Medical Debt Cheat Sheet

2020

Health Consumer Alliance

Applicable statutes and regulations to help fight medical bills for low-income clients.

B&P = Business & Professions Code
CC = California Civil Code5
CCP = California Code of Civil Procedure
CCR = California Code of Regulations
INS = California Insurance Code
CFR = Code of Federal Regulations
H&S = California Health & Safety Code
USC = United States Code
WIC = California Welfare & Institutions Code

A. Statute of Limitations (SOL) on Medical Bills

CCP § 337 for almost all contracts: 4 years from the date of the bill. Notice the "open book" exception that extends the SOL to the last service rendered and §360 which extends it to the date of last payment. If the bill is from a state or county hospital, the law is the same, but cite CCP § 345.

Note: Passage of AB 1526 in 2018 prohibits lawsuits outright once the SOL has run, instead of the expiration of the SOL serving as an affirmative defense. Debt collectors are also required to inform creditors when the SOL has run out. CCP § 337 & CC § 1788.14

B. Helpful Medi-Cal Rules

1. **No billing Medi-Cal beneficiaries**
   Acceptance of Medi-Cal (BIC) Card = agreement to not seek payment from a beneficiary for covered services
   WIC § 14019.4(a), 22 CCR § 51002(a) (this doesn't include co-payments or Share of Cost)
2. **No balance billing Medi-Cal beneficiaries**
   Medi-Cal reimbursement = payment in full
   42 FR § 447.15; WIC §§ 14019.3(d), 14019.4(a)
3. **Further provider restrictions and penalties (WIC § 14019.4)**
   a. Sanctions of up to 3 times the Medi-Cal reimbursement rate for inappropriate billing by Medi-Cal provider or collection agency. WIC § 14019.4(c)
   b. Obligations to cease debt collection efforts upon proof of Medi-Cal eligibility. WIC § 14019.4(d)
   c. Violation of Credit Reporting Agencies Act if provider or collection agency give wrong information to a credit reporting agency or fail to correct information that went to credit reporting agency for Medi-Cal beneficiaries. WIC § 14019.4(f)
4. **Ancillary provider problems**
   Federal conditions of participation in the program require hospitals, LTC facilities, home health agencies and certain other providers to ensure they contract with medical professionals that accept Medicaid. 42 CFR § 482.1 *et seq*.
5. **Emergency services out-of-network**
   No billing for emergency services provided to managed care enrollee by non-contracting provider 42 USC § 1396u-2.

6. **Medi-Cal eligible, but not enrolled**
    a. Retroactive Medi-Cal = 3 calendar months prior to the month of application if would have been eligible at the time. Can ask for coverage up to a year after the bill.
    Ex. Applies April 15th, can get retro for January, February, March, as well as the month of application. Have until January 1st 2021 to seek coverage for bill from January 2nd 2020. 42 USC § 1396a(a)(34); 42 CFR § 435.914; WIC § 14019; 22 CCR § 50148.
    b. Obligations of hospitals to help enroll in Medi-Cal
    H&S § 127420, (also, Hill Burton regulations for hospitals that get Medicaid dollars)
    c. Federal obligations for state and county to provide aid with reasonable promptness 42 USC § 1396a(a)(8)
    d. State obligations for counties to help clients secure maximum benefits to which they are eligible, including Medi-Cal
    WIC § 10500
    e. *Conlan* obligations for out-of-pocket costs while not on Medi-Cal
        i. Beneficiary may seek reimbursement from the state (DHCS) if the provider refuses to reimburse
        ii. Once someone has applied for Medi-Cal, they must see Medi-Cal providers to get reimbursed by DHCS
        iii. Medi-Cal reimbursement claim must be filed within 1 year of services or 90 days after receipt of BIC card, whichever is longer
7. **Share of Cost problems**
    See Chapter 3 of the WCLP health care eligibility guide to check calculations used to determine SOC – often deductions are missed or there is a more beneficial program.
8. **Dual Eligibles**
    a. No balance billing of QMBs—any payment made by Medi-Cal (if any) is payment in full; provider subject to sanctions for violations; dual cannot waive this protection.
    42 U.S.C. Sec. 1396a(n)(3)(B)
    b. No balance billing of Medicare Advantage enrollees – applies to ALL duals in MA 42 CFR Sec. 422.504(g)(1)(iii)

