient debt to a debt buyer, unless specified conditions are met, including that the hospital has found the patient ineligible for financial assistance or the patient has not responded to attempts to bill or offer financial assistance for 180 days. The bill would require a hospital to send a patient a notice with specified information, including an application for the hospital's charity care and financial assistance, before assigning a bill to collections, or selling patient debt to a debt buyer. The bill would prohibit a debt collector or debt buyer from collecting consumer debt that originated with a hospital

without including in the first written communication to the debtor specified information, including a copy of the above-described notice sent by the hospital. The bill would prohibit debt collection before 180 days after the initial billing, regardless of the patient's financial status. The bill would require a hospital to provide the Department of Health Care Access and Information with a copy of its debt collection policy. The bill would require the department to review a hospital's policy for compliance with the law by January 1, 2023, and whenever a significant change is made and submitted to the department, and make this policy, as well as the hospital's discount payment policy and charity care policy, available on the department's internet website. The bill would require the department, commencing on January 1, 2024, to impose an administrative penalty against a hospital that improperly bills a patient, as specified, and to establish an appeals process by regulation. The bill would require a complaint in an action brought by a debt collector for a general acute care hospital debt to allege specified facts and to be accompanied by copies of the application for, and notice from the hospital regarding, financial assistance. The bill would require a hospital to refund a patient any overpayments within 30 days.

Existing law requires a hospital to comply with the above provisions as a condition of licensure.

This bill would delete the provision making compliance a condition of licensure.

This bill would incorporate additional changes to Section 127410 of the Health and Safety Code proposed by AB 532 to be operative only if this bill and AB 532 are enacted and this bill is enacted last.

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

SECTION 1. Section 1788.14 of the Civil Code is amended to read:

1788.14. No debt collector shall collect or attempt to collect a consumer debt by means of the following practices:

(a) Obtaining an affirmation from a debtor of a consumer debt that has been discharged in bankruptcy, without clearly and conspicuously disclosing to the debtor, in writing, at the time the

affirmation is sought, the fact that the debtor is not legally obligated to make an affirmation.

(b) Collecting or attempting to collect from the debtor the whole or any part of the debt collector's fee or charge for services rendered, or other expense incurred by the debt collector in the collection of the consumer debt, except as permitted by law.

(c) Initiating communications, other than statements of account, with the debtor with regard to the consumer debt, when the debt collector has been previously notified in writing by the debtor's attorney that the debtor is represented by the attorney with respect to the consumer debt and the notice includes the attorney's name and address and a request by the attorney that all communications regarding the consumer debt be addressed to the attorney, unless the attorney fails to answer correspondence, return telephone calls, or discuss the obligation in question. This subdivision shall not apply if prior approval has been obtained from the debtor's attorney, or if the communication is a response in the ordinary course of business to a debtor's inquiry.

(d) Sending a written communication to a debtor in an attempt to collect a time-barred debt without providing the debtor with one of the following written notices:

(1) If the debt is not past the date for obsolescence set forth in Section 605(a) of the federal Fair Credit Reporting Act (15 U.S.C. Sec. 1681c), the following notice shall be included in the first written communication provided to the debtor after the debt has become time-barred:

"The law limits how long you can be sued on a debt. Because of the age of your debt, we will not sue you for it. If you do not pay the debt, [insert name of debt collector] may [continue to] report it to the credit reporting agencies as unpaid for as long as the law permits this reporting."

(2) If the debt is past the date for obsolescence set forth in Section 605(a) of the federal Fair Credit Reporting Act (15 U.S.C. Sec. 1681c), the following notice shall be included in the first written communication provided to the debtor after the date for obsolescence:

"The law limits how long you can be sued on a debt. Because of the age of your debt, we will not sue you for it, and we will not report it to any credit reporting agency."

