

Introduced by Senator HernandezFebruary 21, 2014

An act to amend Sections 127400, 127420, 127425, 127450, 127454, and 127455 of the Health and Safety Code, relating to health care billing.

LEGISLATIVE COUNSEL'S DIGEST

SB 1276, as introduced, Hernandez. Health care: fair billing policies.

(1) Existing law requires each hospital, as a condition of licensure, to maintain an understandable written policy regarding discount payments for financially qualified patients as well as a written charity care policy. Existing law requires uninsured patients or patients with high medical costs who are at or below 350% of the federal poverty level to be eligible for charity care or a discount payment policy from a hospital, as specified, and requires that specified patients be eligible for discount payments to an emergency physician. Existing law defines a patient with high medical costs as a person whose family income does not exceed 350% of the federal poverty level and who does not receive a discounted rate from the hospital or physician as a result of his or her 3rd-party coverage.

This bill would change the definition of a person with high medical costs to include those persons who do receive a discounted rate from the hospital as a result of 3rd-party coverage.

(2) Existing law requires a hospital or emergency physician to make a reasonable effort 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, including private health insurance, and requires the hospital or emergency physician to provide a patient who has not shown proof of 3rd-party coverage with specified information, including a statement that he or

she may be eligible for specified health coverage programs, including Medi-Cal and the California Children’s Services Program, and applications for those programs.

This bill would require the hospital or emergency physician to obtain information as to whether the patient may be eligible for the California Health Benefit Exchange and to include in the information provided to a patient that has not shown proof of 3rd-party coverage a statement that the consumer may be eligible for coverage through the California Health Benefit Exchange or other state- or county-funded health coverage programs. The bill would also specify that, when a patient applies, or has a pending application, for another health coverage program at the same time he or she applies for charity care or a discount payment program, that neither application precludes eligibility for the other program.

(3) Existing law requires a hospital or an emergency physician to have a written policy defining standards and practices for the collection of debt, and a written agreement from any agency that collects debt that it will adhere to the standards and practices.

This bill would require the affiliate, subsidiary, or external collection agency that is collecting hospital or emergency physician receivables to comply with the definition and application of a reasonable payment plan, as defined.

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

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

- 1 SECTION 1. Section 127400 of the Health and Safety Code
- 2 is amended to read:
- 3 127400. As used in this article, the following terms have the
- 4 following meanings:
- 5 (a) “Allowance for financially qualified patient” means, with
- 6 respect to services rendered to a financially qualified patient, an
- 7 allowance that is applied after the hospital’s charges are imposed
- 8 on the patient, due to the patient’s determined financial inability
- 9 to pay the charges.
- 10 (b) “Federal poverty level” means the poverty guidelines updated
- 11 periodically in the Federal Register by the United States
- 12 Department of Health and Human Services under authority of

1 subsection (2) of Section 9902 of Title 42 of the United States
2 Code.

3 (c) “Financially qualified patient” means a patient who is both
4 of the following:

5 (1) A patient who is a self-pay patient, as defined in subdivision
6 (f), or a patient with high medical costs, as defined in subdivision
7 (g).

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

10 (d) “Hospital” means a facility that is required to be licensed
11 under subdivision (a), (b), or (f) of Section 1250, except a facility
12 operated by the State Department of State Hospitals or the
13 Department of Corrections and Rehabilitation.

14 (e) “Office” means the Office of Statewide Health Planning and
15 Development.

16 (f) “Self-pay patient” means a patient who does not have
17 third-party coverage from a health insurer, health care service plan,
18 Medicare, or Medicaid, and whose injury is not a compensable
19 injury for purposes of workers’ compensation, automobile
20 insurance, or other insurance as determined and documented by
21 the hospital. Self-pay patients may include charity care patients.

22 (g) “A patient with high medical costs” means a person whose
23 family income does not exceed 350 percent of the federal poverty
24 level, as defined in subdivision (b), ~~if that individual does not~~
25 ~~receive a discounted rate from the hospital as a result of his or her~~
26 ~~third-party coverage.~~ For these purposes, “high medical costs”
27 means any of the following:

28 (1) Annual out-of-pocket costs incurred by the individual at the
29 hospital that exceed 10 percent of the patient’s family income in
30 the prior 12 months.

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

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

37 (h) “Patient’s family” means the following:

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

1 dependent children under 21 years of age, whether living at home
2 or not.

