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Health Care Practice Tip – December 2021

Greater Patient Protections in Hospital Billing Starting 2022

A new bill, AB 1020, expands charity care to more hospital patients and requires clearer ways of informing patients to apply.

When the Hospital Fair Pricing Act passed in 2006,[1] California led the nation with the strongest set of patient protections to ensure that no patient with an income less than 350% of the federal poverty level could be charged more than the Medicare rate. Many patients would even be offered free care. The Act set forth minimum terms for a hospital's financial assistance policy. Fifteen years after its passage, California passed AB 1020 (Friedman), based on the experiences of legal services advocates and patients who wanted the Act strengthened to better protect patients from facing financial ruin. Here is a summary of the key changes starting in **January 2022**, followed by a review of existing provisions and frequently encountered problems with accessing charity care.

New Changes in 2022

Higher Income Eligibility	• Patient eligibility for some level of financial assistance increases from 350% of the federal poverty level to **400%** of the federal poverty level.
Patient Notices	• Hospitals are required to post information about their charity care and discounted payment policies prominently on their websites and link to the full policies themselves.[2] • A related bill, AB 532 (Wood), requires notice of a hospital's policy to be given at the time of services or within three (3) days of discharge and requires notices to include information to contact the Health Consumer Alliance for assistance.[3] • Hospitals are required to give patients a "good-bye letter" when forwarding a bill for collections or selling the bill to another entity. This letter must include information that the hospital has about a patient's insurance coverage, dates of service, entity the bill is being sent to, an application for financial assistance, and how to obtain an itemized hospital bill.[4]

Longer Time Period Before Collections May Start	• Hospitals, debt collectors, and debt buyers now must wait at least 180 days—instead of 150 days—to report adverse information to a credit reporting agency or commence civil action against patients for nonpayment of bills.[5]

Debt Buyers	• When the original Act was passed, debt buyers were not purchasing medical debt in California—at least as far as advocates knew. The terminology used in the original Act is specific to the debt collection industry and needed to be updated to cover debt buyers. In the time since, concerns about debt buying have been raised, such as how to negotiate with a debt buyer when a patient should have been covered by Medi-Cal or offered financial assistance.
	• The amendments in AB 1020 require hospital contracts with debt buyers to include several provisions, in addition to the protections that were already required for debt collectors:
	  • Debt buyers must send back debts that should have been covered by the hospital's financial assistance policy or another party;
	  • Debt buyers may not resell the debt;
	  • Debt buyers must be licensed; and
	  • Debt buyers must not charge interest or fees on patient debt.[6]

Additional Requirements for Collections	• AB 1020 updates the Civil Code on how debt buyers and debt collectors handle hospital debt. It adds many of the protections that debt buyers are already subject to around verifying the debt prior to suing a patient and subjects debt collectors to these same rules.[7] • When first contacting a patient and when filing suit, both debt collectors and debt buyers now must include the hospital's "good-bye letter" (see above section, Patient Notices) and a copy of the hospital's financial assistance policy.[8]
Enforcement by the Department of Health Care Access and Information	• The Department of Health Care Access and Information, formerly known as the Office of Statewide Health Planning and Development (OSHPD), has been required to collect and post hospital financial assistance policies. Until now,

	however, the Department has not had any authority to review these policies for compliance with the law. • Starting in 2022, the Department has until January 1, 2023, to review all hospital policies for compliance and then must re-review any policy whenever a significant change is made.[9]
More Enforcement to Come in 2024	• Starting in 2024, the Department of Health Care Access and Information will take over the enforcement of the Act, including receiving complaints from individual patients and penalizing hospitals up to $40,000 per violation of the Act.[10] • The Department must promulgate regulations laying out the complaint and appeals process for patients and hospitals.[11]

Frequently Encountered Problems with the Hospital Fair Pricing Act

1. **Patients may apply for charity care or discounted payments at *any* time. Hospitals must provide an eligibility determination upon a patient's completion of an application.**

Hospital policies that set a deadline for when patients must complete their charity care and discounted payment applications have always been unlawful under the Hospital Fair Pricing Act. These unlawful provisions often require patients to complete their applications within 150 days of initial billing in order to qualify for financial assistance. Such specific deadlines appear to conflate the time period for when hospitals may commence collections for non-payment of hospital bills—formerly 150 days after initial billing—with when hospitals may stop accepting applications.[12] These two processes are not to be confused.