C. Knox Keene Obligations (H&S 1340 *et seq*.)

Knox Keene covers HMOs & Blue PPOs, including for Medi-Cal managed care, AIM Plans, and most Covered California products. Health plans contract to provide medically necessary services, so if it's a service covered by the policy and the plan is refusing to cover, appeal to the plan and then file a complaint with the Department of Managed Health Care.

1. Emergency Services

Since emergency services are often out-of-network, managed care plans might refuse to pay.
a. Pre-stabilization: ER care shall be covered by health plan if it's an emergency H&S § 1371.5
b. Post-stabilization: Hospital cannot bill consumer if the hospital did not contact consumer's health plan. The health plan has the option of moving the consumer to a contracting provider. H&S § § 1262.8(c), 1371.4(j).

2. **Balance Billing**
   Contracting providers may not seek payment directly from consumers for covered services. H&S § 1379; 28 CCR 1300.71.39. Includes ER services and all hospital-based physicians and on-call specialists.

D. Surprise Medical Bills

1. Starting July 1, 2017, individuals in health plans regulated by the Department of Managed Health Care or the CA Department of Insurance are protected from surprise medical bills when they go to in- network facilities such as hospitals, labs or imaging centers. Inapplicable to Medi-Cal plans, Medicare plans or "self-insured plans." H&S § 1371.9, 1371.31; Ins Code § 10112.8, 10112.82
2. Ex. A consumer who has surgery at an in-network hospital, but the anesthesiologist was not in their health plan network, cannot be billed more than would be charged for an in-network anesthesiologist.
3. See DMHC Surprise Medical Bills Fact Sheet for more information.

E. County Obligations

See Chapter 7 of the WCLP health care eligibility guide for more information.
Counties must cover "subsistence medical care" for indigent adults not eligible for Medi-Cal and unable to pay for their own care. WIC § 17000. *The Affordable Care Act did not change this statutory obligation!*

1. Emergency care: allowed for non-residents by county where emergency occurred. WIC § 17003 *See Fuchino v. Edward- Buckley* (2011) for counties obligation to cover emergency services received out-of-county.
2. Continued debt problem – although counties are obligated to cover indigent adults, it is technically a loan, though there are protections as to how liens may be enforced. *See* WIC § 17107; § 17400 *et seq*.

F. Hospital Bills for the Uninsured & Underinsured

See Chapter 8 of the WCLP health care eligibility guide for more information.

1. Hospital Fair Pricing Act limited charges to uninsured & underinsured persons. AB 774; H&S § 127400, et seq. Hospital policies may be found at https://syfphr.oshpd.ca.gov/FacilityList.aspx
   a. Qualified patients = earns less than 350% FPL and is either uninsured or underinsured (medical expenses = 10% or more of annual income). Statute was modified in 2015 to include a greater number of underinsured people facing high deductibles or out-of-pocket costs. H&S § 127400(g).
   b. Maximum charge = Reimbursement rate of Medicare or other government-sponsored health programs in which the hospital participates. H&S § 127420(d)
   c. Hospitals are required to maintain both financial assistance (discount) and charity care (free) policies that state eligibility criteria. H&S § 127405(a)-(c).
   d. Notice of such policies must be conspicuously posted and given at the time of billing. H&S § 127410(a)-(b).
   e. Negative action may not be taken on bills for 150 days, extended if patient is trying to qualify for financial assistance or a denial of coverage. H&S § 127425(d),(e), 127426.
   f. Additional limitations exist on liens and wage garnishments for hospital bills. H&S § 127425 (f).
   g. Emergency physicians were added in 2011, but not specialists and other services. H&S § 127450.
   h. "Reasonable Payment Plan" added in 2015. If hospital and patient can't come to an agreement, then reasonable payment plan is no more than 10% of patient's monthly income after excluding essential living expenses. Essential living expenses are itemized in H&S § 127400(i).

