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SB-1061 Consumer debt: medical debt. (2023-2024)

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Senate Bill No. 1061

CHAPTER 520

An act to amend Sections 1785.3, 1785.13, 1786.18, and 1788.14 of, and to add Sections 1785.20.6 and 1785.27 to, the Civil Code, to amend Sections 1371.56, 1371.9, 1797.233, and 127425 of the Health and Safety Code, and to amend Sections 10112.8 and 10126.66 of, and to add Section 10112.75 to, the Insurance Code, relating to consumer debt.

[Approved by Governor September 24, 2024. Filed with Secretary of State September 24, 2024.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1061, Limón. Consumer debt: medical debt.

Existing law, the Consumer Credit Reporting Agencies Act, defines and regulates consumer credit reports and consumer credit reporting agencies. The act prohibits a consumer credit reporting agency from making any consumer credit report containing specified items of information, including accounts placed for collection or charged to profit and loss that antedate the report by more than 7 years. Existing law, the Investigative Consumer Reporting Agencies Act, defines and regulates investigative consumer reports and investigative consumer reporting agencies. The act prohibits an investigative consumer reporting agency from making or furnishing any investigative consumer report containing specified items of information, including accounts placed for collection or charged to profit and loss that antedate the report by more than 7 years.

This bill would prohibit a consumer credit reporting agency or an investigative consumer reporting agency from making a consumer credit report or an investigative consumer report containing information about medical debt, as defined. The bill would prohibit a person who uses a consumer credit report in connection with a credit transaction from using medical debt listed on the report as a negative factor when making a credit decision. The bill would prohibit a person from furnishing information regarding a medical debt to a consumer credit reporting agency, make a medical debt void and unenforceable if a person knowingly violates this provision by furnishing information regarding the medical debt to a consumer credit reporting agency, require a contract creating a medical debt entered into on or after July 1, 2025, to include a term describing these requirements, as specified, and make a violation of these provisions by a person holding a license or permit issued by the state to be deemed to be a violation of the law governing that license or permit. By providing that a violation of these provisions is deemed a violation of a licensing statute, and because the violation of some licensing statutes is a crime, this bill would impose a state-mandated local program.

Existing law requires the Department of Health Care Access and Information to review a hospital's policies regarding, among other things, charity care or debt collection for compliance with the law whenever a significant change is made and submitted to the department, as specified. Existing law, among other things, prohibits a hospital from selling patient debt to a specified debt buyer unless several conditions are met and requires a hospital to have a written policy concerning patient debt, as specified.

This bill would require a hospital to maintain all records relating to money owed to the hospital by a patient or a patient's guarantor, as specified. The bill would require any contract entered into by a hospital related to the assignment or sale of medical

debt to require the assignee or buyer and any subsequent assignee or buyer to maintain records related to litigation for 5 years.

Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes a noncontracting individual health professional to advance to collections only the in-network cost-sharing amount that an insured has failed to pay, and prohibits reporting adverse information to a consumer credit reporting agency for a minimum of 150 days after the initial billing to the insured.

This bill would require a health insurer to send notices, with specified information, to an insured and provider if the insurer sends payment directly to the insured and not to the provider for services provided. If the provider does not receive the payment from the insured within 60 days of the notice to the insured, or within one year after initial billing for the service, whichever is later, the bill would authorize the insurer's share of cost in possession of the insured that has not been paid to the provider to be reported to a credit reporting agency as medical debt.

This bill would incorporate additional changes to Section 1788.14 of the Civil Code proposed by SB 1286 to be operative only if this bill and SB 1286 are enacted and this bill is enacted last, and to Section 127425 of the Health and Safety Code proposed by AB 2297 to be operative only if this bill and AB 2297 are enacted and this bill is enacted last.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1785.3 of the Civil Code is amended to read:

1785.3. The following terms as used in this title have the meaning expressed in this section:

(a) "Adverse action" means a denial or revocation of credit, a change in the terms of an existing credit arrangement which is adverse to the interests of the consumer, or a refusal to grant credit in substantially the amount or on substantially the terms requested. "Adverse action" includes all of the following:

(1) Any denial of, increase in any charge for, or reduction in the amount of, insurance for personal, family, or household purposes made in connection with the underwriting of insurance.

(2) Any denial of employment or any other decision made for employment purposes which adversely affects any current or prospective employee.

(3) Any action taken, or determination made, with respect to a consumer (A) for an application for an extension of credit, or an application for the hiring of a dwelling unit, and (B) that is adverse to the interests of the consumer.

"Adverse action" does not include (A) a refusal to extend additional credit to a consumer under an existing credit arrangement if (i) the applicant is delinquent or otherwise in default under that credit arrangement or (ii) the additional credit would exceed a credit limit previously established for the consumer or (B) a refusal or failure to authorize an account transaction at a point of sale.

(b) "Consumer" means a natural individual.

(c) "Consumer credit report" means any written, oral, or other communication of any information by a consumer credit reporting agency bearing on a consumer's credit worthiness, credit standing, or credit capacity, which is used or is expected to be used, or collected in whole or in part, for the purpose of serving as a factor in establishing the consumer's eligibility for: (1) credit to be used primarily for personal, family, or household purposes, or (2) employment purposes, or (3) hiring of a dwelling unit, as defined in subdivision (c) of Section 1940, or (4) other purposes authorized in Section 1785.11.