(e) Collecting consumer debt that originated with a hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code without including in the first written communication to the debtor a copy of the notice required pursuant to subdivision (e) of Section 127425 of the Health and Safety Code and a statement that the debt collector will wait at least 180 days from the date the debtor was initially billed for the hospital services that are the basis of the debt before reporting adverse information to a credit reporting agency or filing a lawsuit against the debtor.

(f) For purposes of this section, "first written communication" means the first communication sent to the debtor in writing or by facsimile, email, or other similar means.

SEC. 2. Section 1788.185 is added to the Civil Code, immediately following Section 1788.18, to read:

1788.185. (a) The complaint in an action brought by a debt collector for debt that originated with a general acute care hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code shall allege all of the following:

(1) That the plaintiff is a debt collector.

(2) That the underlying debt originated with a general acute care hospital.

(3) The information contained in paragraph (6) of subdivision (e) of Section 127425 of the Health and Safety Code and a statement identifying the language in which that information was sent to the debtor.

(4) The balance of the debt upon assignment to the debt collector and an explanation of the amount, nature, and reason for any interest and fees that are added to the debt balance by the debt collector after the assignment of the debt. This paragraph shall not be deemed to require a specific itemization, but the explanation shall identify separately the charge-off balance of the debt upon assignment to the debt collector, the total of any interest, and the total of any fees added to the debt balance by the debt collector after the assignment of the debt.

(5) The date of default or the date of the last payment, and the date the debt was assigned.

(6) The name and address of the hospital at the time of assignment.

(7) The hospital's account number associated with the debt.

(b) Copies of the application for financial assistance that was provided to the debtor by the hospital and the notice that was provided to the debtor by the hospital about applying for financial assistance shall be attached to the complaint. If the notice was provided as part of the hospital bill that cannot be separated, the bill shall be redacted to remove confidential information or a sample hospital bill with the substance of the notice regarding financial assistance in the format in use at the time the patient was billed may be provided.

(c) This title does not require the disclosure in public records of personal, financial, or medical information, the confidentiality of which is protected by state or federal law. The plaintiff shall redact protected information filed with the complaint.

(d) A default or other judgment shall not be entered against a debtor for debt pursuant to this section unless business records, authenticated through a sworn declaration, are submitted by the debt collector to the court to establish the facts required to be alleged pursuant to subdivision (a).

(e) If a debt collector plaintiff seeks a default judgment and has not complied with this title, the court shall not enter a default judgment for the plaintiff and may, in its discretion, dismiss the action.

(f) Except as provided in this title, this section does not modify or otherwise amend the procedures established in Section 585 of the Code of Civil Procedure.

SEC. 3. Section 1788.52 of the Civil Code is amended to read:

1788.52. (a) A debt buyer shall not make any written statement to a debtor in an attempt to collect a consumer debt unless the debt buyer possesses the following information:

(1) That the debt buyer is the sole owner of the debt at issue or has authority to assert the rights of all owners of the debt.

(2) The debt balance at charge off and an explanation of the amount, nature, and reason for all post-charge-off interest and fees, if any, imposed by the charge-off creditor or any subsequent purchasers of the debt. This paragraph shall not be deemed to require a specific itemization, but the explanation shall identify separately the charge-off balance, the total of any post-charge-off interest, and the total of any post-charge-off fees.

(3) The date of default or the date of the last payment.

(4) The name and an address of the charge-off creditor at the time of charge off, and the charge-off creditor's account number associated with the debt. The charge-off creditor's name and address shall be in sufficient form so as to reasonably identify the charge-off creditor.

(5) The name and last known address of the debtor as they appeared in the charge-off creditor's records prior to the sale of the debt. If the debt was sold prior to January 1, 2014, the name and last known address of the debtor as they appeared in the debt owner's records on December 31, 2013, shall be sufficient.

(6) The names and addresses of all persons or entities that purchased the debt after charge off, including the debt buyer making the written statement. The names and addresses shall be in sufficient form so as to reasonably identify each such purchaser.

(7) The California license number of the debt buyer.