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

6 (i) *“Reasonable payment plan” means monthly payments that*
7 *are not more than 5 percent of a patient’s family income for a*
8 *month, excluding deductions for essential living expenses.*

9 SEC. 2. Section 127420 of the Health and Safety Code is
10 amended to read:

11 127420. (a) Each hospital shall make all reasonable efforts to
12 obtain from the patient or his or her representative information
13 about whether private or public health insurance or sponsorship
14 may fully or partially cover the charges for care rendered by the
15 hospital to a patient, including, but not limited to, any of the
16 following:

17 (1) Private health insurance, *including coverage offered through*
18 *the California Health Benefit Exchange.*

19 (2) Medicare.

20 (3) The Medi-Cal program, the Healthy Families Program, the
21 California—~~Childrens~~² *Children’s Services Program*, or other
22 state-funded programs designed to provide health coverage.

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

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

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

32 (3) A statement that, if the consumer does not have health
33 insurance coverage, the consumer may be eligible for Medicare,
34 Healthy Families, Medi-Cal, *coverage offered through the*
35 *California Health Benefit Exchange, California—~~Childrens~~²*
36 *Children’s Services Program, other state- or county-funded health*
37 *coverage, or charity care.*

38 (4) A statement indicating how patients may obtain applications
39 for the Medi-Cal program and the Healthy Families Program,
40 *coverage offered through the California Health Benefit Exchange,*

1 *or other state- or county-funded health coverage programs and*
2 *that the hospital will provide these applications. The hospital shall*
3 *also provide patients with a referral to a local consumer assistance*
4 *center housed at legal services offices. If the patient does not*
5 *indicate coverage by a third-party payer specified in subdivision*
6 *(a), or requests a discounted price or charity care then the hospital*
7 *shall provide an application for the Medi-Cal program, the Healthy*
8 *Families Program or other ~~governmental program to the patient~~*
9 *state- or county-funded health coverage programs. This application*
10 *shall be provided prior to discharge if the patient has been admitted*
11 *or to patients receiving emergency or outpatient care.*

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

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

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

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

26 SEC. 3. Section 127425 of the Health and Safety Code is
27 amended to read:

28 127425. (a) Each hospital shall have a written policy about
29 when and under whose authority patient debt is advanced for
30 collection, whether the collection activity is conducted by the
31 hospital, an affiliate or subsidiary of the hospital, or by an external
32 collection agency.

33 (b) Each hospital shall establish a written policy defining
34 standards and practices for the collection of debt, and shall obtain
35 a written agreement from any agency that collects hospital
36 receivables that it will adhere to the hospital's standards and scope
37 of practices. *This agreement shall require the affiliate, subsidiary,*
38 *or external collection agency of the hospital that collects the debt*
39 *to comply with the hospital's definition and application of a*
40 *reasonable payment plan, as defined in subdivision (i) of Section*

1 127400. The policy shall not conflict with other applicable laws
2 and shall not be construed to create a joint venture between the
3 hospital and the external entity, or otherwise to allow hospital
4 governance of an external entity that collects hospital receivables.
5 In determining the amount of a debt a hospital may seek to recover
6 from patients who are eligible under the hospital's charity care
7 policy or discount payment policy, the hospital may consider only
8 income and monetary assets as limited by Section 127405.

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

13 (d) For a patient that lacks coverage, or for a patient that
14 provides information that he or she may be a patient with high
15 medical costs, as defined in this article, a hospital, any assignee
16 of the hospital, or other owner of the patient debt, including a
17 collection agency, shall not report adverse information to a
18 consumer credit reporting agency or commence civil action against
19 the patient for nonpayment at any time prior to 150 days after
20 initial billing.

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

28 (f) (1) The hospital or other assignee which is an affiliate or
29 subsidiary of the hospital shall not, in dealing with patients eligible
30 under the hospital's charity care or discount payment policies, use
31 wage garnishments or liens on primary residences as a means of
32 collecting unpaid hospital bills.

33 (2) A collection agency or other assignee that is not a subsidiary
34 or affiliate of the hospital shall not, in dealing with any patient
35 under the hospital's charity care or discount payment policies, use
36 as a means of collecting unpaid hospital bills, any of the following:

37 (A) A wage garnishment, except by order of the court upon
38 noticed motion, supported by a declaration filed by the movant
39 identifying the basis for which it believes that the patient has the
40 ability to make payments on the judgment under the wage

1 garnishment, which the court shall consider in light of the size of
2 the judgment and additional information provided by the patient
3 prior to, or at, the hearing concerning the patient's ability to pay,
4 including information about probable future medical expenses
5 based on the current condition of the patient and other obligations
6 of the patient.

