HEALTH AND SAFETY CODE - HSC

DIVISION 107. HEALTH CARE ACCESS AND INFORMATION [127000 - 130079] *(Heading of Division 107 amended by Stats. 2021, Ch. 143, Sec. 28.)*

PART 2. HEALTH POLICY AND PLANNING [127280 - 127697] *(Part 2 added by Stats. 1995, Ch. 415, Sec. 9.)*

CHAPTER 2.5. Fair Pricing Policies [127400 - 127471] *(Chapter 2.5 heading added by Stats. 2010, Ch. 445, Sec. 1.)*

ARTICLE 1. Hospital Fair Pricing Policies [127400 - 127446] *(Heading of Article 1 renumbered from Article 3 (of Chapter 2) by Stats. 2010, Ch. 445, Sec. 2.)*

127400. As used in this article, the following terms have the following meanings:

(a) “Allowance for financially qualified patient” means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the hospital’s charges are imposed on the patient, due to the patient’s determined financial inability to pay the charges.

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

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

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

(2) A patient who has a family income that does not exceed 400 percent of the federal poverty level.

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

(e) “Department” means the Department of Health Care Access and Information.

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

(g) “A patient with high medical costs” means a person whose family income does not exceed 400 percent of the federal poverty level, as defined in subdivision (b). For these purposes, “high medical costs” means any of the following:

(1) Annual out-of-pocket costs incurred by the individual at the hospital that exceed the lesser of 10 percent of the patient’s current family income or family income in the prior 12 months. Out-of-pocket costs means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.

(2) Annual out-of-pocket expenses that exceed 10 percent of the patient’s family income, if the patient provides documentation of the patient’s medical expenses paid by the patient or the patient’s family in the prior 12 months. Out-of-pocket expenses means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.

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

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

(1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not.

(2) For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.

(i) "Reasonable payment plan" means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

(j) "Guarantor" means a person who has legal financial responsibility for the patient's health care services.

(Amended by Stats. 2024, Ch. 511, Sec. 1. (AB 2297) Effective January 1, 2025.)

127400.5. For purposes of this chapter, the following terms have the following meanings:

(a) "Charity care" means free care.

(b) "Discounted payment" or "discount payment" means any charge for care that is reduced but not free.

(Added by Stats. 2024, Ch. 511, Sec. 2. (AB 2297) Effective January 1, 2025.)

127401. (a) The State Department of Public Health shall be responsible for the enforcement of the provisions of this article for violations occurring prior to January 1, 2024. The Department of Health Care Access and Information shall be responsible for the enforcement of the provisions of this article for violations occurring on or after January 1, 2024.

(b) For investigations involving hospital actions required by this article occurring on or after January 1, 2024, the Department of Health Care Access and Information shall also have enforcement authority to assess penalties for violations that occurred on or after January 1, 2022, that arise out of the same investigation. The State Department of Public Health and the Department of Health Care Access and Information shall not impose a penalty for any violation for which the other department has imposed a penalty. Any action brought by the Director of the Department of Health Care Access and Information against a hospital shall not abate by reason of a sale or other transfer of ownership of the hospital that is a party to the action except with the express written consent of the director.

(Amended by Stats. 2024, Ch. 511, Sec. 3. (AB 2297) Effective January 1, 2025.)

127405. (a) (1) (A) Each hospital shall maintain an understandable written policy regarding discount payments for financially qualified patients as well as an understandable written charity care policy. Uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level, as defined in subdivision (b) of Section 127400, shall be eligible for participation under a hospital's charity care policy or discount payment policy. Notwithstanding any other provision of this article, a hospital may choose to grant eligibility for its discount payment policy or charity care policies to patients with incomes over 400 percent of the federal poverty level. Both the charity care policy and the discount payment policy shall state the process used by the hospital to determine whether a patient is eligible for charity care or discounted payment. In the event of a dispute, a patient may seek review from the business manager, chief financial officer, or other appropriate manager as designated in the charity care policy and the discount payment policy.

(B) The written policy regarding discount payments shall also include a statement that an emergency physician, as defined in Section 127450, who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital.