The term does not include (1) any report containing information solely as to transactions or experiences between the consumer and the person making the report, (2) any communication of that information or information from a credit application by a consumer that is internal within the organization that is the person making the report or that is made to an entity owned by, or affiliated by corporate control with, that person; provided that the consumer is informed by means of a clear and conspicuous written disclosure that information contained in the credit application may be provided to these persons; however, where a credit application is taken by telephone, disclosure shall initially be given orally at the time the application is taken, and a clear and conspicuous written disclosure shall be made to the consumer in the first written communication to that consumer after the application is taken, (3) any authorization or approval of a specific extension of credit directly or indirectly by the issuer of a credit card or similar device, (4) any report by a person conveying a decision whether to make a specific extension of credit directly or

indirectly to a consumer in response to a request by a third party, if the third party advises the consumer of the name and address of the person to whom the request was made and the person makes the disclosures to the consumer required under Section 1785.20, (5) any report containing information solely on a consumer's character, general reputation, personal characteristics, or mode of living which is obtained through personal interviews with neighbors, friends, or associates of the consumer reported on, or others with whom the consumer is acquainted or who may have knowledge concerning those items of information, (6) any communication about a consumer in connection with a credit transaction which is not initiated by the consumer, between persons who are affiliated (as defined in Section 150 of the Corporations Code) by common ownership or common corporate control (as defined by Section 160 of the Corporations Code), if either of those persons has complied with paragraph (2) of subdivision (b) of Section 1785.20.1 with respect to a prequalifying report from which the information communicated is taken and provided the consumer has consented to the provision and use of the prequalifying report in writing, or (7) any consumer credit report furnished for use in connection with a transaction which consists of an extension of credit to be used solely for a commercial purpose.

(d) "Consumer credit reporting agency" means any person who, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the business of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer credit reports to third parties, but does not include any governmental agency whose records are maintained primarily for traffic safety, law enforcement, or licensing purposes.

(e) "Credit transaction that is not initiated by the consumer" does not include the use of a consumer credit report by an assignee for collection or by a person with which the consumer has an account for purposes of (1) reviewing the account or (2) collecting the account. For purposes of this subdivision, "reviewing the account" includes activities related to account maintenance and monitoring, credit line increases, and account upgrades and enhancements.

(f) "Employment purposes," when used in connection with a consumer credit report, means a report used for the purpose of evaluating a consumer for employment, promotion, reassignment, or retention as an employee.

(g) "File," when used in connection with information on any consumer, means all of the information on that consumer recorded and retained by a consumer credit reporting agency, regardless of how the information is stored.

(h) "Firm offer of credit" means any offer of credit to a consumer that will be honored if, based on information in a consumer credit report on the consumer and other information bearing on the creditworthiness of the consumer, the consumer is determined to meet the criteria used to select the consumer for the offer and the consumer is able to provide any real property collateral specified in the offer. For purposes of this subdivision, the phrase "other information bearing on the creditworthiness of the consumer" means information that the person making the offer is permitted to consider pursuant to any rule, regulation, or formal written policy statement relating to the federal Fair Credit Reporting Act, as amended (15 U.S.C. Sec. 1681 et seq.), promulgated by the Federal Trade Commission or any federal bank regulatory agency.

(i) "Item of information" means any of one or more informative entries in a credit report which causes a creditor to deny credit to an applicant or increase the cost of credit to an applicant or deny an applicant a checking account with a bank or other financial institution.

(j) (1) "Medical debt" means a debt owed by a consumer to a person whose primary business is providing medical services, products, or devices, or to the person's agent or assignee, for the provision of medical services, products, or devices. Medical debt includes, but is not limited to, medical bills that are not past due or that have been paid.

(2) For the purposes of this subdivision, "medical service, product, or device" does not include cosmetic surgery, as defined in Section 1367.63 of the Health and Safety Code, and includes, but is not limited to, all of the following:

(A) Any service, drug, medication, product, or device sold, offered, or provided to a patient by either of the following:

(i) A person or facility licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code, except for Chapters 3.35 (commencing with Section 1596.60) to 3.65 (commencing with Section 1597.70), inclusive, of that division.

(ii) A person licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, except for Chapter 11 (commencing with Section 4800) of that division.

(B) Initial or subsequent reconstructive surgeries, as defined in Section 1367.63 of the Health and Safety Code, and followup care deemed necessary by the attending physician and surgeon.

(C) Initial or subsequent prosthetic devices, as defined in Section 1367.635 of the Health and Safety Code, and followup care deemed necessary by the attending physician and surgeon.

(D) A mastectomy, as defined in Section 1367.635 of the Health and Safety Code.

(k) "Person" means any individual, partnership, corporation, trust, estate, cooperative, association, government or governmental subdivision or agency, or other entity.

(l) "Prequalifying report" means a report containing the limited information permitted under paragraph (2) of subdivision (b) of Section 1785.11.

(m) "State or local child support enforcement agency" means the Department of Child Support Services or local child support agency acting pursuant to Division 17 (commencing with Section 17000) of the Family Code to establish, enforce or modify child support obligations, and any state or local agency or official that succeeds to these responsibilities under a successor statute.

SEC. 2. Section 1785.13 of the Civil Code is amended to read:

1785.13. (a) No consumer credit reporting agency shall make any consumer credit report containing any of the following items of information:

(1) Bankruptcies that, from the date of the order for relief, antedate the report by more than 10 years.

(2) Suits and judgments that, from the date of entry or renewal, antedate the report by more than seven years or until the governing statute of limitations has expired, whichever is the longer period.

(3) Unlawful detainer actions, unless the lessor was the prevailing party. For purposes of this paragraph, the lessor shall be deemed to be the prevailing party only if (A) final judgment was awarded to the lessor (i) upon entry of the tenant's default, (ii) upon the granting of the lessor's motion for summary judgment, or (iii) following trial, or (B) the action was resolved by a written settlement agreement between the parties that states that the unlawful detainer action may be reported. In any other instance in which the action is resolved by settlement agreement, the lessor shall not be deemed to be the prevailing party for purposes of this paragraph.

(4) Paid tax liens that, from the date of payment, antedate the report by more than seven years.

(5) Accounts placed for collection or charged to profit and loss that antedate the report by more than seven years.

