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 2. Emergency Physician Fair Pricing Policies [127450 - 127462] *(Article 2 added by Stats. 2010, Ch. 445, Sec. 4.)*

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

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

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

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

(d) “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.

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

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

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

(f) “Hospital” means a facility that is required to be licensed under subdivision (a) 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.

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

(h) “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 emergency physician. Self-pay patients may include charity care patients.

(i) “A patient with high medical costs” means a person whose family income does not exceed 400 percent of the federal poverty level if that individual does not receive a discounted rate from the emergency physician as a result of their third-party coverage. 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 provided emergency care that exceed 10 percent of the patient’s 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. The emergency physician may waive the request for documentation.

(3) A lower level determined by the emergency physician in accordance with the emergency physician's discounted payment policy.

(j) "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.

(k) "Reasonable payment formula" 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 all 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.

(Amended by Stats. 2024, Ch. 511, Sec. 9. (AB 2297) Effective January 1, 2025.)

127451. A violation of this article shall not constitute a violation of the terms of a physician and surgeon's licensure.

(Added by Stats. 2010, Ch. 445, Sec. 4. (AB 1503) Effective January 1, 2011.)

127452. (a) Uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level shall be eligible to apply to an emergency physician for a discount payment pursuant to a discount payment policy. Notwithstanding any other provision of this article, an emergency physician may choose to grant eligibility for a discount payment policy to patients with incomes over 400 percent of the federal poverty level.

(b) An emergency physician shall limit expected payment for services provided to a patient at or below 400 percent of the federal poverty level and who is eligible under the emergency physician's discount payment policy to an amount that is no greater than 50 percent of the median of billed charges based on a nationally recognized database of physician and surgeon charges until the nonprofit FAIR Health, Inc. creates a database that makes available the rate of payment received by physician and surgeons from commercial insurers for the same services in the same or similar geographic region. When FAIR Health, Inc. makes available the rate of payment received by physicians and surgeons from commercial insurers for the same services in the same or similar geographic region, the amount of expected payment under this section shall be no greater than the median or average of rates paid by commercial insurers for the same or similar services in the same or similar geographic region.

(c) (1) If an emergency physician seeks reimbursement from the Maddy Fund pursuant to Section 1797.98c, then the emergency physician shall, at that time, cease any further billing or collection activity for that patient.

(2) If the emergency physician does not receive reimbursement from the Maddy Fund after attempting to obtain reimbursement from the Maddy Fund, then the provisions of this article shall apply.

(3) If the emergency physician does not attempt to seek reimbursement from the Maddy Fund, the provisions of this article shall apply.

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

(1) For purposes of determining eligibility for discounted payment, the emergency physician may rely on the determination made by the hospital at which emergency care was provided. If the emergency physician chooses to make a separate determination of eligibility for discounted payment, documentation of income shall be limited to recent pay stubs or income tax returns. The emergency physician, at their discretion, may accept self-attestation by a patient, or a patient's legal representative, but shall not request documentation of income other than that authorized in this paragraph.

(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 emergency physician, collection agency, or assignee independent of the eligibility process for discounted payment.

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

(e) An emergency physician may waive or reduce Medi-Cal and Medicare cost-sharing amounts as part of their discount payment program.

(Amended by Stats. 2024, Ch. 511, Sec. 10. (AB 2297) Effective January 1, 2025.)

127454. (a) Each emergency physician shall make all reasonable efforts 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 emergency care rendered by the emergency physician 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 Healthy Families Program, the California Children's Services program, or other state- or county-funded programs designed to provide comprehensive health coverage.

(b) If the emergency physician or his or her representative 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 emergency physician 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 emergency physician.

(2) A request that the patient inform the emergency physician if the patient has health insurance coverage, Medicare, Healthy Families Program, 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, Healthy Families Program, Medi-Cal, coverage through the California Health Benefit Exchange, California Children's Services program, other state- or county-funded health coverage, or discounted payment care.

(4) Information regarding the financially qualified patient and discounted payment 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. That statement shall also provide patients with a referral to a local consumer assistance center housed at legal services offices.

(B) The name and telephone number of the emergency physician's employee or office from whom or which the patient may obtain information about the emergency physician's discount payment policy, 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 he or she applies for charity care or a discount payment program, neither application shall preclude eligibility for the other program.

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

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

(Amended by Stats. 2014, Ch. 758, Sec. 6. (SB 1276) Effective January 1, 2015.)

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

(b) Each emergency physician 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 emergency physician receivables that it will adhere to the emergency

physician's standards and scope of practice. This agreement shall require the affiliate, subsidiary, or external collection agency of the physician that collects the debt to comply with the physician's definition and application of a reasonable payment formula, as defined in subdivision (k) of Section 127450. The policy shall not conflict with other applicable laws and shall not be construed to create a joint venture between the emergency physician and the external entity, or otherwise to allow physician and surgeon governance of an external entity that collects physician and surgeon receivables. In determining the amount of a debt the emergency physician may seek to recover from patients who are eligible under the emergency physician's charity care policy or discount payment policy, the emergency physician may consider only income as limited by Section 127452.

