

AMENDED IN SENATE MAY 22, 2014

**SENATE BILL**

**No. 1276**

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**Introduced by Senator Hernandez**

February 21, 2014

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An act to amend Sections 127400, 127405, 127420, 127425, 127450, 127454, and 127455 of the Health and Safety Code, relating to health care billing.

LEGISLATIVE COUNSEL'S DIGEST

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

(1) Existing law requires ~~each a hospital, as a condition of licensure, as defined,~~ to maintain an understandable written policy regarding discount payments for financially qualified patients as well as a written charity care policy, *and authorizes a hospital to negotiate the terms of a payment plan with a patient.* Existing law requires *that* 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 *instead require a hospital to negotiate with a patient regarding a payment plan, taking into consideration the patient's family income and essential living expenses. This bill would require the hospital to use a specified formula to create a reasonable payment plan, as defined, if the hospital and the patient cannot agree to a payment plan. 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. *This bill would also require an emergency physician or his or her assignee to use a specified formula to calculate a reasonable payment plan when no agreement can be reached on the amount of payment between a patient attempting to qualify for eligibility under the emergency physician's discount payment policy.*

(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~~, *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  
13 subsection (2) of Section 9902 of Title 42 of the United States  
14 Code.

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

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

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

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

26 (e) “Office” means the Office of Statewide Health Planning and  
27 Development.

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

34 (g) “A patient with high medical costs” means a person whose  
35 family income does not exceed 350 percent of the federal poverty  
36 level, as defined in subdivision (b). For these purposes, “high  
37 medical costs” means any of the following:

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

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

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

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

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

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

18 (i) “Reasonable payment plan” means monthly payments that  
 19 are not more than ~~5~~ 10 percent of a patient’s family income for a  
 20 month, excluding deductions for essential living expenses.  
 21 *“Essential living expenses” means, for purposes of this subdivision,*  
 22 *expenses for any of the following: rent or house payment and*  
 23 *maintenance, food and household supplies, utilities and telephone,*  
 24 *clothing, medical and dental payments, insurance, school or child*  
 25 *care, child or spousal support, transportation and auto expenses,*  
 26 *including insurance, gas, and repairs, installment payments,*  
 27 *laundry and cleaning, and other extraordinary expenses.*

28 SEC. 2. Section 127405 of the Health and Safety Code is  
 29 amended to read:

30 127405. (a) (1) (A) Each hospital shall maintain an  
 31 understandable written policy regarding discount payments for  
 32 financially qualified patients as well as an understandable written  
 33 charity care policy. Uninsured patients or patients with high  
 34 medical costs who are at or below 350 percent of the federal  
 35 poverty level, as defined in subdivision (b) of Section 127400,  
 36 shall be eligible to apply for participation under a hospital’s charity  
 37 care policy or discount payment policy. Notwithstanding any other  
 38 provision of this article, a hospital may choose to grant eligibility  
 39 for its discount payment policy or charity care policies to patients  
 40 with incomes over 350 percent of the federal poverty level. Both

1 the charity care policy and the discount payment policy shall state  
2 the process used by the hospital to determine whether a patient is  
3 eligible for charity care or discounted payment. In the event of a  
4 dispute, a patient may seek review from the business manager,  
5 chief financial officer, or other appropriate manager as designated  
6 in the charity care policy and the discount payment policy.

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

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

19 (b) A hospital's discount payment policy shall clearly state  
20 eligibility criteria based upon income consistent with the  
21 application of the federal poverty level. The discount payment  
22 policy shall also include an extended payment plan to allow  
23 payment of the discounted price over time. The policy shall provide  
24 that the hospital and the patient ~~may~~ shall negotiate the terms of  
25 the payment ~~plan~~ plan, and take into consideration the patient's  
26 family income and essential living expenses. *If the hospital and  
27 the patient cannot agree on the payment plan, the hospital shall  
28 use the formula described in subdivision (i) of Section 127400 to  
29 create a reasonable payment plan.*

30 (c) The charity care policy shall state clearly the eligibility  
31 criteria for charity care. In determining eligibility under its charity  
32 care policy, a hospital may consider income and monetary assets  
33 of the patient. For purposes of this determination, monetary assets  
34 shall not include retirement or deferred compensation plans  
35 qualified under the Internal Revenue Code, or nonqualified deferred  
36 compensation plans. Furthermore, the first ten thousand dollars  
37 (\$10,000) of a patient's monetary assets shall not be counted in  
38 determining eligibility, nor shall 50 percent of a patient's monetary  
39 assets over the first ten thousand dollars (\$10,000) be counted in  
40 determining eligibility.