(b) A debt buyer shall not make any written statement to a debtor in an attempt to collect a consumer debt unless the debt buyer has access to a copy of a contract or other document evidencing the debtor's agreement to the debt. If the claim is based on debt for which no signed contract or agreement exists, the debt buyer shall have access to a copy of a document provided to the debtor while the account was active, demonstrating that the debt was incurred by the debtor. For a revolving credit account, the most recent monthly statement recording a purchase transaction, last payment, or balance transfer shall be deemed sufficient to satisfy this requirement.

(c) A debt buyer shall provide the information or documents identified in subdivisions (a) and (b) to the debtor without charge within 15 calendar days of receipt of a debtor's written request for information regarding the debt or proof of the debt. If the debt buyer cannot provide the information or documents within 15 calendar days, the debt buyer shall cease all collection of the debt until the debt buyer provides the debtor the information or documents described in subdivisions (a) and (b). Except as provided otherwise in this title, the request by the debtor shall be consistent with the validation requirements contained in Section 1692g of Title 15 of the United States Code. A debt buyer shall provide all debtors with whom it has contact an active postal address to which these requests can be sent. A debt buyer may also provide an active email address to which these requests can be

sent and through which information and documents can be delivered, if the parties agree.

(d) (1) A debt buyer shall include with its first written communication with the debtor in no smaller than 12-point type, a separate prominent notice that provides:

"You may request records showing the following: (1) that [insert name of debt buyer] has the right to seek collection of the debt; (2) the debt balance, including an explanation of any interest charges and additional fees; (3) the date of default or the date of the last payment; (4) the name of the charge-off creditor and the account number associated with the debt; (5) the name and last known address of the debtor as it appeared in the charge-off creditor's or debt buyer's records prior to the sale of the debt, as appropriate; and (6) the names of all persons or entities that have purchased the debt. You may also request from us a copy of the contract or other document evidencing your agreement to the debt.

"A request for these records may be addressed to: [insert debt buyer's active mailing address and email address, if applicable]."

(2) When collecting on a time-barred debt where the debt is not past the date for obsolescence provided for in Section 605(a) of the federal Fair Credit Reporting Act (15 U.S.C. Sec. 1681c):

"The law limits how long you can be sued on a debt. Because of the age of your debt, we will not sue you for it. If you do not pay the debt, [insert name of debt buyer] may [continue to] report it to the credit reporting agencies as unpaid for as long as the law permits this reporting."

(3) When collecting on a time-barred debt where the debt is past the date for obsolescence provided for in Section 605(a) of the federal Fair Credit Reporting Act (15 U.S.C. Sec. 1681c):

"The law limits how long you can be sued on a debt. Because of the age of your debt, we will not sue you for it, and we will not report it to any credit reporting agency."

(e) If a language other than English is principally used by the debt buyer in the initial oral contact with the debtor, the notice

required by subdivision (d) shall be provided to the debtor in that language within five working days.

(f) A debt buyer shall not collect, or make any attempt to collect consumer debt that originated with a hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code without including in the first written communication to the debtor a copy of the notice required pursuant to subdivision (e) of Section 127425 of the Health and Safety Code.

(g) In the event of a conflict between the requirements of subdivision (d) and federal law, so that it is impracticable to comply with both, the requirements of federal law shall prevail.

SEC. 4. Section 1788.58 of the Civil Code is amended to read:

1788.58. In an action brought by a debt buyer on a consumer debt:

(a) The complaint shall allege all of the following:

(1) That the plaintiff is a debt buyer.

(2) The nature of the underlying debt and the consumer transaction or transactions from which it is derived, in a short and plain statement.

(3) That the debt buyer is the sole owner of the debt at issue, or has authority to assert the rights of all owners of the debt.

(4) The debt balance at charge off and an explanation of the amount, nature, and reason for all post-charge-off interest and fees, if any, imposed by the charge-off creditor or any subsequent purchasers of the debt. This paragraph shall not be deemed to require a specific itemization, but the explanation shall identify separately the charge-off balance, the total of any post-charge-off interest, and the total of any post-charge-off fees.