Subsection 127405(e)(4) sets the time period for when patients may apply for charity care and discounted payments: **"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."**

Arguably, Subsection 127405(e)(4) is not crystal clear on its face whether hospitals must determine eligibility at any time or whether hospitals may, at their discretion, determine eligibility according to their own deadlines. We can use the tools of statutory interpretation to examine the language of this subsection "in the context of the statutory framework as a whole in order to determine its scope and purpose and to harmonize the

various parts of the enactment."[13] It is also helpful to examine the Hospital Fair Pricing Act's purpose, legislative history and public policy to interpret this language.

While "shall" and "may" typically mean "mandatory" and "directory," respectively, within the Health and Safety Code, "may" could mandate an action when the context of the statute requires this interpretation.[14] Subsection 127405(e)(4) is located in the statute's section that contains the eligibility criteria for charity care and discounted payments. There are no other provisions in this section—or the rest of the Hospital Fair Pricing Act—suggesting or requiring time limits for patients seeking eligibility for financial assistance. The Legislature could have, but did not, enact specific time periods.

The legislative history of the Subsection 127405(e)(4) shows the Legislature intended to require hospitals to determine patients' eligibility for charity care and discounted payments at any time. Enacted with the purpose to provide "consumer and financial protections so that uninsured and underinsured families can get the hospital care they need without facing financial ruin,"[15] the Hospital Fair Pricing Act was meant to create favorable conditions for the most financially vulnerable patients to qualify for assistance. Only one attempt has been made legislatively to impose specific time periods on applications and eligibility determinations under the Hospital Fair Pricing Act—and that attempt failed.[16]

Allowing patients to apply for financial assistance at any time supports the public policy of protecting patients from financial ruin simply for seeking necessary medical care. The Hospital Fair Pricing Act takes into account both the needs of hospitals to stay financially operable and those of financially vulnerable patients to receive hospital services. Patients are responsible to exercise "reasonable effort to provide the hospital with documentation of income and health benefits coverage."[17] On a parallel track, hospitals may start collection activities 180 days after the date of billing even when patients have not applied for financial assistance.[18] Patients could apply and qualify for financial assistance after this 180-day time period.[19]

Check the financial assistance policies of your local hospitals to determine if they have unlawful time limit provisions for accepting patient applications: https://syfphr.hcai.ca.gov/FacilityList.aspx.

2. **Hospitals must inform patients with written notices about the availability of financial assistance and provide applications for these programs.**

AB 1020 and AB 532 enacted additional procedural safeguards throughout the billing and collections process to ensure patients receive adequate notice about financial assistance and an actual application. Patients are entitled to receive written notice of the availability of financial assistance and charity care throughout the life of a bill: starting at the time of service or discharge, with billing statements, during collections, and at the start of a civil suit.[20] At the latest, hospitals must mail patients this written notice within 72 hours of providing services.[21]

Hospitals must also now automatically provide patients with an application form for financial assistance or charity care whether or not a patient requests one.[22] This application must be provided as part of a hospital's billing statements, including those sent before the hospital assigns an account to collections or sells an account to a debt buyer.[23]

Proof that a patient received both sets of documents—notices and an application—is now required prior to commencing collections and suit. Before a hospital assigns an account to collections or sells an account to a debt buyer, the hospital must provide this application again and proof of when the patient received notice about applying for financial assistance.[24] If a debt collector or debt buyer sues a patient, the complaint must include proof that copies of the notice and application for financial assistance were provided to the patient.[25] A hospital, debt collector, or debt buyer's failure to provide adequate notice and application at the correct times can be used as a complete defense if patients are sued for a bill.

3. **Hospitals are limited in the types of income and asset documentation they can request from patients, and could qualify patients for financial assistance with information they already have.**

Hospitals should be encouraged to qualify patients for charity care and discounted payments with financial information they already have on file or through third-party sources, as suggested by IRS regulations governing non-profit hospitals.[26] This is known as presumptive eligibility determinations, made before patients complete their applications. Just as patients must make reasonable efforts to provide hospitals with documentation of income and health coverage,[27] hospitals, too, must make reasonable efforts to determine if patients are eligible for financial assistance.[28] Presumptively qualifying patients for financial assistance fulfills a non-profit hospital's obligation to make these reasonable efforts. If, however, a hospital must obtain more income and asset information from a patient, the hospital is limited to requesting information described in Health and Safety Code Section 127405(e):

(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.