7 (B) Notice or conduct a sale of the patient's primary residence
8 during the life of the patient or his or her spouse, or during the
9 period a child of the patient is a minor, or a child of the patient
10 who has attained the age of majority is unable to take care of
11 himself or herself and resides in the dwelling as his or her primary
12 residence. In the event a person protected by this paragraph owns
13 more than one dwelling, the primary residence shall be the dwelling
14 that is the patient's current homestead, as defined in Section
15 704.710 of the Code of Civil Procedure or was the patient's
16 homestead at the time of the death of a person other than the patient
17 who is asserting the protections of this paragraph.

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

22 (g) ~~Any extended~~ *Extended* payment plans offered by a hospital
23 to assist patients eligible under the hospital's charity care policy,
24 discount payment policy, or any other policy adopted by the
25 hospital for assisting low-income patients with no insurance or
26 high medical costs in settling outstanding past due hospital bills,
27 shall be interest free. The hospital extended payment plan may be
28 declared no longer operative after the patient's failure to make all
29 consecutive payments due during a 90-day period. Before declaring
30 the hospital extended payment plan no longer operative, the
31 hospital, collection agency, or assignee shall make a reasonable
32 attempt to contact the patient by phone and, to give notice in
33 writing, that the extended payment plan may become inoperative,
34 and of the opportunity to renegotiate the extended payment plan.
35 Prior to the hospital extended payment plan being declared
36 inoperative, the hospital, collection agency, or assignee shall
37 attempt to renegotiate the terms of the defaulted extended payment
38 plan, if requested by the patient. The hospital, collection agency,
39 or assignee shall not report adverse information to a consumer
40 credit reporting agency or commence a civil action against the

1 patient or responsible party for nonpayment prior to the time the
2 extended payment plan is declared to be no longer operative. For
3 purposes of this section, the notice and phone call to the patient
4 may be made to the last known phone number and address of the
5 patient.

6 (h) Nothing in this section shall be construed to diminish or
7 eliminate any protections consumers have under existing federal
8 and state debt collection laws, or any other consumer protections
9 available under state or federal law. If the patient fails to make all
10 consecutive payments for 90 days and fails to renegotiate a
11 payment plan, this subdivision does not limit or alter the obligation
12 of the patient to make payments on the obligation owing to the
13 hospital pursuant to any contract or applicable statute from the
14 date that the extended payment plan is declared no longer operative,
15 as set forth in subdivision (g).

16 SEC. 4. Section 127450 of the Health and Safety Code is
17 amended to read:

18 127450. As used in this article, the following terms have the
19 following meanings:

20 (a) “Allowance for financially qualified patient” means, with
21 respect to emergency care rendered to a financially qualified
22 patient, an allowance that is applied after the emergency
23 physician’s charges are imposed on the patient, due to the patient’s
24 determined financial inability to pay the charges.

25 (b) “Emergency care” means emergency medical services and
26 care, as defined in Section 1317.1, that is provided by an
27 emergency physician in the emergency department of a hospital.

28 (c) “Emergency physician” means a physician and surgeon
29 licensed pursuant to Chapter 2 (commencing with Section 2000)
30 of the Business and Professions Code who is credentialed by a
31 hospital and either employed or contracted by the hospital to
32 provide emergency medical services in the emergency department
33 of the hospital, except that an “emergency physician” shall not
34 include a physician specialist who is called into the emergency
35 department of a hospital or who is on staff or has privileges at the
36 hospital outside of the emergency department.

37 (d) “Federal poverty level” means the poverty guidelines updated
38 periodically in the Federal Register by the United States
39 Department of Health and Human Services under authority of

1 subsection (2) of Section 9902 of Title 42 of the United States
2 Code.

3 (e) “Financially qualified patient” means a patient who is both
4 of the following:

5 (1) A patient who is a self-pay patient or a patient with high
6 medical costs.

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

9 (f) “Hospital” means a facility that is required to be licensed
10 under subdivision (a) of Section 1250, except a facility operated
11 by the State Department of State Hospitals or the Department of
12 Corrections and Rehabilitation.

13 (g) “Office” means the Office of Statewide Health Planning and
14 Development.

15 (h) “Self-pay patient” means a patient who does not have
16 third-party coverage from a health insurer, health care service plan,
17 Medicare, or Medicaid, and whose injury is not a compensable
18 injury for purposes of workers’ compensation, automobile
19 insurance, or other insurance as determined and documented by
20 the emergency physician. Self-pay patients may include charity
21 care patients.