(6) Records of arrest, indictment, information, misdemeanor complaint, or conviction of a crime that, from the date of disposition, release, or parole, antedate the report by more than seven years. These items of information shall no longer be reported if at any time it is learned that in the case of a conviction a full pardon has been granted, or in the case of an arrest, indictment, information, or misdemeanor complaint a conviction did not result.

(7) Medical debt.

(8) Any other adverse information that antedates the report by more than seven years.

(b) The seven-year period specified in paragraphs (5) and (8) of subdivision (a) shall commence to run, with respect to any account that is placed for collection (internally or by referral to a third party, whichever is earlier), charged to profit and loss, or subjected to any similar action, upon the expiration of the 180-day period beginning on the date of the commencement of the delinquency that immediately preceded the collection activity, charge to profit and loss, or similar action. Where more than one of these actions is taken with respect to a particular account, the seven-year period specified in paragraphs (5) and (8) shall commence concurrently for all these actions on the date of the first of these actions.

(c) Any consumer credit reporting agency that furnishes a consumer credit report containing information regarding any case involving a consumer arising under the bankruptcy provisions of Title 11 of the United States Code shall include an identification of the chapter of Title 11 of the United States Code under which the case arose if that can be ascertained from what was provided to the consumer credit reporting agency by the source of the information.

(d) A consumer credit report shall not include any adverse information concerning a consumer antedating the report by more than 10 years or that otherwise is prohibited from being included in a consumer credit report.

(e) If a consumer credit reporting agency is notified by a furnisher of credit information that an open-end credit account of the consumer has been closed by the consumer, any consumer credit report thereafter issued by the consumer credit reporting agency with respect to that consumer, and that includes information respecting that account, shall indicate the fact that the consumer has closed the account. For purposes of this subdivision, "open-end credit account" does not include any demand deposit account, such as a checking account, money market account, or share draft account.

(f) Consumer credit reporting agencies shall not include medical information in their files on consumers or furnish medical information for employment, insurance, or credit purposes in a consumer credit report without the consent of the consumer.

(g) A consumer credit reporting agency shall include in any consumer credit report information, if any, on the failure of the consumer to pay overdue child or spousal support, where the information either was provided to the consumer credit reporting agency pursuant to Section 4752 or has been provided to the consumer credit reporting agency and verified by another federal, state, or local governmental agency.

SEC. 3. Section 1785.20.6 is added to the Civil Code, to read:

1785.20.6. A person who uses a consumer credit report in connection with a credit transaction shall not use a medical debt listed on the report as a negative factor when making a credit decision.

SEC. 4. Section 1785.27 is added to the Civil Code, to read:

1785.27. (a) A person shall not furnish information regarding a medical debt to a consumer credit reporting agency.

(b) A medical debt is void and unenforceable if a person knowingly violates this section by furnishing information regarding the medical debt to a consumer credit reporting agency.

(c) (1) On or after July 1, 2025, it is unlawful to enter into a contract creating a medical debt that does not include the following term:

“A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.”

(2) A contract entered into on or after July 1, 2025, that does not include the term described in paragraph (1) is void and unenforceable.

(d) A violation of this section by a person holding a license or permit issued by the state shall be deemed to be a violation of the law governing that license or permit.

SEC. 5. Section 1786.18 of the Civil Code is amended to read:

1786.18. (a) Except as authorized under subdivision (b), an investigative consumer reporting agency may not make or furnish any investigative consumer report containing any of the following items of information:

(1) Bankruptcies that, from the date of the order for relief, antedate the report by more than 10 years.

(2) Suits that, from the date of filing, and satisfied judgments that, from the date of entry, antedate the report by more than seven years.

(3) Unsatisfied judgments that, from the date of entry, antedate the report by more than seven years.

(4) Unlawful detainer actions where the defendant was the prevailing party or where the action is resolved by settlement agreement.

(5) Paid tax liens that, from the date of payment, antedate the report by more than seven years.

(6) Accounts placed for collection or charged to profit and loss that antedate the report by more than seven years.

(7) Records of arrest, indictment, information, misdemeanor complaint, or conviction of a crime that, from the date of disposition, release, or parole, antedate the report by more than seven years. These items of information shall no longer be reported if at any time it is learned that, in the case of a conviction, a full pardon has been granted or, in the case of an arrest, indictment, information, or misdemeanor complaint, a conviction did not result; except that records of arrest, indictment, information, or misdemeanor complaints may be reported pending pronouncement of judgment on the particular subject matter of those records.

(8) Any other adverse information that antedates the report by more than seven years.

(9) Medical debt, as defined in Section 1785.3.

(b) The provisions of subdivision (a) are not applicable in either of the following circumstances:

(1) If the investigative consumer report is to be used in the underwriting of life insurance involving, or that may reasonably be expected to involve, an amount of two hundred fifty thousand dollars (\$250,000) or more.

(2) If the investigative consumer report is to be used by an employer who is explicitly required by a governmental regulatory agency to check for records that are prohibited by subdivision (a) when the employer is reviewing a consumer's qualification for employment.

(c) Except as otherwise provided in Section 1786.28, an investigative consumer reporting agency shall not furnish an investigative consumer report that includes information that is a matter of public record and that relates to an arrest, indictment, conviction, civil judicial action, tax lien, or outstanding judgment, unless the agency has verified the accuracy of the information during the 30-day period ending on the date on which the report is furnished.

(d) An investigative consumer reporting agency shall not prepare or furnish an investigative consumer report on a consumer that contains information that is adverse to the interest of the consumer and that is obtained through a personal interview with a neighbor, friend, or associate of the consumer or with another person with whom the consumer is acquainted or who has knowledge of the item of information, unless either (1) the investigative consumer reporting agency has followed reasonable procedures to obtain confirmation of the information, from an additional source that has independent and direct knowledge of the information, or (2) the person interviewed is the best possible source of the information.