(2) Rural hospitals, as defined in Section 124840, may establish eligibility levels for financial assistance and charity care at less than 400 percent of the federal poverty level as appropriate to maintain their financial and operational integrity.

(b) (1) A hospital's discount payment policy and charity care policy shall clearly state eligibility criteria based upon income consistent with the application of the federal poverty level. In determining eligibility under its discount payment policy or charity care policy, a hospital shall not consider the monetary assets of the patient.

(2) A hospital shall not require a patient to apply for Medicare, Medi-Cal, or other coverage before the patient is screened for, or provided, discount payment. When screening for eligibility for discount payment, a hospital may require the patient to participate in a screening for Medi-Cal eligibility.

(c) A discount payment policy shall include an extended payment plan to allow payment of the discounted price over time. The policy shall provide that the hospital and the patient shall negotiate the terms of the payment plan, and take into consideration the patient's family income and essential living expenses. A hospital may also consider the availability of a patient's health savings account held

by the patient or the patient's family. If the hospital and the patient cannot agree on the payment plan, the hospital shall use the formula described in subdivision (i) of Section 127400 to create a reasonable payment plan.

(d) (1) A hospital shall limit expected payment for services it provides to a patient at or below 400 percent of the federal poverty level, as defined in subdivision (b) of Section 127400, eligible under its discount payment policy to the amount of payment the hospital would expect, in good faith, to receive for providing services from Medicare or Medi-Cal, whichever is greater. If the hospital provides a service for which there is no established payment by Medicare or Medi-Cal, the hospital shall establish an appropriate discounted payment. Patients eligible under this article shall not be required to undergo an independent dispute resolution process.

(2) The hospital may require a patient or guarantor to pay the hospital the entire amount of any reimbursement sent directly to the patient or guarantor by a third-party payer for that hospital's services.

(3) If the patient receives a legal settlement, judgment, or award under a liable third party action that includes payment for health care services or medical care related to the injury, the hospital may require the patient or guarantor to reimburse the hospital for the related health care services rendered up to the amount reasonably awarded for that purpose.

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

(1) For purposes of determining eligibility for discounted payment or charity care, documentation of income shall be limited to recent pay stubs or income tax returns. The hospital may accept other forms of documentation of income but shall not require those other forms. If a patient does not submit an application or documentation of income, a hospital may presumptively determine that a patient is eligible for charity care or discounted payment based on information other than that provided by the patient or based on a prior eligibility determination.

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

(3) Eligibility for discounted payments or charity care shall be determined at any time the hospital is in receipt of information specified in paragraph (1). A hospital shall not impose time limits for applying for charity care or discounted payments, nor deny eligibility based on the timing of a patient's application.

(f) (1) A hospital may waive or reduce Medi-Cal and Medicare cost-sharing amounts as part of its charity care program or discount payment program.

(2) In waiving or reducing Medicare cost-sharing amounts, the hospital may consider the patient's monetary assets to the extent required for the hospital to be reimbursed under the Medicare program for Medicare bad debt without seeking to collect cost-sharing amounts from the patient as required by federal law, including, but not limited to, Section 413.89 of Title 42 of the Code of Federal Regulations. Monetary assets include only assets that are convertible to cash and do not include retirement or deferred compensation plans qualified under the Internal Revenue Code, nonqualified deferred compensation plans, or assets below the maximum community spouse resource allowance under Section 1396r–5(d) of Title 42 of the United States Code.

(Amended by Stats. 2024, Ch. 511, Sec. 4. (AB 2297) Effective January 1, 2025.)

127410. (a) Each hospital shall provide patients with a written notice that shall contain information about availability of the hospital's discount payment and charity care policies, including information about eligibility, as well as contact information for a hospital employee or office from which the person may obtain further information about these policies. The notice shall also include the internet address for the Health Consumer Alliance (https://healthconsumer.org), and shall explain that there are organizations that will help the patient understand the billing and payment process, as well as information regarding Covered California and Medi-Cal presumptive eligibility, if the hospital participates in the presumptive eligibility program. The notice shall also include the internet address for the hospital's list of shoppable services, pursuant to Section 180.60 of Title 45 of the Code of Federal Regulations. This written notice shall be provided in addition to the estimate provided pursuant to Section 1339.585. The notice shall also be provided to patients who receive emergency or outpatient care and who may be billed for that care, but who were not admitted. The notice shall be provided in English, and in languages other than English. The languages to be provided shall be determined in a manner similar to that required pursuant to Section 12693.30 of the Insurance Code. Written correspondence to the patient required by this article shall also be in the language spoken by the patient, consistent with Section 12693.30 of the Insurance Code and applicable state and federal law.

