SENATE COMMITTEE ON HEALTH
Senator Caroline Menjivar, Chair

BILL NO: AB 1312
AUTHOR: Schiavo
VERSION: July 8, 2025
HEARING DATE: July 16, 2025
CONSULTANT: Vincent D. Marchand

SUBJECT: Hospital pricing

SUMMARY: Requires a hospital to presumptively determine that a patient is eligible for charity care or discounted payment policies if the patient is experiencing homelessness or is already enrolled in a means-tested program such as CalFresh or CalWORKS, among others, and requires a hospital to screen patients in other categories that might indicate they could qualify for charity care or discounted payment policies and make a determination if the patient is eligible before sending that patient a bill for hospital services.

Existing law:

1) Establishes Hospital Fair Pricing Policies (FPP), enforcement of which was transferred from the California Department of Public Health (CDPH) to the Department of Health Care Access and Information (HCAI) for violations occurring on or after January 1, 2024. [HSC §127400, et seq. and §127401]

2) Requires each hospital, under the FPP, to maintain understandable written policies on discounted payments and charity care for uninsured patients or patients with high medical costs who have income up to 400% of the federal poverty level (FPL). [HSC §127405]

3) Permits rural hospitals to establish eligibility levels for discounted payment and charity care at less than 400% of FPL as appropriate to maintain their financial and operational integrity. [HSC §127405(a)(2)]

4) Requires a hospital's discount payment policy and charity care policy to clearly state eligibility criteria based upon income consistent with the application of the FPL. Prohibits a hospital from considering the monetary assets of the patient. Requires a hospital to limit expected payment under its discount payment policy to the amount the hospital would expect, in good faith, to receive for providing services from Medicare or Medi-Cal, whichever is greater. [HSC §127405(b) and (d)]

5) Requires a patient who requests a discounted payment or charity care to make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. If the patient fails to provide information, the hospital may consider that failure in making its determination. Requires documentation of income to be limited to pay stubs or income tax returns, although permits a hospital to accept other forms of documentation but cannot require other forms of documentation. [HSC §127405(e)]

6) Requires eligibility for discounted payments or charity care to be determined at any time the hospital is in receipt of information, and prohibits a hospital from imposing time limits for applying for charity care or discounted payments, nor deny eligibility based on the timing of a patient's application. [HSC §127405(e)(3)]

7) Requires each hospital to provide patients with a written notice about the availability of the hospital's discount payment and charity care policies, including information about eligibility, and contact information for a hospital employee or office. Requires the notice to be in English and other languages, and written correspondence to be in the language spoken by the patient, as specified. Requires this notice to be provided at the time of service if the patient is conscious and able to receive it at that time, or if not then at the time of discharge. [HSC §127410]

8) Requires a hospital, if it bills a patient who has not provided proof of coverage by a third party, to provide as part of that billing various specified statements, including a statement regarding discounted payment and charity care policies and how to apply for these policies. [HSC §127420]

This bill:

Provisions establishing presumptive eligibility for charity care and discounted payment:

1) Defines "presumptively determine" as a determination made by a hospital that a patient who did not submit an application or documentation of income is eligible to participate in the charity care or discounted payment programs maintained by the hospital.

2) Requires a hospital to presumptively determine that a patient is eligible for participation under the hospital's charity care or discount payment policy if any of the following apply:

    a) The patient or any member of the patient's family is enrolled in CalFresh, CalWORKs, or Tribal Temporary Assistance for Needy Family (TANF), Women, Infants, and Children (WIC), California Alternative Rates for Energy (CARE), the Low-Income Home Energy Assistance Program (LIHEAP), Housing Choice Voucher (HCV) program, and any other programs as determined by HCAI and any additional programs determined by each hospital that would reasonably reflect the approximate patient household income. Requires enrollment in any of these listed programs to be considered sufficient evidence that a patient is financially qualified for charity care or discount payment policies;
    b) The patient or a member of the patient's family was determined to be eligible for participation under the hospital's discount or charity care payment policy during the previous 12-month period; or,
    c) The patient is experiencing homelessness.