SEC. 6. Section 1788.14 of the Civil Code is amended to read:

1788.14. No debt collector shall collect or attempt to collect a consumer debt by means of the following practices:

(a) Obtaining an affirmation from a debtor of a consumer debt that has been discharged in bankruptcy, without clearly and conspicuously disclosing to the debtor, in writing, at the time the affirmation is sought, the fact that the debtor is not legally obligated to make an affirmation.

(b) Collecting or attempting to collect from the debtor the whole or any part of the debt collector's fee or charge for services rendered, or other expense incurred by the debt collector in the collection of the consumer debt, except as permitted by law.

(c) Initiating communications, other than statements of account, with the debtor with regard to the consumer debt, when the debt collector has been previously notified in writing by the debtor's attorney that the debtor is represented by the attorney with respect to the consumer debt and the notice includes the attorney's name and address and a request by the attorney that all communications regarding the consumer debt be addressed to the attorney, unless the attorney fails to answer correspondence, return telephone calls, or discuss the obligation in question. This subdivision shall not apply if prior approval has been obtained from the debtor's attorney, or if the communication is a response in the ordinary course of business to a debtor's inquiry.

(d) Sending a written communication to a debtor in an attempt to collect a time-barred debt without providing the debtor with one of the following written notices:

(1) If the debt is not past the date for obsolescence set forth in Section 605(a) of the federal Fair Credit Reporting Act (15 U.S.C. Sec. 1681c), the following notice shall be included in the first written communication provided to the debtor after the debt has become time-barred:

"The law limits how long you can be sued on a debt. Because of the age of your debt, we will not sue you for it. If you do not pay the debt, [insert name of debt collector] may [continue to] report it to the credit reporting agencies as unpaid for as long as the law permits this reporting."

(2) If the debt is past the date for obsolescence set forth in Section 605(a) of the federal Fair Credit Reporting Act (15 U.S.C. Sec. 1681c), the following notice shall be included in the first written communication provided to the debtor after the date for obsolescence:

"The law limits how long you can be sued on a debt. Because of the age of your debt, we will not sue you for it, and we will not report it to any credit reporting agency."

(e) Collecting consumer debt that originated with a hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code without including in the first written communication to the debtor a copy of the notice required pursuant to subdivision (e) of Section 127425 of the Health and Safety Code and a statement that the debt collector will wait at least 180 days from the date the debtor was initially billed for the hospital services that are the basis of the debt before filing a lawsuit against the debtor.

(f) For purposes of this section, "first written communication" means the first communication sent to the debtor in writing or by facsimile, email, or other similar means.

SEC. 6.5. Section 1788.14 of the Civil Code is amended to read:

1788.14. No debt collector shall collect or attempt to collect a covered debt by means of the following practices:

(a) Obtaining an affirmation from a debtor of a covered debt that has been discharged in bankruptcy, without clearly and conspicuously disclosing to the debtor, in writing, at the time the affirmation is sought, the fact that the debtor is not legally obligated to make an affirmation.

(b) Collecting or attempting to collect from the debtor the whole or any part of the debt collector's fee or charge for services rendered, or other expense incurred by the debt collector in the collection of the covered debt, except as permitted by law.

(c) Initiating communications, other than statements of account, with the debtor with regard to the covered debt, when the debt collector has been previously notified in writing by the debtor's attorney that the debtor is represented by the attorney with respect to the covered debt and the notice includes the attorney's name and address and a request by the attorney that all communications regarding the covered debt be addressed to the attorney, unless the attorney fails to answer correspondence, return telephone calls, or discuss the obligation in question. This subdivision shall not apply if prior approval has been obtained from the debtor's attorney, or if the communication is a response in the ordinary course of business to a debtor's inquiry.

(d) Sending a written communication to a debtor in an attempt to collect a time-barred debt without providing the debtor with one of the following written notices:

(1) If the debt is not past the date for obsolescence set forth in Section 605(a) of the federal Fair Credit Reporting Act (15 U.S.C. Sec. 1681c), the following notice shall be included in the first written communication provided to the debtor after the debt has become time-barred:

"The law limits how long you can be sued on a debt. Because of the age of your debt, we will not sue you for it. If you do not pay the debt, [insert name of debt collector] may [continue to] report it to the credit reporting agencies as unpaid for as long as the law permits this reporting."

(2) If the debt is past the date for obsolescence set forth in Section 605(a) of the federal Fair Credit Reporting Act (15 U.S.C. Sec. 1681c), the following notice shall be included in the first written communication provided to the debtor after the date for obsolescence:

"The law limits how long you can be sued on a debt. Because of the age of your debt, we will not sue you for it, and we will not report it to any credit reporting agency."

(e) Collecting consumer debt that originated with a hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code without including in the first written communication to the debtor a copy of the notice required pursuant to subdivision (e) of Section 127425 of the Health and Safety Code and a statement that the debt collector will wait at least 180 days from the date the debtor was initially billed for the hospital services that are the basis of the debt before filing a lawsuit against the debtor.

(f) For purposes of this section, "first written communication" means the first communication sent to the debtor in writing or by facsimile, email, or other similar means.

SEC. 7. Section 1371.56 of the Health and Safety Code is amended to read:

1371.56. (a) (1) Unless otherwise required by this chapter, a health care service plan contract issued, amended, or renewed on or after January 1, 2024, shall require an enrollee who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee would pay for the same covered services received from a contracting ground ambulance provider. This amount shall be referred to as the "in-network cost-sharing amount."

(2) An enrollee shall not owe the noncontracting ground ambulance provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the noncontracting provider, the plan shall inform the enrollee and the noncontracting provider of the in-network cost-sharing amount owed by the enrollee and shall disclose whether or not the enrollee's coverage is regulated by the department or if the coverage is not state-regulated.