4. **Hospitals must provide notices and applications in non-English languages. Which languages are covered depends on the population likely to be served by the hospital.**

Federal and state laws on language access apply to hospitals' charity care and discounted payment programs. These laws determine which non-English languages a hospital must translate its financial assistance notices into. The Hospital Fair Pricing Act incorporates the Dymally-Alatorre Bilingual Services Act's formula to translate notices that are spoken by five (5) percent or more of the people served by a hospital.[29] At the same time, hospitals that receive federal funding (which most do in the form of Medicaid and Medicare payments) must follow federal Title VI guidance on language access. Hospitals may adopt the safe harbor guidelines from the U.S. Department of Health and Human Services to translate written notices into all languages that constitute 5% or 1000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered by the hospital.[30] Thus, hospitals can best ensure compliance with these laws by translating charity care and discounted payment policies, notices, and applications into each language group spoken by 5% or 1000 of their existing population and county population.

Few hospitals are currently following these translation requirements. Failure to provide information in the language required can also be a defense to a collection suit.

5. **Even after a patient has paid a bill, a hospital must reimburse the patient if they qualify for charity care or a discounted payment.**

Patients may still apply for charity care or discounted payments after they have paid their hospital bills. As discussed in Section 1, there is no time limit for when a patient may apply for financial assistance. If a patient is found eligible for either program, the hospital must reimburse the patient according to Health and Safety Code Section 127440. A patient's account must be returned from collections or from a debt buyer whenever the patient is found eligible for charity care, discounted payment, or other forms of financial assistance.[31]

6. **Hospitals' financial assistance policies must also comply with Section 501(r) of the Internal Revenue Code (IRC).**

In addition to the Hospital Fair Pricing Act, hospitals must adhere to federal requirements set forth by the IRS for charitable hospitals.[32] When evaluating a hospital's financial assistance policy, it is best to compare it to both sets of rules.

7. **In addition to providing charity care and discounted payments at their hospitals, counties offer their own health programs as required by Welfare and Institutions Code § 17000.**

When a patient is contesting a bill with a county hospital, consider whether the patient might qualify for their county's indigent health program. Welfare and Institutions Code Section 17000 mandates each county "shall relieve and support all incompetent, poor, indigent persons and those incapacitated by age, disease, or accident" when such persons are otherwise not supported.[33] Section 17001 requires each county to "adopt standards of aid and care" for the people who are low income and those who are not able to pay for necessary medical care.[34] County health programs may provide care free of charge or have a sliding fee schedule based on ability to pay.[35]

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Western Center is available to support your evaluation of a hospital's charity care and discounted payment policy and your use of the Hospital Fair Pricing Act to reduce patients' hospital bills. Please contact us so we can help:**; Helen Tran,** htran@wclp.org; **Jen Flory,** jflory@wclp.org**.**

We thank Aris Prince, UCLA School of Law, J.D, 2022, for her contributions to this Practice Tip.

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[1] It is with heavy heart that we remember the original Hospital Fair Pricing Act, AB 774, was authored by no other than former Assemblymember Wilma Chan who died in November 2021 in a fatal car accident. This bill was but just one example of her fearless advocacy on behalf of Californians, particularly in the area of health care.
[2] Health & Safety Code § 127410(c)(5).
[3] Health & Safety Code § 127410 (a)-(b).
[4] Health & Safety Code § 127425 (d).
[5] Health & Safety Code § 127425(f).
[6] Health & Safety § 127425 (a).
[7] Civ. Code § 1788.185.
[8] Civ. Code §§ 1788.14(e) and 1788.185 (debt collectors), and §§ 1788.52(f) and 1788.58(c) (debt buyers).