3) Permits a hospital to require verification from the patient if the hospital is unable to automatically or independently verify the patient's enrollment in one of the programs listed in 2) above. Requires the patient to make every reasonable effort to provide the requested verification and requires the hospital to assist the patient when feasible.

4) Prohibits a hospital from requiring a patient to apply for Medicare, Medi-Cal, or other coverage before the patient is presumptively determined eligible for, or provided with, charity care or discounted payment. However, permits a hospital to require the patient to participate in a screening for Medi-Cal eligibility when presumptively determined eligible for charity care or discounted payment.

Provisions requiring patients to be screened for charity care and discounted payment:

5) Defines "screen" or "screening" as the process a hospital uses to identify and presumptively determine if a patient may be eligible for charity care or discounted payment, and requires this process to serve as an alternative to requiring an application for eligibility determination.

6) Requires a hospital to screen a patient for eligibility for participation under the hospital's charity care or discount payment policy if the patient is any of the following:

    a) Uninsured;
    b) Enrolled in Medi-Cal with cost sharing or eligible for Medi-Cal under the Hospital Presumptive Eligibility program;
    c) Enrolled in a Covered California health plan; or,
    d) Will owe the hospital $500 or more after all adjustments from insurance or third-party payers are made.

7) Prohibits a hospital from requiring a patient to apply for Medicare, Medi-Cal, or other coverage before the patient is screened for, or provided with, charity care or discounted payment. However, permits a hospital to require the patient to participate in a screening for Medi-Cal eligibility when being screened for charity care or discounted payment.

8) Requires the hospital, if the screening concludes that a patient is financially qualified for charity care or discounted payment, to determine the patient is eligible for participation without requiring the patient to complete a separate application.

9) Requires the hospital to make best efforts to collect all of the information required to complete the screening process prior to discharge. However, permits the hospital to continue to collect information after discharge if necessary.

10) Permits the hospital to make the eligibility determination after the patient is discharged, but requires the hospital to provide the patient with the written notice required in 19) below, prior to, or in conjunction with, any billing statement, which is required to reflect any adjustments to hospital charges imposed on the patient.

11) Permits a hospital, at its discretion or as established in its charity care or discount payment policy, to:

    a) Presumptively determine that a patient who does not meet the presumptive eligibility requirements in 1) above to be eligible for charity care or discounted payment; or,
    b) Screen a patient who does not meet the criteria for required screening in 4) above for eligibility for charity care or discounted payment.

12) Specifies that this bill does not preclude a rural hospital's ability to establish eligibility levels for charity care and discounted payment at less than 400% of FPL, as appropriate to maintain their financial and operational integrity, consistent with a specified provision of existing law.

13) Requires each hospital, effective July 1, 2026, to establish a written process for screening patients within its charity care and discount payment policies that is accessible to the public and is provided to HCAI, as specified under existing law. Requires written policy process documentation to disclose the name of the software products and all other third-party services used to presumptively determine, or determine, eligibility for charity care and discounted payment.

14) Prohibits screening conducted pursuant to this bill from being considered a request or application for charity care or a discounted payment, and prohibits screening from

disqualifying a patient from requesting charity care or discounted payment or submitting an application or documentation of income for the purposes of determining eligibility for charity care or discounted payment.

15) Permits a hospital to accept voluntary submission of information or documentation that would assist the hospital in the screening process as long as the hospital does not compel the patient to provide the information as a condition of screening.

16) Permits a hospital to use existing patient information in the screening process for the sole purpose of determining eligibility for charity care or discounted payment. Permits a hospital to incorporate the use of this information into its standard intake, registration, or billing workflows. Permits this information to include, but not be limited to:

    a) Existing patient medical or billing records;
    b) Information routinely collected during patient registration or admission;
    c) Information voluntarily supplied by the patient;
    d) Prior eligibility determination for charity care or discounted payment; and,
    e) Any other information routinely collected or maintained by a hospital that reasonably indicates financial hardship or eligibility for charity care or discount payment under the hospital's charity care or discount payment policy.