1 (d) A hospital shall limit expected payment for services it  
2 provides to a patient at or below 350 percent of the federal poverty  
3 level, as defined in subdivision (b) of Section 127400, eligible  
4 under its discount payment policy to the amount of payment the  
5 hospital would expect, in good faith, to receive for providing  
6 services from Medicare, Medi-Cal, the Healthy Families Program,  
7 or another government-sponsored health program of health benefits  
8 in which the hospital participates, whichever is greater. If the  
9 hospital provides a service for which there is no established  
10 payment by Medicare or any other government-sponsored program  
11 of health benefits in which the hospital participates, the hospital  
12 shall establish an appropriate discounted payment.

13 (e) A patient, or patient's legal representative, who requests a  
14 discounted payment, charity care, or other assistance in meeting  
15 his or her financial obligation to the hospital shall make every  
16 reasonable effort to provide the hospital with documentation of  
17 income and health benefits coverage. If the person requests charity  
18 care or a discounted payment and fails to provide information that  
19 is reasonable and necessary for the hospital to make a  
20 determination, the hospital may consider that failure in making its  
21 determination.

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

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

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

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

4 ~~SEC. 2.~~

5 *SEC. 3.* Section 127420 of the Health and Safety Code is  
6 amended to read:

7 127420. (a) Each hospital shall make all reasonable efforts to  
8 obtain from the patient or his or her representative information  
9 about whether private or public health insurance or sponsorship  
10 may fully or partially cover the charges for care rendered by the  
11 hospital to a patient, including, but not limited to, any of the  
12 following:

13 (1) Private health insurance, including coverage offered through  
14 the California Health Benefit Exchange.

15 (2) Medicare.

16 (3) The Medi-Cal program, the Healthy Families Program, the  
17 California Children’s Services ~~Program~~, *program*, or other  
18 state-funded programs designed to provide health coverage.

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

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

25 (2) A request that the patient inform the hospital if the patient  
26 has health insurance coverage, Medicare, Healthy Families  
27 *Program*, Medi-Cal, or other coverage.

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

34 (4) A statement indicating how patients may obtain applications  
35 for the Medi-Cal program and the Healthy Families Program,  
36 coverage offered through the California Health Benefit Exchange,  
37 or other state- or county-funded health coverage programs and that  
38 the hospital will provide these applications. The hospital shall also  
39 provide patients with a referral to a local consumer assistance  
40 center housed at legal services offices. If the patient does not

1 indicate coverage by a third-party payer specified in subdivision  
 2 (a); or requests a discounted price or charity care, then the hospital  
 3 shall provide an application for the Medi-Cal program, the Healthy  
 4 Families Program, or other state- or county-funded health coverage  
 5 programs. This application shall be provided prior to discharge if  
 6 the patient has been admitted or to patients receiving emergency  
 7 or outpatient care.

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

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

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

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

22 ~~SEC. 3.~~

23 *SEC. 4.* Section 127425 of the Health and Safety Code is  
 24 amended to read:

25 127425. (a) Each hospital shall have a written policy about  
 26 when and under whose authority patient debt is advanced for  
 27 collection, whether the collection activity is conducted by the  
 28 hospital, an affiliate or subsidiary of the hospital, or by an external  
 29 collection agency.

30 (b) Each hospital shall establish a written policy defining  
 31 standards and practices for the collection of debt, and shall obtain  
 32 a written agreement from any agency that collects hospital  
 33 receivables that it will adhere to the hospital's standards and scope  
 34 of practices. This agreement shall require the affiliate, subsidiary,  
 35 or external collection agency of the hospital that collects the debt  
 36 to comply with the hospital's definition and application of a  
 37 reasonable payment plan, as defined in subdivision (i) of Section  
 38 127400. The policy shall not conflict with other applicable laws  
 39 and shall not be construed to create a joint venture between the  
 40 hospital and the external entity, or otherwise to allow hospital

1 governance of an external entity that collects hospital receivables.  
2 In determining the amount of a debt a hospital may seek to recover  
3 from patients who are eligible under the hospital’s charity care  
4 policy or discount payment policy, the hospital may consider only  
5 income and monetary assets as limited by Section 127405.

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

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

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

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

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

34 (A) A wage garnishment, except by order of the court upon  
35 noticed motion, supported by a declaration filed by the movant  
36 identifying the basis for which it believes that the patient has the  
37 ability to make payments on the judgment under the wage  
38 garnishment, which the court shall consider in light of the size of  
39 the judgment and additional information provided by the patient  
40 prior to, or at, the hearing concerning the patient’s ability to pay,

1 including information about probable future medical expenses  
2 based on the current condition of the patient and other obligations  
3 of the patient.