(5) The date of default or the date of the last payment.

(6) The name and an address of the charge-off creditor at the time of charge off and the charge-off creditor's account number associated with the debt. The charge-off creditor's name and address shall be in sufficient form so as to reasonably identify the charge-off creditor.

(7) The name and last known address of the debtor as they appeared in the charge-off creditor's records prior to the sale of the debt. If the debt was sold prior to January 1, 2014, the debtor's name and last known address as they appeared in the debt owner's records on December 31, 2013, shall be sufficient.

(8) The names and addresses of all persons or entities that purchased the debt after charge off, including the plaintiff debt buyer. The names and addresses shall be in sufficient form so as to reasonably identify each such purchaser.

(9) That the debt buyer has complied with Section 1788.52.

(b) A copy of the contract or other document described in subdivision (b) of Section 1788.52 shall be attached to the complaint.

(c) The complaint in an action brought by a debt buyer for debt that originated with a general acute care hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code shall also contain both of the following:

(1) The information contained in paragraph (6) of subdivision (e) of Section 127425 of the Health and Safety Code and a statement identifying the language in which that information was sent to the debtor.

(2) Copies of the application for financial assistance that was provided to the debtor by the hospital and the notice that was provided to the debtor by the hospital about applying for financial assistance, attached to the complaint. If the notice was provided as part of the hospital bill that cannot be separated, the bill shall be redacted to remove confidential information, or a sample hospital bill with the substance of the notice regarding financial assistance in the format in use at the time the patient was billed may be provided.

(d) The requirements of this title shall not be deemed to require the disclosure in public records of personal, financial, or medical information, the confidentiality of which is protected by any state or federal law.

SEC. 5. Section 127400 of the Health and Safety Code, as amended by Section 83 of Chapter 143 of the Statutes of 2021, is amended to read:

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 high medical costs, 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 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) "Department" means the Department of Health Care Access and Information.

(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 400 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 the lesser of 10 percent of the patient's current family income or 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.

SEC. 6. Section 127401 of the Health and Safety Code is amended to read:

127401. Each general acute care hospital licensed pursuant to subdivision (a) of Section 1250 shall comply with the provisions of this article. The State Department of Public Health shall be responsible for the enforcement of these provisions for violations occurring prior to January 1, 2024. The Department of Health Care Access and Information shall be responsible for the enforcement of these provisions for violations occurring on or after January 1, 2024.

SEC. 7. Section 127405 of the Health and Safety Code is amended to read:

127405. (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 400 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 400 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 400 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 400 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 400 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 or Medi-Cal, whichever is greater. If the hospital provides a service for which there is no established payment by Medicare or Medi-Cal, the hospital shall establish an appropriate discounted payment. Patients eligible under this article shall not be required to undergo an independent dispute resolution process.

(e) A 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 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.

SEC. 8. Section 127410 of the Health and Safety Code is amended to read:

127410. (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.

(5) Prominently displayed on the hospital's internet website, with a link to the policy itself.

SEC. 8.5. Section 127410 of the Health and Safety Code is amended to read:

127410. (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. The notice shall also include the internet address for the Health Consumer Alliance (https://healthconsumer.org), and shall explain that there are organizations that will help the patient understand the billing and payment process, as well as information regarding Covered California and Medi-Cal presumptive eligibility, if the hospital participates in the presumptive eligibility program. The notice

shall also include the internet address for the hospital's list of shoppable services, pursuant to Section 180.60 of Title 45 of the Code of Federal Regulations. 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) The written notice shall be provided at the time of service if the patient is conscious and able to receive written notice at that time. If the patient is not able to receive notice at the time of service, the notice shall be provided during the discharge process. If the patient is not admitted, the written notice shall be provided when the patient leaves the facility. If the patient leaves the facility without receiving the written notice, the hospital shall mail the notice to the patient within 72 hours of providing services.