(b) The written notice shall be provided at the time of service if the patient is conscious and able to receive written notice at that time. If the patient is not able to receive notice at the time of service, the notice shall be provided during the discharge process. If the

patient is not admitted, the written notice shall be provided when the patient leaves the facility. If the patient leaves the facility without receiving the written notice, the hospital shall mail the notice to the patient within 72 hours of providing services.

(c) Notice of the hospital's policy for financially qualified and self-pay patients shall be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to, all of the following:

(1) Emergency department, if any.

(2) Billing office.

(3) Admissions office.

(4) Other outpatient settings, including observation units.

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

(Amended by Stats. 2021, Ch. 473, Sec. 8.5. (AB 1020) Effective January 1, 2022.)

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

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

(2) Medicare.

(3) The Medi-Cal program, the California Children's Services program, or other state-funded programs designed to provide health coverage.

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

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

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

(3) A statement that, if the consumer does not have health insurance coverage, the consumer may be eligible for Medicare, Medi-Cal, coverage offered through the California Health Benefit Exchange, California Children's Services program, other state- or county-funded health coverage, or charity care.

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

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

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

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

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

(Amended by Stats. 2021, Ch. 473, Sec. 9. (AB 1020) Effective January 1, 2022.)

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

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

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

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

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

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

(b) A hospital shall have a written policy about when and under whose authority patient debt is advanced for collection, whether the collection activity is conducted by the hospital, an affiliate or subsidiary of the hospital, or by an external collection agency, or debt buyer.

(c) A hospital shall establish a written policy defining standards and practices for the collection of debt, and shall obtain a written agreement from any agency that collects hospital receivables that it will adhere to the hospital's standards and scope of practices. This agreement shall require the affiliate, subsidiary, debt buyer, or external collection agency of the hospital that collects the debt to comply with the hospital's definition and application of a reasonable payment plan, as defined in subdivision (i) of Section 127400. The policy shall not conflict with other applicable laws and shall not be construed to create a joint venture between the hospital and the external entity, or otherwise to allow hospital governance of an external entity that collects hospital receivables. In determining the amount of a debt a hospital may seek to recover from patients who are eligible under the hospital's charity care policy or discount payment policy, the hospital may consider only income as limited by Section 127405.

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

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

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

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

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

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

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

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

(f) A hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency or debt buyer, shall not do either of the following:

(1) Report adverse information to a consumer credit reporting agency.

(2) Commence civil action against the patient for nonpayment before 180 days after initial billing.

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

(h) (1) The hospital or other assignee that is an affiliate or subsidiary of the hospital shall not, in dealing with patients eligible under the hospital's charity care or discount payment policies, use wage garnishments or liens on any real property as a means of collecting unpaid hospital bills.

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

(A) A wage garnishment, except by order of the court upon noticed motion, supported by a declaration filed by the movant identifying the basis for which it believes that the patient has the ability to make payments on the judgment under the wage garnishment, which the court shall consider in light of the size of the judgment and additional information provided by the patient before or at the hearing concerning the patient's ability to pay, including information about probable future medical expenses based on the current condition of the patient and other obligations of the patient.

(B) Notice or conduct a sale of any real property owned, in part or completely, by the patient.

(C) Liens on any real property.

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

(i) Extended payment plans offered by a hospital to assist patients eligible under the hospital's charity care policy, discount payment policy, or any other policy adopted by the hospital for assisting low-income patients with no insurance or high medical costs in settling outstanding past due hospital bills, shall be interest free. The hospital extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during a 90-day period. Before declaring the hospital extended payment plan no longer operative, the hospital, collection agency, debt buyer, or assignee shall make a reasonable attempt to contact the patient by telephone and, to give notice in writing, that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. Before the hospital extended payment plan being declared inoperative, the hospital, collection agency, debt buyer, or assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The hospital, collection agency, debt buyer, or assignee shall not commence a civil action against the patient or responsible party for nonpayment before the time the extended payment plan is declared to be no longer operative. For purposes of this section, the notice and telephone call to the patient may be made to the last known telephone number and address of the patient.