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

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

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

1 the notice and ~~phone~~ *telephone* call to the patient may be made to  
2 the last known ~~phone~~ *telephone* number and address of the patient.

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

13 ~~SEC. 4.~~

14 *SEC. 5.* Section 127450 of the Health and Safety Code is  
15 amended to read:

16 127450. As used in this article, the following terms have the  
17 following meanings:

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

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

26 (c) “Emergency physician” means a physician and surgeon  
27 licensed pursuant to Chapter 2 5 (commencing with Section 2000)  
28 of *Division 2* of the Business and Professions Code who is  
29 credentialed by a hospital and either employed or contracted by  
30 the hospital to provide emergency medical services in the  
31 emergency department of the hospital, except that an “emergency  
32 physician” shall not include a physician specialist who is called  
33 into the emergency department of a hospital or who is on staff or  
34 has privileges at the hospital outside of the emergency department.

35 (d) “Federal poverty level” means the poverty guidelines updated  
36 periodically in the Federal Register by the United States  
37 Department of Health and Human Services under authority of  
38 subsection (2) of Section 9902 of Title 42 of the United States  
39 Code.

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

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

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

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

11 (g) “Office” means the Office of Statewide Health Planning and  
12 Development.

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

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

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

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

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

37 (j) “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 (k) “Reasonable payment plan” means monthly payments that  
7 are not more than ~~5~~ 10 percent of a patient’s family income for a  
8 month, excluding deductions for essential living expenses.  
9 “Essential living expenses” means, for purposes of this subdivision,  
10 expenses for all of the following: rent or house payment and  
11 maintenance, food and household supplies, utilities and telephone,  
12 clothing, medical and dental payments, insurance, school or child  
13 care, child or spousal support, transportation and auto expenses,  
14 including insurance, gas, and repairs, installment payments,  
15 laundry and cleaning, and other extraordinary expenses.

16 ~~SEC. 5.~~

17 SEC. 6. Section 127454 of the Health and Safety Code is  
18 amended to read:

19 127454. (a) Each emergency physician shall make all  
20 reasonable efforts to obtain from the patient, or his or her  
21 representative, information about whether private or public health  
22 insurance or sponsorship may fully or partially cover the charges  
23 for emergency care rendered by the emergency physician to a  
24 patient, including, but not limited to, any of the following:

25 (1) Private health insurance, including coverage offered through  
26 the California Health Benefit Exchange.

27 (2) Medicare.

28 (3) The Medi-Cal program, the Healthy Families Program, the  
29 California Children’s Services ~~Program~~, *program*, or other state-  
30 or county-funded programs designed to provide comprehensive  
31 health coverage.

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

37 (1) A statement of charges for services rendered by the  
38 emergency physician.

1 (2) A request that the patient inform the emergency physician  
2 if the patient has health insurance coverage, Medicare, Healthy  
3 Families *Program*, Medi-Cal, or other coverage.

4 (3) A statement that if the consumer does not have health  
5 insurance coverage, the consumer may be eligible for Medicare,  
6 Healthy Families *Program*, Medi-Cal, coverage through the  
7 California Health Benefit Exchange, California Children's Services  
8 ~~Program~~, *program*, other state- or county-funded health coverage,  
9 or discounted payment care.

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

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

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

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

25 (c) (1) In addition to the statement of the charges, if the  
26 emergency ~~physician's~~ *physician* uses the following notice in any  
27 billing, that emergency physician shall be deemed to have complied  
28 with the notice requirements of this section: "If you are uninsured  
29 or have high medical costs, please contact \_\_\_\_ (name of person  
30 responsible for discount payment policy) at \_\_\_\_ (area code and  
31 ~~phone~~ *telephone* number) for information on discounts and  
32 programs for which you may be eligible, including the Medi-Cal  
33 program. If you have coverage, please tell us so that we may bill  
34 your plan."

35 (2) If the emergency physician or the assignee of the emergency  
36 physician lacks the capacity to provide the notice specified in  
37 paragraph (1), the emergency physician or his or her assignee shall  
38 be deemed to have complied with the notice requirements of this  
39 section if the information required under this section is provided

1 upon request and if the following is printed on the bill in 14-point  
2 bold type: “If uninsured or high medical bill, call re: discount.”

3 ~~SEC. 6.~~

4 *SEC. 7.* Section 127455 of the Health and Safety Code is  
5 amended to read:

6 127455. (a) Each emergency physician shall have a written  
7 policy about when and under whose authority patient debt is  
8 advanced for collection.