22 (i) “A patient with high medical costs” means a person whose
23 family income does not exceed 350 percent of the federal poverty
24 level ~~if that individual does not receive a discounted rate from the~~
25 ~~emergency physician as a result of his or her third-party coverage.~~
26 For these purposes, “high medical costs” means any of the
27 following:

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

31 (2) Annual out-of-pocket expenses that exceed 10 percent of
32 the patient’s family income, if the patient provides documentation
33 of the patient’s medical expenses paid by the patient or the patient’s
34 family in the prior 12 months. The emergency physician may waive
35 the request for documentation.

36 (3) A lower level determined by the emergency physician in
37 accordance with the emergency physician’s discounted payment
38 policy.

39 (j) “Patient’s family” means the following:

1 (1) For persons 18 years of age and older, spouse, domestic
2 partner, as defined in Section 297 of the Family Code, and
3 dependent children under 21 years of age, whether living at home
4 or not.

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

8 (k) *“Reasonable payment plan” means monthly payments that*
9 *are not more than 5 percent of a patient’s family income for a*
10 *month, excluding deductions for essential living expenses.*

11 SEC. 5. Section 127454 of the Health and Safety Code is
12 amended to read:

13 127454. (a) Each emergency physician shall make all
14 reasonable efforts to obtain from the patient, or his or her
15 representative, information about whether private or public health
16 insurance or sponsorship may fully or partially cover the charges
17 for emergency care rendered by the emergency physician to a
18 patient, including, but not limited to, any of the following:

19 (1) Private health insurance, *including coverage offered through*
20 *the California Health Benefit Exchange.*

21 (2) Medicare.

22 (3) The Medi-Cal program, the Healthy Families Program, the
23 California Children’s Services Program, or other ~~publicly funded~~
24 *state- or county-funded* programs designed to provide
25 comprehensive health coverage.

26 (b) If the emergency physician or his or her representative bills
27 a patient who has not provided proof of coverage by a third party
28 at the time the care is provided or upon discharge, as a part of that
29 billing, the emergency physician shall provide the patient with a
30 clear and conspicuous notice that includes all of the following:

31 (1) A statement of charges for services rendered by the
32 emergency physician.

33 (2) A request that the patient inform the emergency physician
34 if the patient has health insurance coverage, Medicare, Healthy
35 Families, Medi-Cal, or other coverage.

36 (3) A statement that if the consumer does not have health
37 insurance coverage, the consumer may be eligible for Medicare,
38 Healthy Families, Medi-Cal, *coverage through the California*
39 *Health Benefit Exchange*, California Children’s Services Program,

1 *other state- or county-funded health coverage, or discounted*
2 *payment care.*

3 (4) Information regarding the financially qualified patient and
4 discounted payment application, including the following:

5 (A) A statement that indicates that if the patient lacks, or has
6 inadequate, insurance, and meets certain low-and moderate-income
7 requirements, the patient may qualify for discounted payment.
8 *That statement shall also provide patients with a referral to a local*
9 *consumer assistance center housed at legal services offices.*

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

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

18 (c) (1) In addition to the statement of the charges, if the
19 emergency physician's uses the following notice in any billing,
20 that emergency physician shall be deemed to have complied with
21 the notice requirements of this section: "If you are uninsured or
22 have high medical costs, please contact ____ (name of person
23 responsible for discount payment policy) at ____ (area code and
24 phone number) for information on discounts and programs for
25 which you may be eligible, including the Medi-Cal program. If
26 you have coverage, please tell us so that we may bill your plan."

27 (2) If the emergency physician or the assignee of the emergency
28 physician lacks the capacity to provide the notice specified in
29 paragraph (1), the emergency physician or his or her assignee shall
30 be deemed to have complied with the notice requirements of this
31 section if the information required under this section is provided
32 upon request and if the following is printed on the bill in 14-point
33 bold type: "If uninsured or high medical bill, call re: discount."

34 SEC. 6. Section 127455 of the Health and Safety Code is
35 amended to read:

36 127455. (a) Each emergency physician shall have a written
37 policy about when and under whose authority patient debt is
38 advanced for collection.