(b) (1) The in-network cost-sharing amount paid by the enrollee pursuant to this section shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006.

(2) Cost sharing arising pursuant to this section shall count toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.

(3) The in-network cost-sharing amount paid by the enrollee pursuant to this section shall satisfy the enrollee's obligation to pay cost sharing for the health service.

(c) A noncontracting ground ambulance provider shall only advance to collections the in-network cost-sharing amount, as determined by the plan pursuant to subdivision (a), that the enrollee failed to pay.

(1) A noncontracting ground ambulance provider, or an entity acting on its behalf, including a debt buyer or assignee of the debt, shall not do either of the following:

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

(B) Commence civil action against the enrollee for a minimum of 12 months after the initial billing regarding amounts owed by the enrollee pursuant to subdivision (a).

(2) With respect to an enrollee, a noncontracting ground ambulance provider, or an entity acting on its behalf, including an assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills pursuant to this section.

(d) (1) Unless otherwise agreed to by the noncontracting ground ambulance provider and the health care service plan, the plan shall directly reimburse a noncontracting ground ambulance provider for ground ambulance services the difference between the in-network cost-sharing amount and an amount described, as follows:

(A) If there is a rate established or approved by a local government, at the rate established or approved by the governing body of the local government having jurisdiction for that area or subarea, including an exclusive operating area pursuant to Section 1797.85.

(B) If the local government having jurisdiction where the service was provided does not have an established or approved rate for that service, the amount established by Section 1300.71 (a)(3)(B) of Title 28 of the California Code of Regulations.

(2) A local government has jurisdiction over the ground ambulance transport if either of the following applies:

(A) The ground ambulance transport is initiated within the boundaries of the local government's regulatory jurisdiction.

(B) In the case of ground ambulance transports provided on a mutual or automatic aid basis into another jurisdiction, the local government where the noncontracting ground ambulance provider is based.

(3) A payment made by the health care service plan to the noncontracting ground ambulance provider for services as required in subdivision (a), plus the applicable cost sharing owed by the enrollee, shall constitute payment in full for services rendered.

(4) Notwithstanding any other law, the amounts paid by a health care service plan for services under this section shall not constitute the prevailing or customary charges, the usual fees to the general public, or other charges for other payers for an individual ground ambulance provider.

(e) A health care service plan or a provider may seek relief in any appropriate court for the purpose of resolving a payment dispute. A ground ambulance provider may use a health care service plan's existing dispute resolution processes.

(f) Ground ambulance service providers remain subject to the balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.

(g) This section does not apply to a Medi-Cal managed health care service plan or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 8. Section 1371.9 of the Health and Safety Code is amended to read:

1371.9. (a) (1) Except as provided in subdivision (c), a health care service plan contract issued, amended, or renewed on or after July 1, 2017, shall provide that if an enrollee receives covered services from a contracting health facility at which, or as a result of which, the enrollee receives services provided by a noncontracting individual health professional, the enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from a contracting individual health professional. This amount shall be referred to as the "in-network cost-sharing amount."

(2) An enrollee shall not owe the noncontracting individual health professional more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the noncontracting individual health professional, the plan shall inform the enrollee and the noncontracting individual health professional of the in-network cost-sharing amount owed by the enrollee.

(3) A noncontracting individual health professional shall not bill or collect any amount from the enrollee for services subject to this section except for the in-network cost-sharing amount. Any communication from the noncontracting individual health professional to the enrollee prior to the receipt of information about the in-network cost-sharing amount pursuant to paragraph (2) shall include a notice in 12-point bold type stating that the communication is not a bill and informing the enrollee that the enrollee shall not pay until the enrollee is informed by the enrollee's health care service plan of any applicable cost sharing.

(4) (A) If the noncontracting individual health professional has received more than the in-network cost-sharing amount from the enrollee for services subject to this section, the noncontracting individual health professional shall refund any overpayment to the enrollee within 30 calendar days after receiving payment from the enrollee.

(B) If the noncontracting individual health professional does not refund any overpayment to the enrollee within 30 calendar days after being informed of the enrollee's in-network cost-sharing amount, interest shall accrue at the rate of 15 percent per annum beginning with the date payment was received from the enrollee.

(C) A noncontracting individual health professional shall automatically include in their refund to the enrollee all interest that has accrued pursuant to this section without requiring the enrollee to submit a request for the interest amount.

(b) Except for services subject to subdivision (c), the following shall apply:

(1) Any cost sharing paid by the enrollee for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting individual health professional.

(3) The cost sharing paid by the enrollee pursuant to this section shall satisfy the enrollee's obligation to pay cost sharing for the health service and shall constitute "applicable cost sharing owed by the enrollee."

(c) For services subject to this section, if an enrollee has a health care service plan that includes coverage for out-of-network benefits, a noncontracting individual health professional may bill or collect from the enrollee the out-of-network cost sharing, if applicable, only when the enrollee consents in writing and that written consent demonstrates satisfaction of all the following criteria:

(1) At least 24 hours in advance of care, the enrollee shall consent in writing to receive services from the identified noncontracting individual health professional.

(2) The consent shall be obtained by the noncontracting individual health professional in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent shall not be obtained by the facility or any representative of the facility. The consent shall not be obtained at the time of admission or at any time when the enrollee is being prepared for surgery or any other procedure.

(3) At the time consent is provided, the noncontracting individual health professional shall give the enrollee a written estimate of the enrollee's total out-of-pocket cost of care. The written estimate shall be based on the professional's billed charges for the service to be provided. The noncontracting individual health professional shall not attempt to collect more than the estimated amount without receiving separate written consent from the enrollee or the enrollee's authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate.