[9] Health & Safety Code § 127435.
[10] Health & Safety Code § 127436.
[11] Health & Safety Code § 127439.
[12] With the passage of AB 1020, hospitals, debt collectors, and debt buyers now must wait *180 days*—rather than 150 days—after initial billing to commence civil action against patients for nonpayment and report adverse information to credit reporting agencies. Health & Safety Code § 127425(f).
[13] *Coal. of Concerned Communities, Inc. v. City of Los Angeles*, 34 Cal. 4th 733, 737 (2004).
[14] Health & Safety Code §§ 5, 16; *see Lara v. Board of Supervisors*, 50 Cal.App.3d 399, 407 (1978) ("'may' may be construed to be mandatory where the object to be obtained compels such a construction, or where that construction is necessary to give effect to the legislative intent") (citing Health & Safety Code § 16); *Kizer v. Hillhaven, Inc.*, 19 Cal.App.4th 309, 317 (1993) (determining whether the context of a statute requires a mandatory or directory interpretation of "may" requires the court to "ascertain the legislative intent" of the statute, including whether the consequences of interpretation would defeat or promote the purpose of the statute); *Hess Collection Winery v. Agricultural Labor Relations Bd.*, 140 Cal.App.4th 1584, 1607 (2006) ("'may' may be either mandatory or permissive, depending on the circumstances"), disagreed with on other grounds by *Gerawan Farming, Inc. v. Agricultural Labor Relations Bd.*, 236 Cal.App.4th 1024 (2015).
[15] Cal. Assem. Comm. Analysis, A.B. 774, at 11 (April 12, 2005).
[16] S.B. 350, introduced immediately the year after the Legislature passed the Hospital Fair Pricing Act, proposed "a time limit for patients to apply for charity care or discounted payments of 60 days after the date they are initially billed, as well as a time limit for hospitals to make determinations of their eligibility of 120 days after initial billing." Cal. S. Health Comm. Analysis, S.B. 350, at 3 (April 25, 2007). The Senate Health Committee believed "such time limits could harm consumers who may in some cases have valid reasons for not applying for assistance sooner and/or who are already attempting to settle their bills." *Id.* at 4. Concluding "[i]t is not clear that specific time limits for applying and qualifying for charity care and discounted payments are necessary," the Committee rejected this amendment. *Id.* While the Committee did attempt to remove the phrase "at any time" and replace it with "receipt of a timely application," the final version of SB 350 restored the provision back to its original language: "Eligibility for discounted payments or charity care may be determined at any time . . . ." S.B. 350 (version June 28, 2007). SB 350 passed without amending Subsection 127405(e)(4).

Note, the Legislature's rejection of an amendment or bill is not, on its own, conclusive of legislative intent. SB 350 and its deleted time provision is helpful in understanding the meaning of Subsection 127405(e)(4) when used with other tools of statutory interpretation. *See Am. Fin. Servs. Assn. v. City of Oakland*, 34 Cal. 4th 1239, 1261–62, (2005) ("[O]ur prior cases establish that even when the Legislature amends a bill to add

a provision, and then deletes that provision in a subsequent version of the bill, this failure to enact the provision is of little assistance in determining the intent of the Legislature."); *Dyna-Med, Inc. v. Fair Emp. & Hous. Com.*, 43 Cal. 3d 1379, 1396, (1987) ("Similarly inconclusive is the Legislature's rejection of specific provisions which would have expressly allowed the award of damages. Unpassed bills, as evidences of legislative intent, have little value.").

[17] Health & Safety Code § 127405(e).

[18] Health & Safety Code § 127425(f).

[19] Health & Safety Code § 127425(b)

[20] Health & Safety Code §§ 127410(b), 127425(d).

[21] Health & Safety Code § 127410(b).

[22] Health & Safety Code § 1339.585. (amended by AB 532 (passed Oct. 4, 2021) ("This bill would require the hospital to automatically provide the person with an estimate and an application form for financial assistance or charity care, without need for a specific request."))

[23] Health & Safety Code § 127425(e)(5).

[24] Health & Safety Code § 127425(e)(6).

[25] Civil Code §§ 1788.185(b), 1788.58(c)(2).

[26] 26 C.F.R. § 1.50(r)-6(c)(2).

[27] Health & Safety Code § 127405(e).

[28] Health & Safety Code § 127420(a); *see also* 26 C.F.R. § 1.501(r)-6(a) (applying to only non-profit hospitals).

[29] Health & Safety Code § 127410(a) (referencing Insurance Code § 12693.30 and Government Code § 7295).

[30] *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*. 68 Fed. Reg. 47311 (2003), https://www.govinfo.gov/content/pkg/FR-2003-08-08/pdf/03-20179.pdf.

[31] Health & Safety Code § 127425(a)(2).

[32] *See generally* 26 C.F.R. §§ 501(r)(4), (r)(5) & (r)(6) and IRS, Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78954 (Dec. 31, 2014), available at https://www.federalregister.gov/documents/2014/12/31/2014-30525/additional-requirements-for-charitable-hospitals-community-health-needs-assessments-for-charitable.

[33] We recognize the offensive wording and grammatical construction on this statute, which was passed in 1965.

[34] *See Hunt v. Superior Court*, 21 Cal.4th 984, 1013 (1999) (recognizing individuals are entitled to receive health care from their county if they have "insufficient means to pay for subsistence medical care").

[35] Welf. & Inst. Code § 16804.1.