17) Permits a hospital to use third-party software tools or services, or contract with a third party, including a public agency, to conduct screening. However, requires a hospital that elects to conduct screening using third-party software tools or services, or by contracting with a third party, to ensure:

    a) The process does not cause any negative impact on a patient's credit score;
    b) Evaluations are based on eligibility criteria established in the hospital's written charity care or discount payment policies, and prohibits evaluations from considering any assessment, evaluation, or score that predicts the patient's propensity or ability to pay;
    c) The third-party software tool or service is used in a way that is reasonable calculated to lead to an accurate result; and,
    d) In the event a third-party service or software tool fails to return information about the patient, or specifies the patient's income is unknown, the hospital makes a good faith effort to evaluate the patient's eligibility status based on information available to the hospital.

18) Requires a hospital to document any information or methods it utilized in 16) and 17) above to screen a patient.

19) Requires a hospital to provide a written notice to patients presumptively determined to be eligible pursuant to the presumptive eligibility provisions of this bill, or determined to be eligible under the screening provisions of this bill, for charity care or discounted payment. Requires this written notice, for patients determined to be eligible for discounted payment, to include a statement that additional assistance may be available under the hospital's charity care and discount payment policies.

20) Requires a hospital to promptly provide the patient with a written notice of the hospital's charity care policy and discount payment policy, as required under specified provisions of existing law, in the event a screening process determines that a patient is not eligible for

charity care or discounted payment, or if the hospital is unable to determine a patient's eligibility.

21) Requires written notices required by this bill to be provided in English and the language spoken by the patient, consistent with applicable state and federal law, as specified.

22) Prohibits a billing statement to be sent to a patient who is presumptively determined to be eligible for charity care or discounted payment, or determined to be eligible pursuant to the screening process in this bill, prior to the issuance of the written notice required in 19) above.

23) Requires any billing statement sent to a patient who is presumptively determined to be eligible for charity care or discounted payment, or determined to be eligible pursuant to the screening process in this bill, to reflect the adjustments made to the patient's hospital charges under the hospital's charity care or discount payment policies.

FISCAL EFFECT: According to the Assembly Appropriations Committee, HCAI estimates General Fund costs of approximately $1.44 million annually to collect information necessary to determine compliance and assess penalties for any identified violations. HCAI's estimate includes seven staff to review the added presumptive eligibility requirements in a hospital's charity care and discount payment policies, and investigate whether the hospital met the presumptive eligibility requirements in this bill. HCAI would also investigate, through the patient complaint process, whether a hospital complied with its policies for individual patients, and assess administrative penalties if HCAI identifies violations.

PRIOR VOTES:

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COMMENTS:

1) *Author's statement.* According to the author, rising health care costs are threatening access to care, and patients continue to face barriers to financial assistance. With as little as someone's full name and zip code, a hospital can quickly estimate a patient's eligibility for free or discounted care and immediately apply that financial assistance before a patient receives a bill. Under the FPP, hospitals are already required to provide free or discounted care to patients who are income eligible. However, we hear story after story of patients not receiving assistance they were eligible for. This bill will ensure that income-eligible patients actually receive the care they deserve without the heavy burden of medical debt.

2) *Background on the FPP.* After several years of debate between consumer advocates and hospitals, AB 774 (Chan, Chapter 755, Statutes of 2006) established the Hospital Fair Pricing Policies Act. AB 774 did several things: it required hospitals to establish charity care and discount billing policies, and included notices about those policies; it limited the amount that uninsured patients could be charged to no more than the hospital could expect to receive for the same services from Medicare or Medi-Cal or other government sponsored benefits; it ensured that patients would additionally be screened for government-subsidized programs for which they may qualify; and, it established practices for collections on bills, including that a hospital or collection agent may not take adverse action against a consumer for at least 150 days after the initial bill. AB 1503 (Lieu, Chapter 445, Statutes of 2010) used the model of AB 774 to apply very similar discount and charity care requirements to emergency