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

(d) If a patient is attempting to qualify for eligibility under the emergency physician's discount payment policy and is attempting in good faith to settle an outstanding bill with the physician and surgeon by negotiating an extended payment plan, the emergency physician or their assignee, including a collection agency, shall not report adverse information to a consumer credit agency or commence a civil action.

(e) (1) The emergency physician or other assignee shall not, in dealing with patients eligible under the emergency physician's discount payment policies, use wage garnishments or liens on any real property as a means of collecting unpaid emergency physician bills.

(2) A collection agency or other assignee shall not, in dealing with any patient under the emergency physician's discount payment policy, use as a means of collecting unpaid emergency physician 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 its belief that the patient has the ability to make payments on the judgment under the wage garnishment, that 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 the emergency physician, collection agency, or other assignee from pursuing reimbursement and any enforcement remedy or remedies from third-party liability settlements, tortfeasors, or other legally responsible parties.

(f) Extended payment plans offered by an emergency physician to assist patients eligible under the emergency physician's discount payment policy or any other policy adopted by the emergency physician for assisting low-income patients with no insurance or high medical costs in settling outstanding past due emergency physician bills, shall be interest free. The emergency physician's 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 emergency physician's extended payment plan no longer operative, the emergency physician, collection agency, or assignee shall make a reasonable attempt to contact the patient by telephone, if the telephone number is known, 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 emergency physician's extended payment plan being declared inoperative, the emergency physician, collection agency, or assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. If the patient wishes to renegotiate the terms of the defaulted extended payment plan but no agreement can be reached on the amount of the payment, the emergency physician or their assignee shall apply the reasonable payment formula in subdivision (k) of Section 127450 to determine a monthly payment amount for a subsequent extended payment plan. If the reasonable payment formula would result in a payment of less than ten dollars ($10) a month, the subsequent extended payment plan shall be ten dollars ($10) per month. The emergency physician, collection agency, or assignee shall not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment before the time the extended payment plan is declared to be no longer operative. If after having defaulted on an extended payment plan the patient has entered into another extended payment plan with payments in the amount of either the reasonable payment formula or ten dollars ($10) per month and the patient fails to make all consecutive payments due during a 90-day period, that extended payment plan is inoperative. 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.

(g) For purposes of determining the reasonable payment formula in subdivision (k) of Section 127450, the emergency physician or their assignee may rely on the determination of family income and essential living expenses made by the hospital at which emergency care was provided. The emergency physician or their assignee, at their discretion, may accept self-attestation of family income and essential living expenses by a patient or a patient's legal representative.

(h) This section shall not be construed to 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 emergency physician 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 (f).

(Amended by Stats. 2024, Ch. 511, Sec. 11. (AB 2297) Effective January 1, 2025.)

127456. (a) The period described in Section 127455 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 emergency physician 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. 2010, Ch. 445, Sec. 4. (AB 1503) Effective January 1, 2011.)

127457. (a) After the period described in Section 127455, and upon the completion of appeals consistent with Section 127456, prior to commencing further collection activities against a patient, the emergency physician, any assignee of the emergency physician, or other owner of the patient debt, including a collection agency, shall not report adverse information to a consumer credit reporting agency or commence a civil action, until after the patient has been provided 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 a.m. or after 9 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 reporting adverse information to a consumer credit reporting agency or commencing a civil action against the patient. If an emergency physician 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.

(Added by Stats. 2010, Ch. 445, Sec. 4. (AB 1503) Effective January 1, 2011.)

127458. The emergency physician 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 emergency physician 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 emergency physician. However, an emergency physician is not required to reimburse the patient or pay interest if the amount due is less than five dollars ($5). The emergency physician shall give the patient a credit for the amount due for at least 60 days from the date the amount is due.

(Added by Stats. 2010, Ch. 445, Sec. 4. (AB 1503) Effective January 1, 2011.)

127459. 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. 2010, Ch. 445, Sec. 4. (AB 1503) Effective January 1, 2011.)

127460. Nothing in this article shall be construed to prohibit the emergency physician from uniformly imposing charges from its established charge schedule or published rates, nor shall this article preclude the recognition of an emergency physician's established charge schedule or published rates for purposes of applying any payment limit, interim payment amount, or other payment calculation based upon an emergency physician'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. No health care service plan, insurer, or any other person shall reduce the amount it would otherwise reimburse a claim for emergency physician services because an emergency physician has waived, or will waive, collection of all or a portion of a patient's bill for emergency physician services in accordance with the emergency physician's discount payment policy, notwithstanding any contractual provision.

(Added by Stats. 2010, Ch. 445, Sec. 4. (AB 1503) Effective January 1, 2011.)

127461. Notwithstanding any other provision of law, the amounts paid by parties for services resulting from reduced or waived charges under an emergency physician's discounted payment policy shall not constitute an emergency physician'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 an emergency physician's median non-Medicare or non-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. 2010, Ch. 445, Sec. 4. (AB 1503) Effective January 1, 2011.)

127462. To the extent that any requirement of this article results in a federal determination that an emergency physician's established charge schedule or published rates are not the physician and surgeon's customary or prevailing charges for services, the requirement in question shall be inoperative for all emergency physicians. 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.

(Added by Stats. 2010, Ch. 445, Sec. 4. (AB 1503) Effective January 1, 2011.)