9 (b) Each emergency physician shall establish a written policy  
10 defining standards and practices for the collection of debt, and  
11 shall obtain a written agreement from any agency that collects  
12 emergency physician receivables that it will adhere to the  
13 emergency physician’s standards and scope of practice. This  
14 agreement shall require the affiliate, subsidiary, or external  
15 collection agency of the physician that collects the debt to comply  
16 with the physician’s definition and application of a reasonable  
17 payment plan, as defined in subdivision (k) of Section 127450.  
18 The policy shall not conflict with other applicable laws and shall  
19 not be construed to create a joint venture between the emergency  
20 physician and the external entity, or otherwise to allow physician  
21 and surgeon governance of an external entity that collects physician  
22 and surgeon receivables. In determining the amount of a debt the  
23 emergency physician may seek to recover from patients who are  
24 eligible under the emergency physician’s charity care policy or  
25 discount payment policy, the emergency physician may consider  
26 only income and monetary assets as limited by Section 127452.

27 (c) For a patient that lacks coverage, or for a patient that  
28 provides information that he or she may be a patient with high  
29 medical costs, the emergency physician, an assignee of the  
30 emergency physician, or other owner of the patient debt, including  
31 a collection agency, shall not report adverse information to a  
32 consumer credit reporting agency or commence civil action against  
33 the patient for nonpayment at any time prior to 150 days after  
34 initial billing.

35 (d) If a patient is attempting to qualify for eligibility under the  
36 emergency physician’s discount payment policy and is attempting  
37 in good faith to settle an outstanding bill ~~with the physician and~~  
38 ~~surgeon by negotiating a reasonable payment plan or by making~~  
39 ~~regular partial payments of a reasonable amount, and no agreement~~  
40 *can be made on the amount of payment, the emergency physician*

1 *or his or her assignee shall apply the reasonable payment plan*  
2 *formula in subdivision (k) of Section 127450, and the emergency*  
3 *physician or his or her assignee, including a collection agency,*  
4 *shall not report adverse information to a consumer credit agency,*  
5 *or commence a civil action unless that entity has agreed to comply*  
6 *with this article.*

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

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

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

25 (B) Notice or conduct a sale of the patient's primary residence  
26 during the life of the patient or his or her spouse, or during the  
27 period a child of the patient is a minor, or a child of the patient  
28 who has attained the age of majority is unable to take care of  
29 himself or herself and resides in the dwelling as his or her primary  
30 residence. In the event a person protected by this paragraph owns  
31 more than one dwelling, the primary residence shall be the dwelling  
32 that is the patient's current homestead, as defined in Section  
33 704.710 of the Code of Civil Procedure, or was the patient's  
34 homestead at the time of the death of a person other than the patient  
35 who is asserting the protections of this paragraph.

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

1 (f) Extended payment plans offered by an emergency physician  
2 to assist patients eligible under the emergency physician's discount  
3 payment policy or any other policy adopted by the emergency  
4 physician for assisting low-income patients with no insurance or  
5 high medical costs in settling outstanding past due emergency  
6 physician bills, shall be interest free. The emergency physician's  
7 extended payment plan may be declared no longer operative after  
8 the patient's failure to make all consecutive payments due during  
9 a 90-day period. Before declaring the emergency physician's  
10 extended payment plan no longer operative, the emergency  
11 physician, collection agency, or assignee shall make a reasonable  
12 attempt to contact the patient by telephone, if the telephone number  
13 is known, and to give notice in writing that the extended payment  
14 plan may become inoperative, and of the opportunity to renegotiate  
15 the extended payment plan. Prior to the emergency physician's  
16 extended payment plan being declared inoperative, the emergency  
17 physician, collection agency, or assignee shall attempt to  
18 renegotiate the terms of the defaulted extended payment plan, if  
19 requested by the patient. The emergency physician, collection  
20 agency, or assignee shall not report adverse information to a  
21 consumer credit reporting agency or commence a civil action  
22 against the patient or responsible party for nonpayment prior to  
23 the time the extended payment plan is declared to be no longer  
24 operative. For purposes of this section, the notice and telephone  
25 call to the patient may be made to the last known telephone number  
26 and address of the patient.

27 (g) Nothing in this section shall be construed to diminish or  
28 eliminate any protections consumers have under existing federal  
29 and state debt collection laws, or any other consumer protections  
30 available under state or federal law. If the patient fails to make all  
31 consecutive payments for 90 days and fails to renegotiate a  
32 payment plan, this subdivision does not limit or alter the obligation  
33 of the patient to make payments on the obligation owing to the  
34 emergency physician pursuant to any contract or applicable statute  
35 from the date that the extended payment plan is declared no longer  
36 operative, as set forth in subdivision (f).

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