PRACTICAL LEGISLATIVE UPDATE
CAHAM 55th ANNUAL CONFERENCE

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HIERARCHY OF LAWS

- US CONSTITUTION
  - STATUTES
  - REGULATIONS
- STATE CONSTITUTION
  - STATUTES
  - REGULATIONS

LEGAL LANGUAGE

- PRECISION-WORDS MATTER-
  - STATUTES ARE SIMILAR TO HSA AND OPERATIONS MANUALS
  - LIVE AND DIE WITH WORDS USED
- STANDARDS OF INTERPRETATION-
  - BLACK AND WHITE/LEGISLATIVE INTENT
  - SIMILAR TO CONTRACTS THAT DEFINE RELATIONSHIP.
- JUDICIAL REVIEW OF STATUTES
  - WHAT WAS INTENDED?
  - HOW DO WE DETERMINE WHAT WAS INTENDED? Legislative intent

LANGUAGE OF THE LAW

- WHAT HAS FOUR LETTERS, SOMETIMES HAS NINE, AND NEVER HAS FIVE?

Telemarketing Rules

State government, business, and consumer legal representatives and advocates testified at a hearing on telemarketing rules contained in the Telephone Consumer Protection Act of 1991. Topics included “Do Not Call” lists, automatic dialing systems known as “robocalls,” and the effects these rules have on businesses.

STATUTORY LANGUAGE

- REAL LIFE

The Telephone Consumer Protection Act at 25_ Effects on Consumers and Business - ... 2.0.html

MONETARY ASSETS IN CHARITY ELIGIBILITY

- **AB 2297** would prohibit hospitals from considering patients' **monetary assets** when determining eligibility for charity care or discount payments **or imposing a time limit on eligibility.**
- Amendments made on Aug. 5 remove previously agreed-upon language that would have allowed hospitals to consider health savings accounts, health insurance company payments made directly to patients, and funds received from lawsuits to compensate for hospital expenses.
- Further, amendments remove hospitals' ability to consider a Medicare patient's assets (not just income) when determining eligibility for charity care.
- New amendments would grant the Department of Health Care Access and Information the authority to assess penalties on hospitals for violations that occurred from Jan. 1, 2022, if these violations are discovered during investigations of hospital actions from Jan. 1, 2024, onward. (ex post facto law) Article I, Section 10: Prohibits states from passing ex post facto laws
- Additionally, new amendments would prohibit hospitals from requiring a patient to apply for Medicare, Medi-Cal, or other coverage before the patient is screened for or provided discount payment. CHA is continuing discussions with the author.