(c) 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, including observation units.

(5) Prominently displayed on the hospital's internet website, with a link to the policy itself.

SEC. 9. Section 127420 of the Health and Safety Code is amended to read:

127420. (a) Each hospital shall make all reasonable efforts to obtain from the patient or the patient's 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 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, 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, 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, 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 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 the patient applies for a hospital charity care or discount payment program, neither application shall preclude eligibility for the other program.

SEC. 10. Section 127425 of the Health and Safety Code is amended to read:

127425. (a) A hospital shall not sell patient debt to a debt buyer, as defined in Section 1788.50 of the Civil Code, unless all of the following apply:

(1) The hospital has found the patient ineligible for financial assistance or the patient has not responded to any attempts to bill or offer financial assistance for 180 days.

(2) The hospital includes contractual language in the sales agreement in which the debt buyer agrees to return, and the hospital agrees to accept, any account in which the balance has been determined to be incorrect due to the availability of a third-party payer, including a health plan or government health coverage program, or the patient is eligible for charity care or financial assistance.

(3) The debt buyer agrees to not resell or otherwise transfer the patient debt, except to the originating hospital or a tax-exempt organization described in Section 127444, or if the debt buyer is sold or merged with another entity.

(4) The debt buyer agrees not to charge interest or fees on the patient debt.

(5) The debt buyer is licensed as a debt collector by the Department of Financial Protection and Innovation.

(b) A 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, or debt buyer.

(c) A 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, debt buyer, 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.

(d) At time of billing, a 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.

(e) Before assigning a bill to collections, or selling patient debt to a debt buyer, a hospital shall send a patient a notice with all of the following information:

(1) The date or dates of service of the bill that is being assigned to collections or sold.

(2) The name of the entity the bill is being assigned or sold to.

(3) A statement informing the patient how to obtain an itemized hospital bill from the hospital.

(4) The name and plan type of the health coverage for the patient on record with the hospital at the time of services or a statement that the hospital does not have that information.

(5) An application for the hospital's charity care and financial assistance.

(6) The date or dates the patient was originally sent a notice about applying for financial assistance, the date or dates the patient was sent a financial assistance application, and, if applicable, the date a decision on the application was made.

(f) A hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency or debt buyer, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment before 180 days after initial billing.

(g) 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, debt buyer, or other assignee, unless that entity has agreed to comply with this article.

(h) (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, debt buyer, 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 the patient's 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 themselves and resides in the dwelling as their 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, debt buyer, or other assignee from pursuing reimbursement and any enforcement remedy or remedies from third-party liability settlements, tortfeasors, or other legally responsible parties.

(i) 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, debt buyer, 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, debt buyer, or assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The hospital, collection agency, debt buyer, 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.

(j) This section does not 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 (i).

SEC. 11. Section 127435 of the Health and Safety Code, as amended by Section 84 of Chapter 143 of the Statutes of 2021, is amended to read:

127435. (a) A hospital shall provide to the department 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, as well as a copy of its debt collection policy. The department may determine whether the information is to be provided electronically or in some other similar 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 department of the lack of change shall meet the requirements of this section. The department shall make this information available to the public on its internet website.

(b) The department shall review a hospital's policy for compliance with this article by January 1, 2023, and whenever a significant change is made and submitted to the department.

(c) A patient shall not be denied financial assistance that would be available pursuant to the policy published on the department's internet website at the time of service.

SEC. 12. Section 127436 is added to the Health and Safety Code, to read:

127436. (a) Upon promulgation of regulations as required in subdivisions (b) and (c) no later than January 1, 2024, the Director of the Department of Health Care Access and Information shall impose an administrative penalty for each violation against a hospital that fails to comply with this article, unless the administrative penalty is waived pursuant to this section. For purposes of this section, multiple violations identified during the same investigation shall constitute a single violation for purposes of assessing an administrative penalty.