physicians who provide emergency medical services in a hospital. In the intervening years, a number of bills have modified what is now called the Hospital and Emergency Physicians Fair Pricing Policies Act. AB 1020 (Friedman, Chapter 473, Statutes of 2021) shifted enforcement of the FPP from CDPH to HCAI, increased the income threshold for eligibility from 350% of FPL to 400% of FPL, and placed limitations on medical debt collection practices. AB 2297 (Friedman, Chapter 511, Statutes of 2024) prohibited a hospital from considering the monetary assets of the patient in determining eligibility for charity care or discount payment policies, and prohibited hospitals or emergency physicians from imposing time limits for applying for charity care or discounted payments.

3) *Medical debt.* According to the 2024 California Health Care Foundation's Health Policy Survey, nearly four in ten Californians report having any kind of medical debt, and Californians who report any kind of medical debt are more likely to report skipping care. Black (53%) and Latino (46%) are more likely to report debt than White (33%) or Asian Californians (28%). Among Californians who report medical debt, 18% owe $5,000 or more, 10% owe between $5,000 and $10,000, 4% owe between $10,000 and $25,000, and another 4% report owing more than $25,000. According to a March 2023 brief from the Urban Institute' Health Reform Monitoring Survey, more than one in seven adults live in families with past-due medical debt, and nearly three in four with past due-medical debt report owing at least some of that debt to hospitals. Most adults with past-due hospital bills reported that a collection agency contacted them about the debt. Although nearly 36% of adults with past-due hospital bills reported working out a payment plan, only about 22% reported received discounted care. Additionally, adults with incomes below 250% of FPL were as likely as those with higher incomes to experience hospital debt collection actions and to have received discounted care.

   An October 14, 2019, *Kaiser Health News* report indicates that 45% of nonprofit hospital organizations are routinely sending medical bills to patients whose incomes are low enough to qualify for charity care, according to the analysis of reports, the nonprofits submit annually to the Internal Revenue Service (IRS). Those 1,134 organizations operate 1,651 hospitals. Together, the hospitals estimated they had given up collecting $2.7 billion in bills sent to patients who probably would have qualified for financial assistance under the hospitals' own policies if they had filled out the applications. These written-off bills, known as bad debt, represented a tenth of all nonprofit hospital bad debt reported to the IRS in 2017 (the most recent year for which data is available). That sum may represent an undercount because it is based on self-reported estimates from hospitals and is not independently audited. In addition, it does not include money that financially struggling patients eventually paid. There were several California hospitals included in this analysis. Many small and rural hospitals, but also in urban Southern California regions.

4) *Recently enacted Oregon law had a challenging roll-out.* Proponents have pointed to a recently enacted law require hospitals to prescreen patients for financial assistance as part of the inspiration for this bill. This legislation was passed in 2023, and took effect on July 1, 2024. In January 2025, the Oregon Health Authority (OHA) published a report reflecting feedback from hospitals on the first three to five months of implementation. According to this report, the legislation created requirements for hospitals to screen certain patients for presumptive eligibility of financial assistance, and to apply that financial assistance to the patient's bill prior to sending the first billing statement. The legislation also required hospitals to adopt a process to allow a patient to appeal a denial of financial assistance, and a mechanism for patients to correct financial assistance applications that have errors or missing