AB 2297

- AB 2297, as amended, Friedman. Hospital and Emergency Physician Fair Pricing Policies.
- Existing law requires a hospital to maintain a written charity care policy and a discount payment policy for uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. Existing law requires the written policy regarding discount payments to also include a statement that an emergency physician who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. Existing law authorizes an emergency physician to choose to grant eligibility for a discount payment policy to patients with incomes over 350% of the federal poverty level. Existing law defines "high medical costs" for these purposes to mean, among other things, specified annual out-of-pocket costs incurred by the individual at the hospital or a hospital that provided emergency care.
- This bill would authorize an emergency physician to choose to grant eligibility for a discount payment policy to patients with incomes over 400% of the federal poverty level. The bill would also clarify that out-of-pocket costs for the above-described definition of "high medical costs" means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.
- Existing law requires a hospital's discount payment policy to clearly state the eligibility criteria based upon income, and authorizes a hospital to consider the income and monetary assets of the patient or the patient's family, as defined, in determining eligibility under its charity care policy.
- This bill would prohibit a hospital from considering the monetary assets of the patient in determining eligibility for both the charity care and the discount payment policies, but would authorize the hospital to consider the availability of a patient's health savings account held by the patient or the patient's family, as specified. The bill would revise the definition of patient's family, as specified. The bill would instead require that the eligibility for charity care or discounted payments be determined at any time the hospital is in receipt of of, among other things, recent pay stubs or income tax returns. The bill would prohibit a hospital or an emergency physician from imposing time limits for applying for charity care or discounted payments, and would prohibit a hospital or emergency physician from denying eligibility based on the timing of a patient's application. The bill would authorize a hospital or emergency physician to waive or reduce Medi-Cal and Medicare cost-sharing amounts as part of its charity care program or discount payment program. program, as specified.
- Existing law requires a hospital or an emergency physician to establish a written policy defining standards and practices for the collection of debt. Existing law authorizes a hospital or emergency physician to consider only income and monetary assets, as specified, in determining the amount of debt a hospital or emergency physician may seek to recover from patients who are eligible under the hospital's or emergency physician's charity care or discount payment policy.
- This bill would eliminate the authorization for a hospital or an emergency physician to consider monetary assets in determining the amount of debt the hospital or emergency physician may seek to recover from patients who are eligible under these policies.
- Existing law prohibits a hospital, in dealing with patients eligible under the hospital's charity care or discount payment policies, or emergency physician, in dealing with patients eligible under the emergency physician's discount payment policies, from using liens on primary residences as a means of collecting unpaid hospital or emergency physician bills. Existing law prohibits a collection agency, in dealing with a patient under a hospital's charity care or discount payment policies or in dealing with a patient under the emergency physician's discount payment policy, from conducting a sale of a patient's primary residence, as specified, as a means of collecting unpaid hospital or emergency physician bills.
- This bill would prohibit a hospital or emergency physician from using liens on any real property as a means of collecting unpaid hospital or emergency physician bills, and would prohibit a collection agency from conducting a sale of any real property owned, in part or completely, by a patient or placing a lien on any real property as a means of collecting unpaid hospital or emergency physician bills.
- The bill would define "charity care" and "discount payment" for the purposes described above.
- Existing law requires a hospital to reimburse a patient any amount actually paid in excess of the amount due, including interest. Under existing law, a hospital is not required to reimburse the patient or pay interest if the amount due is less than $5.
- This bill would authorize the hospital to reimburse the patient, but is not required to do so, if the hospital or the department determines that a patient qualified for financial assistance at the time the patient was first billed and it has been 7 5 years or more since the last payment to the hospital, hospital assignee, or debt buyer or the patient debt was sold to a debt buyer in accordance with state law in effect at the time the debt was sold, if sold before January 1, 2022.
- Existing law requires the State Department of Public Health to be responsible for the enforcement of the hospital pricing policy provisions for violations occurring prior to January 1, 2024. Existing law requires the Department of Health Care Access and Information to be responsible for the enforcement of these provisions for violations occurring on or after January 1, 2024.

CREDIT REPORTING

- **SB 1061** would:
  - Prohibit consumer credit reporting agencies from including medical debt in consumer credit reports (Priority of payment)
  - Prohibit a health care provider from furnishing information regarding a medical debt to a consumer credit reporting agency.
  - The bill also requires hospitals to maintain all documents related to an individual's medical debt, including litigation documents.

SB 1061

- 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.

TIMELY REIMBURSEMENT

AB 3275 would update and clarify requirements for health care service plans or health insurers to timely reimburse services provided by hospitals.

AB 3275

- Existing law requires a health insurer or health care service plan, including a specialized health care service plan, to reimburse a claim or portion of a claim no later than 30 working days after receipt of the claim, unless the plan contests or denies the claim, in which case the plan is required to notify the claimant within 30 working days that the claim is contested or denied. Under existing law, if a claim or portion thereof is contested on the basis that a health insurer or health care service plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided, the health insurer or health care service plan has 30 working days after receipt of the additional information to complete reconsideration of the claim. Existing law extends these timelines to 45 working days for a health care service plan that is a health maintenance organization. Under existing law, if a claim is not reimbursed, contested, or denied pursuant to these timelines, as specified, interest accrues at a rate of 15% per annum for a health care service plan and 10% per annum for a health insurer.
- Commencing January 1, 2026, this bill instead would require a health care service plan, including a Medi-Cal managed care plan, or health insurer to reimburse a complete claim or a portion thereof within 30 calendar days after receipt of the claim, or, if a claim or portion thereof does not meet the criteria for a complete claim or portion thereof, to notify the claimant as soon as practicable, but no later than 30 calendar days that the claim or portion thereof is contested or denied. The bill would authorize the departments to issue guidance and regulations related to these provisions. The bill would exempt the guidance and amendments from the Administrative Procedure Act until December 31, 2027.

