

**EFFECTIVE JANUARY 1, 2007, CALIFORNIA HOSPITALS MUST HAVE WRITTEN CHARITY CARE AND DISCOUNT PAYMENT POLICIES**

AB 774, effective January 1, 2007, requires general acute care hospitals to establish a charity care policy and discount payment policy for patients whose families are at or below 350 percent of the federal poverty level ("FPL"). The policy applies to self-pay patients as well as insured patients with high medical costs (i.e., whose annual medical expenses exceed 10 percent of family income in the prior twelve months).

**WRITTEN POLICIES**

Every general acute care hospital must have written, understandable policies on charity care and discount payments for financially qualified patients. The discount policy must state eligibility criteria based upon income (documentation of income can only come from pay stubs or income tax returns) and provide for extended payment over time (without interest), the terms of which are to be negotiated between the hospital and the patient. The charity care policy must also state eligibility criteria and may consider income and monetary assets, excluding retirement or deferred-compensation plans, and excluding the first \$10,000 of assets and 50% of monetary assets over the first \$10,000. All uninsured patients and patients with high medical costs who are at or below 350% of the federal poverty level ("FPL") are eligible to apply for participation under the charity care policy or discount policy.

Underinsured patients, such as those with consumer driven health care high deductible policies, are eligible under the hospital charity care and discount payment policies. To be eligible, patients must incur out-of-pocket costs that exceed 10 percent of their family income in the prior 12 months. In addition, patients are only eligible if they do not receive a discounted rate as a result of third-party coverage. The 10 percent threshold may be documented in two ways: (1) the out-of-pocket costs incurred at the hospital; or (1) the patient provides documentation of health care expenses incurred elsewhere.

Each hospital must limit expected payments from eligible patients to not more than the highest amount of payment it would receive from any government-sponsored health program that the hospital participates in. Both discount payment and charity care policies must clearly state the process the hospital will use to determine eligibility, and the process to appeal the determination.

**NOTICE**

Every general acute care hospital is required to provide patients with a written notice about the availability of the hospital's charity care and discount payment policies, and information about eligibility and contact information in English and any other primary language that is representative of 5 percent or more of the service population. Written notice must specifically be provided to patients who receive emergency or outpatient care, who may be billed, but are not admitted. Hospitals must make all reasonable efforts to obtain information about insurance coverage and if patients are billed who have not provided proof of coverage, the bill must contain a conspicuous notice that includes the charges; a request for information about insurance coverage; a statement that if there is no coverage, the patient may be eligible for governmental coverage or charity care; and a statement that if there is no or inadequate coverage and the patient meets income requirements, the patient may qualify for discounted payment or charity care. Notices of the policies must be clearly and conspicuously posted in public locations including, without limitation, the emergency department, billing office, admissions office and other outpatient settings. Prior to commencing

collection activities, hospitals must provide patients with specific written notices that summarize their rights under fair debt laws and contain a statement that free credit counseling may be available.

## **PATIENT RESPONSIBILITY**

A patient applying under a hospital charity care or discount payment policy must make "every reasonable effort" to provide the hospital with documentation of income and health benefits coverage. If the patient fails to provide information that is "reasonable and necessary" for the hospital to make a determination, the hospital may consider that failure in making its determination.

## **POTENTIAL GOVERNMENT PROGRAM OR THIRD PARTY PAYER ELIGIBILITY**

Hospitals must make "all reasonable efforts" to obtain information from the patients about whether private or public health insurance might fully or partially cover the charges for care, including private health insurance, Medicare, Medi-Cal, Healthy Families, Health Kids, the California Children's Services Program, or other state-funded programs.

## **COLLECTION ACTIVITIES**

Hospitals must have written policies about collection practices and have a written agreement with any collection agency that requires the agency to adhere to the hospital's collection policies. Patients who are uninsured or whose information indicates that they may have "high medical costs" (defined as patients whose family income does not exceed 350% of the FPL and whose annual out-of-pocket costs exceed family income by 10% for the prior 12 months), may not be reported to a consumer credit reporting agency or be sued in a civil action for nonpayment prior to 150 days after the initial billing (this time period can be extended if the patient has an appeal pending). For patients attempting to qualify for a hospital's discount or charity care policies and attempting in good faith to settle payment, as evidenced by a reasonable payment plan or making regular partial payments, a hospital may not send the unpaid bill to a collection agency unless the collection agency agrees to comply with the provisions of the new law. For eligible patients, a hospital or its affiliate that does collection may not use wage garnishment or liens on primary residences as a collection method. An independent collection agency engaged by a hospital may use wage garnishment if ordered by a court based on evidence that the patient has the ability to pay, and can notice/conduct a sale of a primary residence under very limited circumstances. If a hospital determines it has overcharged an eligible patient, it must repay the patient the amount of excess, plus interest.

## **REPORTING AND ENFORCEMENT REQUIREMENTS**

Every general acute care hospital must provide the California Department of Health Services ("DHS") Office of Statewide Health Planning and Development ("OSHPD") with a copy of its charity care and discount payment policies, eligibility procedures, review process, and the applications at least once every 2 years beginning on January 1, 2007 or whenever there is a material change. As a result of AB 774, all hospitals will have to update their voluntary charity care and discount policies to comply with the strict requirements of the new law.

OSHPD will be responsible for enforcing AB 774. Patients must be reimbursed for any amount paid in excess of the amount due under AB 774, including interest. Regulations are currently being developed, that will authorize hospital penalties for a violation of AB 774.

It is important for all hospitals to carefully review AB 774 and work with their health care law attorneys to ensure that they are compliant with the requirements. We can provide practical advice as you develop and implement your charity care and discount policies. If you have any questions about complying with the AB 774 or would like additional information, please contact Michael Dowell at [mdowell@sortm.com](mailto:mdowell@sortm.com) or the lawyer in the firm who generally handles your legal matters.