(4) The consent shall advise the enrollee that the enrollee may elect to seek care from a contracted provider or may contact the enrollee's health care service plan in order to arrange to receive the health service from a contracted provider for lower out-of-pocket costs.

(5) The consent and estimate shall be provided to the enrollee in the language spoken by the enrollee, if the language is a Medi-Cal threshold language, as defined in subdivision (d) of Section 128552.

(6) The consent shall also advise the enrollee that any costs incurred as a result of the enrollee's use of the out-of-network benefit shall be in addition to in-network cost-sharing amounts and may not count toward the annual out-of-pocket maximum on in-network benefits or a deductible, if any, for in-network benefits.

(d) A noncontracting individual health professional who fails to comply with the requirements of subdivision (c) has not obtained written consent for purposes of this section. Under those circumstances, subdivisions (a) and (b) shall apply and subdivision (c) shall not apply.

(e) (1) A noncontracting individual health professional may advance to collections only the in-network cost-sharing amount, as determined by the plan pursuant to subdivision (a) or the out-of-network cost-sharing amount owed pursuant to subdivision (c), that the enrollee has failed to pay.

(2) The noncontracting individual health professional, or any entity acting on their behalf, including any assignee of the debt, shall not do either of the following:

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

(B) Commence civil action against the enrollee for a minimum of 150 days after the initial billing regarding amounts owed by the enrollee under subdivision (a) or (c).

(3) With respect to an enrollee, the noncontracting individual health professional, or any entity acting on their behalf, including any assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills under this section.

(f) For purposes of this section and Sections 1371.30 and 1371.31, the following definitions shall apply:

(1) "Contracting health facility" means a health facility that is contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract. A contracting health care facility includes, but is not limited to, the following providers:

(A) A licensed hospital.

(B) An ambulatory surgery or other outpatient setting, as described in subdivision (a), (d), (e), (g), or (h) of Section 1248.1.

(C) A laboratory.

(D) A radiology or imaging center.

(2) "Cost sharing" includes any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the enrollee other than premium or share of premium.

(3) "Individual health professional" means a physician and surgeon or other professional who is licensed by this state to deliver or furnish health care services. For this purpose, an "individual health professional" shall not include a dentist, licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code).

(4) "In-network cost-sharing amount" means an amount no more than the same cost sharing the enrollee would pay for the same covered service received from a contracting health professional. The in-network cost-sharing amount with respect to an enrollee with coinsurance shall be based on the amount paid by the plan pursuant to paragraph (1) of subdivision (a) of Section 1371.31.

(5) "Noncontracting individual health professional" means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services and who is not contracted with the enrollee's health care service product. For this purpose, a "noncontracting individual health professional" shall not include a dentist, licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code). Application of this definition is not precluded by a noncontracting individual health professional's affiliation with a group.

(g) This section shall not be construed to require a health care service plan to cover services not required by law or by the terms and conditions of the health care service plan contract.

(h) This section shall not be construed to exempt a plan or provider from the requirements under Section 1371.4 or 1373.96, nor abrogate the holding in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497.

(i) If a health care service plan delegates payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, the delegated entity shall comply with this section.

(j) This section shall not apply to a Medi-Cal managed health care service plan or any other entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(k) This section shall not apply to emergency services and care, as defined in Section 1317.1.

SEC. 9. Section 1797.233 of the Health and Safety Code is amended to read:

1797.233. (a) A ground ambulance provider shall not require an uninsured patient or self-pay patient to pay an amount more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater.

(b) (1) A ground ambulance provider shall only advance to collections the Medicare or Medi-Cal payment amount, as determined pursuant to subdivision (a), that the uninsured or self-pay patient failed to pay.

(2) The ground ambulance provider, or an entity acting on its behalf, including a debt buyer or assignee of the debt, shall not do either of the following:

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

(B) Commence civil action against the individual for a minimum of 12 months after the initial billing regarding amounts owed by the individual pursuant to subdivision (a).

(3) With respect to an uninsured patient or self-pay patient, the ground ambulance provider, or an entity acting on its behalf, including an assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills pursuant to this section.

(c) Ground ambulance service providers remain subject to balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.

SEC. 10. Section 127425 of the Health and Safety Code is amended to read:

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 and monetary assets 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 primary residences 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 prior to, 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 the patient's primary residence during the life of the patient or the patient's spouse, or during the period a child of the patient is a minor, or a child of the patient who has attained the age of majority is unable to take care of themselves and resides in the dwelling as their primary residence. In the event a person protected by this paragraph owns more than one dwelling, the primary residence shall be the dwelling that is the patient's current homestead, as defined in Section 704.710 of the Code of Civil Procedure, or was the patient's homestead at the time of the death of a person other than the patient who is asserting the protections of this paragraph.

(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. Prior to 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 prior to 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).

SEC. 10.5. Section 127425 of the Health and Safety Code is amended to read:

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).

SEC. 11. Section 10112.75 is added to the Insurance Code, to read:

10112.75. (a) If a health insurer sends payment for services provided directly to the insured and not to the provider, the insurer shall send notice to the insured and the provider who provided the services that the insurer has sent payment to the insured.

(b) The notice sent to the insured pursuant to subdivision (a) shall include all of the following:

(1) The date the notice was sent and the name and address of the provider who billed for the service.

(2) A statement that if the insured has paid the full bill for the service, including both their cost-sharing and the insurer share of cost obligation, the actions described to collect the insurer obligated payment in paragraph (3) do not apply, and that this check is for reimbursement of the consumer for paying the insurer share of cost obligation.

(3) Information about action that may be taken if the insured does not send the insurer's obligated payment to the provider, including all of the following:

(A) That an unpaid bill may be sent to collections and the insured may be subject to collections.

(B) That the provider or debt collector may pursue litigation against the insured to collect the bill.