documentation. According to OHA, hospitals reported significant challenges in implementing the new prescreening requirements. Hospitals expressed concerns about the software tools they used for prescreening, reporting that the third-party vendor tools hospitals were currently using often lead them to provide financial assistance to patient that do not qualify. OHA noted that while software screening was not required, the volume of patients that the law required hospitals to prescreen made it a practical requirement for most large hospitals, with high-volume hospitals noting that manually screening patients would be infeasible. There are two third-party vendor tools that hospitals purchased to prescreen for eligibility. One of these, by Experian, used 2020 Census data, loan applications, mortgages, credit and debt information in a waterfall method to evaluate a patient's household size and income. The other, by Waystar, uses census data at the zip code +4 digit extension level to estimate income based on a census tract, and then employing a proprietary algorithm as a charity care scoring tool. Neither use tax returns or any other confirmed source of actual income, so they can only provide an estimate of income and household size based on secondary data, and errors occur. The law requires that if a patient is determined to be eligible based on the prescreening, the eligibility decision is required to remain in effect for nine months, whether or not the decision accurately reflected true eligibility. Hospitals reported that this extended time period exacerbates the problem of inaccurate screening. OHA reported that hospitals doing more front-end work, such as asking patients questions or prescreening prior to the time of service, reported greater success than hospitals with entirely back-end prescreening processes, though fewer hospitals were doing front-end work. Back-end processes prescreen patients by querying tools after service and prior to billing. Hospitals struggled to implement and manage the high volume of prescreenings they are required to conduct, and the increase in financial assistance awards translated into significant lost hospital revenue. Hospitals reported to OHA that the new law added a large amount of work and staff time. OHA noted that the interviews with hospitals were conducted after three to five months of prescreening implementation, and that hospitals anticipated another six to nine months of challenging implementation before the programs run smoothly.

5) *Prior legislation.* AB 2297 (Friedman, Chapter 511, Statutes of 2024) prohibited a hospital from considering the monetary assets of the patient in determining eligibility for charity care or discount payment policies, and prohibited hospitals or emergency physicians from imposing time limits for applying for charity care or discounted payments.

   SB 1061 (Limón, Chapter 520, Statutes of 2024) prohibits medical debt from being furnished to a consumer credit reporting agency, and, prohibits a person who uses a consumer credit report in connection with a credit transaction from using medical debt as a negative factor when making a credit decision.

   AB 1020 (Friedman, Chapter 473, Statutes of 2021) increases the income threshold for qualifying for hospital discount payment programs to 400% of FPL, transfers oversight of hospital fair pricing policies to HCAI, adds requirements on debt collectors and debt buyers (including increasing time before unpaid hospital debt can be reported to credit agencies), and makes other changes to help inform patients about charity care and discount payment requirements and avoid debt collection litigation.

   AB 532 (Wood, Chapter 465, Statutes of 2021) creates additional disclosure requirements on hospitals related to written notices about the availability of discounted payment and charity care policies for uninsured patients and patients with high medical costs, such as inclusion of the internet address of an organization that will help patients understand billing and payment

processes, the timing of disclosures, and posting in observation units.

AB 1503 (Lieu, Chapter 445, Statutes of 2010) required emergency physicians who provide emergency medical services in a hospital to provide discounts to uninsured patients, establishes limits on the expected payment for emergency medical services, limited debt-collection activities, and required hospitals to include a written description of the hospital discount policy.

AB 774 (Chan, Chapter 755, Statutes of 2006) established Hospital Fair Pricing Policies, which requires every hospital to offer reduced rates to uninsured and underinsured patients who may have low or moderate income, and to provide policies that clearly state the qualifications for free care and discounted payments.

6) *Support.* This bill is co-sponsored by Health Access, the California Pan-Ethnic Health Network, the Leukemia & Lymphoma Society, and Rising Communities. The sponsors state that healthcare costs are primary reasons patients delay or skip treatment. Financial assistance or charity care at a hospital is supposed to ease these financial burdens, but patients continue to face barriers in receiving the aid they may be eligible for. As a result, a visit to a hospital that should be covered by existing charity care can instead result in thousands of dollars in medical bills. Sponsors state that hospital bills are driving a medical debt crisis in California, with more than 1 in 3 Californians reporting medical debt. Those who report medical debt are disproportionately high among communities that have historically faced barriers to health care, including Black, Spanish-speaking, and those with low income. The sponsors state that this bill requires hospital to screen patients to prevent medical debt. It does this by first requiring hospital to determine if patients are enrolled in an income-verified, means-tested program such as CalWORKs or WIC, among others. Patients enrolled in these programs are presumptively eligible for financial assistance by the time they receive their first medical bill. Secondly, this bill requires screening other patients, such as those on a Covered California health plan or with a medical bill of more than $500, to determine if they are eligible for financial assistance. Sponsors state that hospitals can decide how to determine eligibility and collect the needed information to make a determination. Requiring proactive screening of patients will mean more eligible patients will walk away from a hospital visit without having incurred medical debt. According to sponsors, more than half of California hospitals, including Kaiser, Providence, Dignity Health, and MLK Jr. Community Hospital, already implement presumptive eligibility policies. This bill captures these best practices and ensures that eligible patients receive the financial assistance they are entitled to by law. Numerous other organizations also support this bill, making similar arguments.

