Office of Senate Floor Analyses
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THIRD READING

Bill No: AB 1312
Author: Schiavo (D)
Amended: 9/3/25 in Senate
Vote: 21

SENATE HEALTH COMMITTEE: 8-0, 7/16/25
AYES: Menjivar, Durazo, Gonzalez, Limón, Padilla, Richardson, Rubio, Wiener
NO VOTE RECORDED: Valladares, Grove, Weber Pierson

SENATE APPROPRIATIONS COMMITTEE: 5-2, 8/29/25
AYES: Caballero, Cabaldon, Grayson, Richardson, Wahab
NOES: Seyarto, Dahle

ASSEMBLY FLOOR: 51-16, 6/2/25 - See last page for vote

SUBJECT: Hospital pricing

SOURCE: California Pan-Ethnic Health Network
Health Access California
Leukemia and Lymphoma Society
Rising Communities

DIGEST: This bill requires a hospital, beginning on July 1, 2027, 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, as specified, and also 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.

Senate Floor Amendments of 9/3/25 incorporated technical assistance from the Department of Health Care Access and Information and also addressed some stakeholder concerns, including removing the prohibition on a hospital requiring a patient to apply for Medicare, Medi-Cal, or other coverage for a person who is

screened for, or provided, charity care, specifying that a hospital is required to request eligibility verification prior to billing the patient rather than before discharge, removing provisions about collecting information after the patient is discharged, and making other technical, clarifying, and conforming changes.

ANALYSIS:

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. [Health and Safety Code (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 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. [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:

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, beginning on July 1, 2027, to screen patients to determine if they meet any of the following criteria, and if so, presumptively determine that a patient is eligible for participation under the hospital's charity care or discount payment policy, subject to verification:

   a) The patient or any member of the patient's family is enrolled in CalFresh, CalWORKs, or Tribal Temporary Assistance for Needy Family (Tribal 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 their family was determined to be eligible for participation under the hospital's discount or charity care payment policy for services billed or provided during the previous 6-month period, and the patient attests that their income and insurance has not changed; 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 screened for, or provided with, discounted payment. However, permits a hospital to require the patient to participate in a screening for Medi-Cal eligibility when screening for discounted payment.

5) Defines "screening" as the process a hospital uses to identify 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, beginning on July 1, 2027, 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; or,
   c) Enrolled in a Covered California health plan.

7) Requires a hospital to inform a patient of its intent to screen the patient for eligibility and that any personal and financial information provided by the patient will be used solely for those purposes. Requires the hospital to inform the patient of their right to opt out of screening, and to provide the patient with a form to sign to opt out of screening, which is required to be placed in the patient's medical record.

8) 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, discounted payment. However, permits a hospital to require the patient to participate in a screening for Medi-Cal eligibility when being screened for discounted payment.

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

10) Permits a hospital to verify a patient's eligibility as part of, or after, the screening to determine if a patient is financially qualified, and permits a hospital to attempt to independently verify the patient's information before billing. If unable to independently verify eligibility, requires the hospital to request verification from the patient prior to billing. Requires the request to be in writing and include the documentation necessary to determine eligibility.

11) Permits the hospital to collect all of the information required to verify eligibility prior to discharge.

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, 2027, 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 the names of any software products and any other third-party services used to presumptively determine, or determine, eligibility for charity care and discounted payment to be disclosed with the written process.

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.

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 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 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 or voluntarily provided by the patient.

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. Permits this notice to be sent prior to, or in conjunction with, a billing notice, but prohibits a billing statement to be sent to a patient determined to be eligible prior to the issuance of this notice.

20) 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.

21) 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 may be eligible for charity care or discounted payment, but is later determined to be ineligible, or if the hospital is unable to verify a patient's eligibility.

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

Comments

According to the author of this bill:

> 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.

Background

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.

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.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: No

According to the Senate Appropriations Committee, HCAI estimates ongoing General Fund costs of approximately $1.6 million beginning in 2026-27 to collect information necessary to determine compliance and assess penalties for any identified violations.

SUPPORT: (Verified 9/4/25)

California Pan-Ethnic Health Network (co-source)
Health Access California (co-source)
Leukemia and Lymphoma Society (co-source)

Rising Communities (co-source)
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
Americans for Democratic Action, Southern California Chapter
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 Coverage & Health Initiatives
California Federation of Teachers
California LGBTQ Health and Human Services Network
California Low-Income Consumer Coalition
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 Access National Network
Communities Actively Living Independent & Free
County of Los Angeles
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
Healthy House Within A MATCH Coalition
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
San Francisco Senior and Disability Action
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
Transitions Clinic Network
United Latino Voices of Contra Costa County
Vision Y Compromiso
Western Center on Law & Poverty, Inc.
Youth Alive!
Three individuals

OPPOSITION: (Verified 9/4/25)

None received

ARGUMENTS IN 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.

ASSEMBLY FLOOR: 51-16, 6/2/25
AYES: Addis, Aguiar-Curry, Ahrens, Alanis, Alvarez, Arambula, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Caloza, Connolly, Davies, Elhawary, Fong, Gabriel, Garcia, Gipson, Mark González, Haney, Harabedian, Irwin, Jackson, Kalra, Krell, Lee, Lowenthal, McKinnor, Muratsuchi, Nguyen, Ortega, Papan, Patel, Pellerin, Quirk-Silva, Ransom, Celeste Rodriguez, Rogers, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Stefani, Wallis, Ward, Wicks, Zbur, Rivas
NOES: Ávila Farías, Castillo, Chen, DeMaio, Ellis, Flora, Gallagher, Jeff Gonzalez, Hadwick, Hoover, Lackey, Macedo, Patterson, Sanchez, Ta, Tangipa
NO VOTE RECORDED: Bains, Calderon, Carrillo, Dixon, Hart, Pacheco, Petrie-Norris, Ramos, Michelle Rodriguez, Blanca Rubio, Valencia, Wilson

Prepared by: Vincent D. Marchand / HEALTH / (916) 651-4111
9/6/25 10:36:38

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