(b) Upon receipt of a complaint by a patient that a hospital has not followed the requirements of Sections 127405 to 127435, inclusive, the director shall do all of the following:

(1) Review the patient's eligibility for charity care or financial assistance under the hospital's published financial assistance policy in effect at the time the patient was first billed.

(2) Review the hospital's compliance with this article.

(3) If, after completing the actions in paragraphs (1) and (2), the director believes that the hospital may have violated this article, issue a notice to the hospital describing the alleged violation. The notice shall state all of the facts supporting the alleged violation. The hospital shall have 30 days after issuance of the notice to file a response with the director.

(4) If, after considering all of the information included in any response filed by the hospital, the director determines that a violation has occurred, assess an administrative penalty. The administrative penalty may be up to forty thousand dollars ($40,000), which amount shall be adjusted every five years to reflect the percentage change in the calendar year average, for the five-year period, of the medical care index of the Consumer Price Index, as published by the United States Bureau of Labor Statistics. The department shall promulgate regulations establishing criteria to determine the amount of an administrative penalty. The criteria shall include, at a minimum, all of the following:

(A) The actual financial harm to patients, if any.

(B) The nature, scope, and severity of the violation, including whether the hospital's policies, postings, and screening practices are in compliance with Sections 127405 to 127435, inclusive, or whether the violation was a mistake that resulted in a violation of those policies and practices.

(C) The facility's history of compliance with related state and federal statutes and regulations.

(D) Factors beyond the facility's control that restrict the facility's ability to comply with this chapter or the rules and regulations promulgated thereunder.

(E) The demonstrated willfulness of the violation.

(F) The extent to which the facility detected the violation and took steps to immediately correct the violation and prevent the violation from recurring.

(G) The special circumstances of small and rural hospitals, as defined in Section 124840, if that consideration is needed to protect access to quality care in those hospitals.

(5) Notify the patient of the violation and the patient's right to reimbursement pursuant to Section 127440.

(6) Begin collection efforts for the penalty after the deadline to appeal pursuant to subdivision (c) has passed, or, if the hospital files an appeal, when all appeals have been exhausted and the department's findings have been upheld.

(c) The department shall promulgate regulations to establish a process whereby a hospital may appeal the director's determination that a violation has occurred or the amount of any penalty assessed, subject to the following requirements:

(1) A hospital shall have 30 days from issuance to appeal any determination or penalty.

(2) A hospital may submit any relevant evidence during the appeal process.

(3) The department shall provide the patient who filed a complaint with timely notice of the appeal and a copy of any evidence submitted by the hospital, and offer the patient 30 days to submit a response, including any additional evidence in support of the complaint.

(4) The department shall consider all relevant evidence.

(5) The department may reduce or waive an assessment in the interest of fairness.

(6) The department may reduce or waive a penalty if a violation was due to factors beyond the hospital's control, such as a patient failing to provide accurate information or an unauthorized person removing signage from hospital walls.

SEC. 13. Section 127440 of the Health and Safety Code is amended to read:

127440. 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 refund the patient within 30 days.

SEC. 14. Section 127444 of the Health and Safety Code is amended to read:

127444. (a) This article does not prohibit a hospital from uniformly imposing charges from its established charge schedule or published rates or 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.

(b) This article does not prohibit a hospital, debt collector, or debt buyer from selling or otherwise transferring patient debt to

an organization that is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code for the explicit purpose of the tax-exempt organization abolishing the patient debt by cancellation of the indebtedness, or otherwise prohibit payment of the patient's debt by a third party.

(c) A health care service plan, insurer, or any other person shall not 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.

SEC. 15. Section 8.5 of this bill incorporates amendments to Section 127410 of the Health and Safety Code proposed by both this bill and Assembly Bill 532. That section shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2022, (2) each bill amends Section 127410 of the Health and Safety Code, and (3) this bill is enacted after Assembly Bill 532, in which case Section 8 of this bill shall not become operative.

Approved _____, 2021

_____

Governor