(C) That the unpaid insurer share of cost obligation may be reported to a credit reporting agency as medical debt if the provider does not receive the payment within 60 days of the notice, or within one year after initial billing for the service, whichever is later.

(c) The required notice sent to the provider pursuant to subdivision (a) shall include the date that the notice to the insured was sent and the amount sent to the insured to reimburse the provider.

(d) If the provider does not receive the payment from the insured within 60 days of the notice to the insured, or within one year after initial billing for the service, whichever is later, the insurer's share of cost in possession of the insured that has not been paid to the provider may be reported to a credit reporting agency as medical debt and shall not be considered medical debt for purposes of Sections 1785.13, 1785.20.6, 1785.27, and 1786.18 of the Civil Code if both of the following are true:

(1) The entity reporting the information has adequate documentation to substantiate that the insured actually received the funds from the insurer.

(2) The insured has not raised a dispute with the insurer, provider, or department as to whether the amount was received.

(e) This section does not limit existing requirements under this chapter protecting insureds from balance billing, including Sections 10112.8 and 10126.66.

(f) This section does not apply if the direct payment for services provided to the insured is a reimbursement from the insurer because the insured paid the insurer's share of cost obligation.

SEC. 12. Section 10112.8 of the Insurance Code is amended to read:

10112.8. (a) (1) Except as provided in subdivision (c), a health insurance policy issued, amended, or renewed on or after July 1, 2017, that provides benefits through contracts with providers at alternative rates of payment pursuant to Section 10133, shall provide that if an insured receives covered services from a contracting health facility at which, or as a result of which, the insured receives services provided by a noncontracting individual health professional, the insured shall pay no more than the same cost sharing that the insured would pay for the same covered services received from a contracting individual health professional. This amount shall be referred to as the "in-network cost-sharing amount."

(2) Except as provided in subdivision (c), an insured shall not owe the noncontracting individual health professional more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the insurer to the noncontracting individual health professional, the insurer shall inform the insured and the noncontracting individual health professional of the in-network cost-sharing amount owed by the insured.

(3) A noncontracting individual health professional shall not bill or collect any amount from the insured for services subject to this section except the in-network cost-sharing amount. Any communication from the noncontracting individual health professional to the insured prior to the receipt of information about the in-network cost-sharing amount pursuant to paragraph (2) shall include a notice in 12-point bold type stating that the communication is not a bill and informing the insured that the insured shall not pay until they are informed by their insurer of any applicable cost sharing.

(4) (A) If the noncontracting individual health professional has received more than the in-network cost-sharing amount from the insured for services subject to this section, the noncontracting individual health professional shall refund any overpayment to the insured within 30 calendar days after receiving payment from the insured.

(B) If the noncontracting individual health professional does not refund any overpayment to the insured within 30 calendar days after being informed of the insured's in-network cost-sharing amount, interest shall accrue at the rate of 15 percent per annum beginning with the date payment was received from the insured.

(C) A noncontracting individual health professional shall automatically include in their refund to the insured all interest that has accrued pursuant to this section without requiring the insured to submit a request for the interest amount.

(b) Except for services subject to subdivision (c), the following shall apply:

(1) Any cost sharing paid by the insured for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting individual health professional.

(3) The cost sharing paid by the insured pursuant to this section shall satisfy the insured's obligation to pay cost sharing for the health service and shall constitute "applicable cost sharing owed by the insured."

(c) For services subject to this section, if an insured has an insurance contract that includes coverage for out-of-network benefits, a noncontracting individual health professional may bill or collect from the insured the out-of-network cost sharing, if applicable, only when the insured consents in writing and that written consent demonstrates satisfaction of all the following criteria:

(1) At least 24 hours in advance of care, the insured shall consent in writing to receive services from the identified noncontracting individual health professional.

(2) The consent shall be obtained by the noncontracting individual health professional in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent shall not be obtained by the facility or any representative of the facility. The consent shall not be obtained at the time of admission or at any time when the enrollee is being prepared for surgery or any other procedure.

(3) At the time consent is provided the noncontracting individual health professional shall give the insured a written estimate of the insured's total out-of-pocket cost of care. The written estimate shall be based on the professional's billed charges for the service to be provided. The noncontracting individual health professional shall not attempt to collect more than the estimated amount without receiving separate written consent from the insured or the insured's authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate.

(4) The consent shall advise the insured that they may elect to seek care from a contracted provider or may contact the insured's insurer in order to arrange to receive the health service from a contracted provider for lower out-of-pocket costs.

(5) The consent and estimate shall be provided to the insured in the language spoken by the insured, if the language is a Medi-Cal threshold language, as defined in subdivision (d) of Section 128552 of the Health and Safety Code.

(6) The consent shall also advise the insured that any costs incurred as a result of the insured's use of the out-of-network benefit shall be in addition to in-network cost-sharing amounts and may not count toward the annual out-of-pocket maximum on in-network benefits or a deductible, if any, for in-network benefits.

(d) A noncontracting individual health professional who fails to comply with provisions of this subdivision has not obtained written consent for purposes of this section. Under those circumstances, subdivisions (a) and (b) shall apply and subdivision (c) shall not apply.

(e) (1) A noncontracting individual health professional may advance to collections only the in-network cost-sharing amount, as determined by the insurer pursuant to subdivision (a) or the out-of-network cost-sharing amount owed pursuant to subdivision (c), that the insured has failed to pay.

(2) The noncontracting individual health professional, or any entity acting on their behalf, including any assignee of the debt, shall not do either of the following:

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

(B) Commence civil action against the insured for a minimum of 150 days after the initial billing regarding amounts owed by the insured under subdivision (a) or (c).

(3) With respect to an insured, a noncontracting individual health professional, or any entity acting on their behalf, including any assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills under this section.