(j) (1) A hospital shall maintain all records relating to money owed to the hospital by a patient or a patient's guarantor for five years, including, but not limited to, all of the following:

(A) Documents related to litigation filed by the hospital.

(B) A contract and significant related records by which a hospital assigns or sells medical debt to a third party.

(C) A list, updated at least annually, of every person, including the person's name and contact information, that meets at least one of the following criteria:

(i) The person is a debt collector to whom the hospital sold or assigned a debt that a patient of the hospital owed the hospital.

(ii) The person is retained by the hospital to pursue litigation for debts owed by patients on behalf of the hospital.

(2) Any contract entered into by a hospital related to the assignment or sale of medical debt shall require the assignee or buyer and any subsequent assignee or buyer to maintain records related to litigation for five years.

(3) For purposes of this subdivision, "debt collector" and "person" have the same meanings as defined in Section 1788.2 of the Civil Code.

(k) This section does not diminish or eliminate any protections consumers have under existing federal and state debt collection laws, or any other consumer protections available under state or federal law. If the patient fails to make all consecutive payments for 90 days and fails to renegotiate a payment plan, this subdivision does not limit or alter the obligation of the patient to make payments on the obligation owing to the hospital pursuant to any contract or applicable statute from the date that the extended payment plan is declared no longer operative, as set forth in subdivision (i).

(Amended by Stats. 2024, Ch. 520, Sec. 10.5. (SB 1061) Effective January 1, 2025.)

127426. (a) The period described in Section 127425 shall be extended if the patient has a pending appeal for coverage of the services, until a final determination of that appeal is made, if the patient makes a reasonable effort to communicate with the hospital about the progress of any pending appeals.

(b) For purposes of this section, “pending appeal” includes any of the following:

(1) A grievance against a contracting health care service plan, as described in Chapter 2.2 (commencing with Section 1340) of Division 2, or against an insurer, as described in Chapter 1 (commencing with Section 10110) of Part 2 of Division 2 of the Insurance Code.

(2) An independent medical review, as described in Section 10145.3 or 10169 of the Insurance Code.

(3) A fair hearing for a review of a Medi-Cal claim pursuant to Section 10950 of the Welfare and Institutions Code.

(4) An appeal regarding Medicare coverage consistent with federal law and regulations.

(Added by Stats. 2006, Ch. 755, Sec. 1. Effective January 1, 2007.)

127430. (a) Prior to commencing collection activities against a patient, the hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall provide the patient with a clear and conspicuous written notice containing both of the following:

(1) A plain language summary of the patient’s rights pursuant to this article, the Rosenthal Fair Debt Collection Practices Act (Title 1.6C (commencing with Section 1788) of Part 4 of Division 3 of the Civil Code), and the federal Fair Debt Collection Practices Act (Subchapter V (commencing with Section 1692) of Chapter 41 of Title 15 of the United States Code). The summary shall include a statement that the Federal Trade Commission enforces the federal act.

The summary shall be sufficient if it appears in substantially the following form: “State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov.”

(2) A statement that nonprofit credit counseling services may be available in the area.

(b) The notice required by subdivision (a) shall also accompany any document indicating that the commencement of collection activities may occur.

(c) The requirements of this section shall apply to the entity engaged in the collection activities. If a hospital assigns or sells the debt to another entity, the obligations shall apply to the entity, including a collection agency, engaged in the debt collection activity.

(Amended by Stats. 2007, Ch. 347, Sec. 4. Effective January 1, 2008.)

127435. (a) A hospital shall provide to the department a copy of its discount payment policy, charity care policy, eligibility procedures for those policies, review process, and the application for charity care or discounted payment programs, as well as a copy of its debt collection policy. The department may determine whether the information is to be provided electronically or in some other similar manner. The information shall be provided at least biennially on January 1, or when a significant change is made. If no significant change has been made by the hospital since the information was previously provided, notifying the department of the lack of change shall meet the requirements of this section. The department shall make this information available to the public on its internet website.