39 (b) Each emergency physician shall establish a written policy
40 defining standards and practices for the collection of debt, and

1 shall obtain a written agreement from any agency that collects
2 emergency physician receivables that it will adhere to the
3 emergency physician's standards and scope of practice. *This*
4 *agreement shall require the affiliate, subsidiary, or external*
5 *collection agency of the physician that collects the debt to comply*
6 *with the physician's definition and application of a reasonable*
7 *payment plan, as defined in subdivision (k) of Section 127450.* The
8 policy shall not conflict with other applicable laws and shall not
9 be construed to create a joint venture between the emergency
10 physician and the external entity, or otherwise to allow physician
11 and surgeon governance of an external entity that collects physician
12 and surgeon receivables. In determining the amount of a debt the
13 emergency physician may seek to recover from patients who are
14 eligible under the emergency physician's charity care policy or
15 discount payment policy, the emergency physician may consider
16 only income and monetary assets as limited by Section 127452.

17 (c) For a patient that lacks coverage, or for a patient that
18 provides information that he or she may be a patient with high
19 medical costs, the emergency physician, ~~any~~ *an* assignee of the
20 emergency physician, or other owner of the patient debt, including
21 a collection agency, shall not report adverse information to a
22 consumer credit reporting agency or commence civil action against
23 the patient for nonpayment at any time prior to 150 days after
24 initial billing.

25 (d) If a patient is attempting to qualify for eligibility under the
26 emergency physician's discount payment policy and is attempting
27 in good faith to settle an outstanding bill with the physician and
28 surgeon by negotiating a reasonable payment plan or by making
29 regular partial payments of a reasonable amount, the emergency
30 physician or his or her assignee, including a collection agency,
31 shall not report adverse information to a consumer credit agency
32 or commence a civil action unless that entity has agreed to comply
33 with this article.

34 (e) (1) The emergency physician or other assignee shall not, in
35 dealing with patients eligible under the emergency physician's
36 discount payment policies, use wage garnishments or liens on
37 primary residences as a means of collecting unpaid emergency
38 physician bills.

39 (2) A collection agency or other assignee shall not, in dealing
40 with any patient under the emergency physician's discount payment

1 policy, use as a means of collecting unpaid emergency physician
2 bills, any of the following:

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

12 (B) Notice or conduct a sale of the patient's primary residence
13 during the life of the patient or his or her spouse, or during the
14 period a child of the patient is a minor, or a child of the patient
15 who has attained the age of majority is unable to take care of
16 himself or herself and resides in the dwelling as his or her primary
17 residence. In the event a person protected by this paragraph owns
18 more than one dwelling, the primary residence shall be the dwelling
19 that is the patient's current homestead, as defined in Section
20 704.710 of the Code of Civil Procedure or was the patient's
21 homestead at the time of the death of a person other than the patient
22 who is asserting the protections of this paragraph.

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

27 (f) ~~Any extended~~ *Extended* payment plans offered by an
28 emergency physician to assist patients eligible under the emergency
29 physician's discount payment policy or any other policy adopted
30 by the emergency physician for assisting low-income patients with
31 no insurance or high medical costs in settling outstanding past due
32 emergency physician bills, shall be interest free. The emergency
33 physician's extended payment plan may be declared no longer
34 operative after the patient's failure to make all consecutive
35 payments due during a 90-day period. Before declaring the
36 emergency physician's extended payment plan no longer operative,
37 the emergency physician, collection agency, or assignee shall make
38 a reasonable attempt to contact the patient by telephone, if the
39 telephone number is known, and to give notice in writing that the
40 extended payment plan may become inoperative, and of the

1 opportunity to renegotiate the extended payment plan. Prior to the
2 emergency physician’s extended payment plan being declared
3 inoperative, the emergency physician, collection agency, or
4 assignee shall attempt to renegotiate the terms of the defaulted
5 extended payment plan, if requested by the patient. The emergency
6 physician, collection agency, or assignee shall not report adverse
7 information to a consumer credit reporting agency or commence
8 a civil action against the patient or responsible party for
9 nonpayment prior to the time the extended payment plan is declared
10 to be no longer operative. For purposes of this section, the notice
11 and telephone call to the patient may be made to the last known
12 telephone number and address of the patient.

13 (g) Nothing in this section shall be construed to diminish or
14 eliminate any protections consumers have under existing federal
15 and state debt collection laws, or any other consumer protections
16 available under state or federal law. If the patient fails to make all
17 consecutive payments for 90 days and fails to renegotiate a
18 payment plan, this subdivision does not limit or alter the obligation
19 of the patient to make payments on the obligation owing to the
20 emergency physician pursuant to any contract or applicable statute
21 from the date that the extended payment plan is declared no longer
22 operative, as set forth in subdivision (f).