(f) For purposes of this section and Sections 10112.81 and 10112.82, the following definitions shall apply:

(1) "Contracting health facility" means a health facility that is contracted with the insured's health insurer to provide services under the insured's policy. A contracting health care facility includes, but is not limited to, the following providers:

(A) A licensed hospital.

(B) An ambulatory surgery or other outpatient setting, as described in subdivision (a), (d), (e), (g), or (h) of Section 1248.1 of the Health and Safety Code.

(C) A laboratory.

(D) A radiology or imaging center.

(2) "Cost sharing" includes any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the insured other than premium or share of premium.

(3) "Individual health professional" means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services. For this purpose, an "individual health professional" shall not include a dentist, licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code).

(4) "In-network cost-sharing amount" means an amount no more than the same cost sharing the insured would pay for the same covered service received from a contracting health professional. The in-network cost-sharing amount with respect to an insured with coinsurance shall be based on the amount paid by the insurer pursuant to paragraph (1) of subdivision (a) of Section 10112.82.

(5) "Noncontracting individual health professional" means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services and who is not contracted with the insured's health insurance product. For this purpose, a "noncontracting individual health professional" shall not include a dentist, licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code). Application of this definition is not precluded by a noncontracting individual health professional's affiliation with a group.

(g) This section shall not be construed to require an insurer to cover services not required by law or by the terms and conditions of the health insurance policy.

(h) If a health insurer delegates payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, the delegated entity shall comply with this section.

(i) This section shall not apply to emergency services and care, as defined in Section 1317.1 of the Health and Safety Code.

SEC. 13. Section 10126.66 of the Insurance Code is amended to read:

10126.66. (a) (1) Unless otherwise required by this chapter, a health insurance policy issued, amended, or renewed on or after January 1, 2024, shall require an insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the insured would pay for the same covered services received from a contracting ground ambulance provider. This amount shall be referred to as the "in-network cost-sharing amount."

(2) An insured shall not owe the noncontracting ground ambulance provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the insurer to the noncontracting provider, the insurer shall inform the insured and the noncontracting provider of the in-network cost-sharing amount owed by the insured and shall disclose whether or not the insured's coverage is regulated by the department or if the coverage is not state-regulated.

(b) (1) The in-network cost-sharing amount paid by the insured pursuant to this section shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.

(2) Cost sharing arising pursuant to this section shall count toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.

(3) The in-network cost-sharing amount paid by the insured pursuant to this section shall satisfy the insured's obligation to pay cost sharing for the health service.

(c) A noncontracting ground ambulance provider shall only advance to collections the in-network cost-sharing amount, as determined by the insurer pursuant to subdivision (a), that the insured failed to pay.

(1) A noncontracting ground ambulance provider, or an entity acting on its behalf, including a debt buyer or assignee of the debt, shall not do either of the following:

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

(B) Commence civil action against the insured for a minimum of 12 months after the initial billing regarding amounts owed by the insured pursuant to subdivision (a).

(2) With respect to an insured, a noncontracting ground ambulance provider, or an entity acting on its behalf, including an assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills pursuant to this section.

(d) (1) Unless otherwise agreed to by the noncontracting ground ambulance provider and the health insurer, the insurer shall directly reimburse a noncontracting ground ambulance provider for ground ambulance services the difference between the in-network cost-sharing amount and an amount described, as follows:

(A) If there is a rate established or approved by a local government, at the rate established or approved by the governing body of the local government having jurisdiction for that area or subarea, including an exclusive operating area pursuant to Section 1797.85 of the Health and Safety Code.

(B) If the local government having jurisdiction where the service was provided does not have an established or approved rate for that service, the reasonable and customary value for the services rendered, based upon statistically credible information that is updated at least annually and takes into consideration all of the following:

(i) The ambulance provider's training, qualifications, and length of time in practice.

(ii) The nature of the services provided.

(iii) The fees usually charged by the ambulance provider.

(iv) Prevailing ground ambulance provider rates charged in the general geographic areas in which the services were rendered.

(v) Other aspects of the economics of the ambulance provider's practice that are relevant.

(vi) Any unusual circumstances in the case.

(2) A local government has jurisdiction over the ground ambulance transport if either of the following applies:

(A) The ground ambulance transport is initiated within the boundaries of the local government's regulatory jurisdiction.

(B) In the case of ground ambulance transports provided on a mutual or automatic aid basis into another jurisdiction, the local government where the noncontracting ground ambulance provider is based.

(3) A payment made by the health insurer to the noncontracting ground ambulance provider for services as required in subdivision (a), plus the applicable cost sharing owed by the insured, shall constitute payment in full for services rendered.

(4) Notwithstanding any other law, the amounts paid by a health insurer for services under this section shall not constitute the prevailing or customary charges, the usual fees to the general public, or other charges for other payers for an individual ground ambulance provider.

(e) A health insurer or ground ambulance provider may seek relief in any appropriate court for the purpose of resolving a payment dispute. A ground ambulance provider may use a health insurer's existing dispute resolution process under Section 10123.137.

(f) This section does not affect the balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.

SEC. 14. (a) Section 6.5 of this bill incorporates amendments to Section 1788.14 of the Civil Code proposed by both this bill and Senate Bill 1286. That section of this bill shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2025, (2) each bill amends Section 1788.14 of the Civil Code, and (3) this bill is enacted after Senate Bill 1286, in which case Section 6 of this bill shall not become operative.

(b) Section 10.5 of this bill incorporates amendments to Section 127425 of the Health and Safety Code proposed by both this bill and Assembly Bill 2297. That section of this bill shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2025, (2) each bill amends Section 127425 of the Health and Safety Code, and (3) this bill is enacted after Assembly Bill 2297, in which case Section 10 of this bill shall not become operative.

SEC. 15. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.