2. New IRS regulations on non-profit hospitals: 79 Fed. Reg. 78954 (Dec. 31, 2014). Many of the protections are similar, with a few notable additional protections.
    a. 240-day period in which a hospital *must* accept an application. 26 C.F.R. § 1.501(r)-1(b)(3)
    b. Ability to recall bill from collections (otherwise may be a prohibited *extraordinary collection action*). 26 C.F.R. § 1.501(r)-6(b)(2)
    c. Give a written plain language description of policy and attempt to notify patient orally of financial assistance available 26 C.F.R. §1.501(r)-6(c)(4)(i)

G. Special Protections for Medical Credit Cards

1. AB 171, effective 1/1/10: in response to a number of predatory-lending type scenarios involving dentists and medical credit cards, AB 171 requires written treatment plans, an estimate of costs, and a signed acknowledgment of the patient's rights and responsibilities that is provided in the appropriate threshold language. B&P § 654.3. Willful violations of this law entitle patients to relief under the Consumer Legal Remedies Act (CC § 1780).
2. SB 1256, passed in 2014, expanded the above rules to any licensed health care provider.
3. SB 639, effective 7/1/20, prohibits medical providers from offering medical credit cards with deferred interest provisions, completing credit card applications that are not completely filled out by the patient, charging for treatment or costs to a medical credit card more than 30 days before the date of services/costs incurred (except for incremental fees for orthodontic treatment), and signing patients up for medical credit cards in treatment areas. B&P § 654.3
   This bill also requires Medi-Cal providers to specify whether or not services are covered by Medi-Cal in patients' treatment plans. Under this updated rule, language about medical credit cards must also be written at a 6th grade reading level.

H. Key Fair Debt Collection Concepts

1. Federal Fair Debt Collection Practices Act (FDCPA) applies to collection agencies, not providers, but regulates what collection agencies may say, when they may contact, what "proof" of the debt they must provide, etc. 15 USC § 1692 *et seq*.
2. Rosenthal Fair Debt Collection Practices Act – California law that essentially incorporates all of the protections of the FDCPA, with a couple of other state provisions, but also covers the entity where the debt originates (providers).
   CC § 1788 *et seq*.
3. Enforcement of Judgments – California Code of Civil Procedure – Part 2, Title 9 (CCP § 681.010 *et seq*.
    a. Judgment proof
       If someone is judgment proof, they have nothing that can be collected, so it does not matter if they are sued for a debt (other than the ruined credit). Judgment proof = no wages that can be garnished and no assets. Consider at least the next 10 years when determining if judgment proof. CCP § 695.010 *et seq*.
    b. Wage garnishment limits
       CCP § 706.050 – wage garnishment limits are the lessor of 25% of disposable earnings or amount in excess of 40 times the state minimum hourly wage. (In other words, if you're not working at least 40 hours at minimum wage, you have nothing that can be garnished.)
    c. Bank account levies - CCP § 704.080 contains the public benefits exceptions to amounts that can be levied from bank accounts.
    d. Home equity limits - CCP §704.730
    e. Claim of exemption

If someone does have a judgment against them, they may seek a claim of exemption from wage garnishment if the debt is for medical services. (AB 1388 amended CCP § 706.051 to remove the "necessities of life" exception from exemptions).

I. Other theories of non-liability

1. Tort
2. Contract
3. Consumer Legal Remedies Act
4. Malpractice
5. Business & Professions Code §17200 (Unfair Business Practices Act)

J. Other potential payers

1. Physicians Compensation Fund
2. Pharmaceutical Assistance Programs (e.g. NeedyMeds)
3. Victims of Crime Funding
4. Co-pay assistance programs (e.g. Patient Advocate