MEDICAL REVIEW PROCESS

- **SB 999** will impose certain requirements on health plans and insurers, including:
  - Having qualified health care providers in the relevant clinical specialty review appeals and make initial review determinations
  - Maintaining telephone and other direct communication access during normal business hours for health care providers to request authorization for mental health and substance use disorder care
  - Providing health care providers and enrollees the clinical citations used for denials of care

SB999

- SB 999, as amended, Cortese. Health coverage: mental health and substance use disorders.
- Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law also requires the Department of Insurance to regulate health insurers. Existing law requires a health care service plan or disability insurer, as specified, to base medical necessity determinations and the utilization review criteria the plan or insurer, and any entity acting on the plan's or insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders, on current generally accepted standards of mental health and substance use disorder care.
- This bill would require a health care service plan and a disability insurer, and an entity acting on a plan's or insurer's behalf, to ensure compliance with specific requirements for utilization review, including maintaining telephone access and other direct communication access during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conducting peer-to-peer discussions regarding specific patient issues related to treatment. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.
- 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.

AUDITS OF PAYER PROVIDER DIRECTORIES

- **AB 236** would require a health plan or insurer to annually audit and delete inaccurate listings from its provider directories, including deleting a provider from its directory if the plan or insurer has not financially compensated a provider in the prior year. It would also require the Department of Managed Health Care and the Department of Insurance to develop uniform formats for plans and insurers to use to request directory information from providers, and it would authorize the departments to establish methodology and processes to ensure accuracy of provider directories.

AB 236

AB 236, as amended, Holden. Health care coverage: provider directories.

- Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a health plan's provider directory or directories.
- This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2025, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2028. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. The bill would require a plan or insurer to arrange care and provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the contracted amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances.
- On or before January 1, 2025, this bill would authorize the Department of Managed Health Care and the Department of Insurance to develop uniform formats for plans and insurers to use to request directory information from providers and to establish a methodology and processes to ensure accuracy of provider directories and consistency with other laws, regulations, or standards. The bill would require the health plan or the insurer, as applicable, to ensure the accuracy of a request to add back a provider who was previously removed from a directory and approve the request within 10 business days of receipt, if accurate.
- Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.
- 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

PARAMEDICINE, TRIAGE TO ALTERNATE DESTINATION

- **SB 1180** would require a health care service plan contract issued, amended, or renewed on or after July 1, 2025, to establish a process to reimburse for services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program. The bill would also require coverage of these programs under Medi-Cal, upon appropriation and receipt of any necessary federal approvals and the availability of federal financial participation.

SB 1180

- SB 1180, as amended, Ashby. Health care coverage: emergency medical services.
- Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies to provide coverage for certain services and treatments, including medical transportation services. Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including emergency medical transport. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.
- Existing law, until January 1, 2031, authorizes a local emergency medical services (EMS) agency to develop a community paramedicine or triage to alternate destination program that, among other things, provides case management services to frequent EMS users or triage paramedic assessments, respectively.
- This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2025, to establish a process to reimburse for services provided by a community paramedicine program, a triage to alternate destination program, and a mobile integrated health program, as defined.
- The bill would require those contracts and policies to require an enrollee or insured who receives covered services from a noncontracting program to pay no more than the same cost-sharing amount that they would pay for the same covered services received from a contracting program. The bill would prohibit reimbursement rates adopted pursuant to this provision from exceeding the health care service plan's or health insurer's usual and customary charges for services rendered.
- Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.
- The bill would also make services provided by these programs covered benefits under the Medi-Cal program. The bill would condition this Medi-Cal coverage on an appropriation, receipt of any necessary federal approvals, and the availability of federal financial participation.
- 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.

QUESTIONS!!!!

THANK YOU

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