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

(c) A patient shall not be denied financial assistance that would be available pursuant to the policy published on the department’s internet website at the time the patient was first billed.

(Amended by Stats. 2024, Ch. 511, Sec. 6. (AB 2297) Effective January 1, 2025.)

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

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

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

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

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

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

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

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

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

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

(E) The demonstrated willfulness of the violation.

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

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

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

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

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

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

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

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

(4) The department shall consider all relevant evidence.

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

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

(Amended by Stats. 2024, Ch. 511, Sec. 7. (AB 2297) Effective January 1, 2025.)

127440. (a) The hospital shall reimburse the patient or patients any amount actually paid in excess of the amount due under this article, including interest. Interest owed by the hospital to the patient shall accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date payment by the patient is received by the hospital. However, a hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars ($5.00). The hospital shall refund the patient within 30 days.

(b) The hospital may reimburse the patient, but is not required to do so, if the hospital or the department determines that a patient qualified for financial assistance at the time the patient was first billed and either of the following has occurred:

(1) It has been five years or more since the last payment to the hospital, hospital assignee, or debt buyer.

(2) The patient debt was sold to a debt buyer in accordance with state law in effect at the time the debt was sold, if sold before January 1, 2022.

(c) This section does not diminish or eliminate any rights or responsibilities a hospital may have, nor any rights that a patient may have under existing federal and state laws, including, but not limited to, 26 CFR Sec. 1.501(r)-6.

(Amended by Stats. 2024, Ch. 511, Sec. 8. (AB 2297) Effective January 1, 2025.)

127443. The rights, remedies, and penalties established by this article are cumulative, and shall not supersede the rights, remedies, or penalties established under other laws.

(Added by Stats. 2006, Ch. 755, Sec. 1. Effective January 1, 2007.)

127444. (a) This article does not prohibit a hospital from uniformly imposing charges from its established charge schedule or published rates or preclude the recognition of a hospital's established charge schedule or published rates for purposes of applying any payment limit, interim payment amount, or other payment calculation based upon a hospital's rates or charges under the Medi-Cal program, the Medicare Program, workers' compensation, or other federal, state, or local public program of health benefits.

(b) This article does not prohibit a hospital, debt collector, or debt buyer from selling or otherwise transferring patient debt to an organization that is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code for the explicit purpose of the tax-exempt organization abolishing the patient debt by cancellation of the indebtedness, or otherwise prohibit payment of the patient's debt by a third party.

(c) A health care service plan, insurer, or any other person shall not reduce the amount it would otherwise reimburse a claim for hospital services because a hospital has waived, or will waive, collection of all or a portion of a patient's bill for hospital services in accordance with the hospital's charity care or discount payment policy, notwithstanding any contractual provision.

(Amended by Stats. 2021, Ch. 473, Sec. 14. (AB 1020) Effective January 1, 2022.)

127445. Notwithstanding any other provision of law, the amounts paid by parties for services resulting from reduced or waived charges under a hospital's discounted payment or charity care policy shall not constitute a hospital's uniform, published, prevailing, or customary charges, its usual fees to the general public, or its charges to non-Medi-Cal purchasers under comparable circumstances, and shall not be used to calculate a hospital's median non-Medicare or Medi-Cal charges, for purposes of any payment limit under the federal Medicare Program, the Medi-Cal program, or any other federal or state-financed health care program.

(Added by Stats. 2006, Ch. 755, Sec. 1. Effective January 1, 2007.)

127446. To the extent that any requirement of Section 127400, 127401, or 127405 results in a federal determination that a hospital's established charge schedule or published rates are not the hospital's customary or prevailing charges for services, the requirement in question shall be inoperative for all general acute care hospitals, including, but not limited to, a hospital that is licensed to and operated by a county or a hospital authority established pursuant to Section 101850. The State Department of Public Health shall seek federal guidance regarding modifications to the requirement in question. All other requirements of this article shall remain in effect.

(Amended by Stats. 2007, Ch. 483, Sec. 36. Effective January 1, 2008.)