7) *Support if amended.* Los Angeles County (LAC) states that it would support this bill if amended to delay implementation until January 1, 2028. LAC states that this bill represents a meaningful step toward improving how hospitals identify patients eligible for financial assistance, however, the current deadline of July 1, 2026 provides less than six months for hospitals to comply. This is an unrealistic timeframe given the operational changes required. A phased implementation would allow hospitals to allocate resources appropriately, train staff, and coordinate with the state to ensure successful adoption.

8) *Oppose unless amended.* The California Hospital Association (CHA) is opposed to this bill unless it is amended to address the following provisions and concerns:

- *Guaranteed financial assistance for patients or a family member previously determined eligible for financial assistance in the last twelve months.* CHA notes that a patient's income can change within a 12-month period, and that automatically applying prior eligibility risks misdirecting limited resources to those who may not need it. CHA requests this provision be removed.
- *Financial assistance screening for any patient that will owe the hospital $500 or more after insurance adjustments.* CHA states that because a patient's exact needs and coverage is unknown upon intake, hospitals are unable to predict or calculate their out-of-pocket costs at the time of service or upon their discharge, and request this provision be removed.
- *No option for patient to opt out of screening.* CHA states that as currently drafted, hospitals must screen all the patients who meet one of the specified categories, and there is no ability for a patient to decide whether or not they want to be screened. Some patients may not wish to disclose or discuss their personal finances, and so CHA requests that a patient opt-out provision be included.
- *Two-year delay*. Finally, CHA request a two-year implementation delay so that hospitals have sufficient time to make the operational changes that are necessary to ensure compliance.

SUPPORT AND OPPOSITION:

Support: California Pan-Ethnic Health Network (co-sponsor)
Health Access California (co-sponsor)
Leukemia and Lymphoma Society (co-sponsor)
Rising Communities (co-sponsor)
AARP
Alliance of Californians for Community Empowerment
Alliance San Diego
ALS Association
American Cancer Society Cancer Action Network, Inc.
American Federation of State, County, and Municipal Employees
APLA Health
Asian Americans Advancing Justice – Southern California
Asian Resources, Inc.
Bet Tzedek Legal Services
Black Women for Wellness Action Project
Black Alliance for Just Immigration
Buen Vecino
California Alliance for Retired Americans
California Federation of Teachers
California LGBTQ Health and Human Services Network
California Physicians Alliance
California Rural Legal Assistance Foundation
California State Council of Service Employees International Union
Center for Empowering Refugees & Immigrants
Centro Binacional Para El Desarrollo Indígena Oaxaqueno
Communities Actively Living Independent & Free
Courage California
Dollar For

First Day Foundation
Friends Committee on Legislation of California
Grace Institute - End Child Poverty in CA
Haven Neighborhood Services
Having Our Say Coalition
Health Care for All - California
Healthy Contra Costa
Indivisible CA: Statestrong
La Cooperativa Campesina De California
Latino Coalition for a Healthy California
Mockingbird Analytics
National Health Law Program
National Multiple Sclerosis Society
Our Time to ACT
Public Counsel
Regional Pacific Islander Taskforce
San Diego Refugee Communities Coalition
Sister Warriors Freedom Coalition
Small Business Majority
South Asian Network
Southeast Asia Resource Action Center
Starting Over Strong
The Cambodian Family
The Children's Partnership
United Latino Voices of Contra Costa County
Vision Y Compromiso
Western Center on Law & Poverty, Inc.
Youth Alive!
Three individuals

Oppose: California Hospital Association (unless amended)

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