Senate Bill No. 359

Passed the Senate August 31, 2012

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Secretary of the Senate

Passed the Assembly August 31, 2012

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2012, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Section 1371.4 of, and to add and repeal Article 3 (commencing with Section 127465) of Chapter 2.5 of Part 2 of Division 107 of, the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 359, Hernandez. Hospital billing: emergency services and care.

Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health and requires a licensed facility that maintains and operates an emergency department to provide emergency services and care to any person requesting the services or care for any condition in which the person is in danger of loss of life or serious injury or illness, as specified. Existing law requires hospitals to maintain a written policy regarding discount payments for financially qualified patients as well as a written charity care policy. Existing law requires a hospital to limit the expected payment for services it provides to certain low-income patients to the highest amount the hospital would expect to receive for providing services from a government-sponsored program of health benefits in which the hospital participates.

This bill would require a hospital with an out-of-network emergency utilization rate, as defined, of 50% or more to notify payers that its total billed charges for emergency services and care provided to a patient prior to stabilization are subject to adjustment such that the hospital's total expected payment would be 60% of the payer's average in-network payments, as defined, but less than 150% of the payment the hospital reasonably could expect to receive from Medicare for providing similar emergency services and care prior to stabilization. The bill would authorize a payer that receives this notice to reimburse hospitals in accordance with that adjustment. The bill would specify that these provisions do not apply to charges billed by physicians or other licensed professionals who are members of the hospital medical staff or to charges provided as treatment for an injury that is compensable

for purposes of workers' compensation. The bill would also specify that its provisions do not apply in specified instances, including if any other law requires the hospital to limit expected payment for the emergency services and care to a lesser amount, if a contract governs the total billed charges for the emergency services and care, or if a government program of health benefits, as specified, is the primary payer for the emergency services and care. The bill would provide for the repeal of its provisions on January 1, 2017.

The people of the State of California do enact as follows:

SECTION 1. Section 1371.4 of the Health and Safety Code is amended to read:

1371.4. (a) A health care service plan that covers hospital, medical, or surgical expenses, or its contracting medical providers, shall provide 24-hour access for enrollees and providers, including, but not limited to, noncontracting hospitals, to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.

(b) A health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan, or its contracting medical providers, reasonably determines that the emergency services and care were never performed; provided that a health care service plan, or its contracting medical providers, may deny reimbursement

to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

(e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.

(f) Subdivisions (b), (c), (d), (h), and (i) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician.

(g) A health care service plan, or its contracting medical providers, that is obligated to reimburse providers for emergency services and care provided to its enrollees prior to stabilization pursuant to subdivision (b) may adjust its reimbursement to hospitals in accordance with Section 127466.

(h) The Department of Managed Health Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when an enrollee requires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization.

(i) The Department of Managed Health Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider requires necessary medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan.

(j) The definitions set forth in Section 1317.1 shall control the construction of this section.

(k) (1) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall, within 30 minutes of the time the hospital makes the initial telephone call requesting information, either authorize poststabilization care or inform the hospital that it will arrange for the prompt transfer of the enrollee to another hospital.

(2) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall reimburse the hospital for poststabilization care rendered to the enrollee if any of the following occur:

(A) The health care service plan authorizes the hospital to provide poststabilization care.

(B) The health care service plan does not respond to the hospital's initial contact or does not make a decision regarding whether to authorize poststabilization care or to promptly transfer the enrollee within the timeframe set forth in paragraph (1).

(C) There is an unreasonable delay in the transfer of the enrollee, and the noncontracting physician and surgeon determines that the enrollee requires poststabilization care.

(3) A health care service plan shall not require a hospital representative or a noncontracting physician and surgeon to make more than one telephone call pursuant to Section 1262.8 to the number provided in advance by the health care service plan. The representative of the hospital that makes the telephone call may be, but is not required to be, a physician and surgeon.

(4) An enrollee who is billed by a hospital in violation of Section 1262.8 may report receipt of the bill to the health care service plan and the department. The department shall forward that report to the State Department of Public Health.

(5) For purposes of this section, "poststabilization care" means medically necessary care provided after an emergency medical condition has been stabilized.

SEC. 2. Article 3 (commencing with Section 127465) is added to Chapter 2.5 of Part 2 of Division 107 of the Health and Safety Code, to read:

Article 3. Hospital Emergency Pricing

127465. (a) For purposes of this article, the following definitions shall apply:

(1) "Average in-network payments" means the average amount of payments made pursuant to a contract during the preceding calendar year to hospitals in California that offer a comparable range of services and, if applicable, education and research programs, by a health care service plan or health insurer for reimbursement of care provided by the hospital or hospitals at a negotiated rate, provided that payments made by the plan or insurer during the preceding calendar year for in-system care shall not be included in the calculation of the average.

(2) "Health care service plan" has the same meaning as that term is defined in Section 1345.

(3) "Health insurer" means an insurer that issues policies of health insurance, as defined in Section 106 of the Insurance Code.

(4) "Hospital" means a hospital licensed under subdivision (a) or (f) of Section 1250, with an emergency department licensed by the State Department of Public Health, with the following exceptions:

(A) "Hospital" does not include designated public hospitals described in subdivision (d) of Section 14166.1 of the Welfare and Institutions Code.

(B) "Hospital" does not include a hospital owned and operated by an entity that is a city, a county, a city and county, the State of California, the University of California, a local health or hospital authority, a health care district, any other political subdivision of the state, any combination of political subdivisions of the state organized pursuant to a joint powers agreement, or a new hospital that is described in Section 14165.50 of the Welfare and Institutions Code.

(C) "Hospital" does not include any of the following:

(i) A rural general acute care hospital, as defined in subdivision (a) of Section 1250.

(ii) A small and rural hospital, as defined in Section 124840.

(iii) A general acute care hospital that is located within both of the following:

(I) A county with a population of 1,500,000 or less according to the 2010 federal census.

(II) A medically underserved population, a medically underserved area, or a health professions shortage area, as designated by the federal government pursuant to Section 254b, 254c-14, or 254e of Title 42 of the United States Code.

(D) "Hospital" does not include a hospital that is part of a health system in which, as of January 1, 2013, at least 50 percent of the hospitals are rural general acute care hospitals, as defined in subdivision (a) of Section 1250, or small and rural hospitals, as defined in Section 124840, provided that the health system includes at least five hospitals that are either rural general acute care hospitals or small and rural hospitals. For purposes of this subparagraph, both of the following shall apply:

(i) Hospitals are part of the same health system if they are owned, operated, or substantially controlled by the same person or other legal entity or entities.

(ii) Hospitals are considered separate hospitals if they are located at least one mile apart and each has at least 30 beds, regardless of whether the hospitals operate under the same name or license.

(5) "In-network" refers to care provided to a patient by a hospital that has contracted with the patient's health care service plan or health insurer for reimbursement at a negotiated rate with respect to the care provided.

(6) "In-system" refers to care provided to a patient by a hospital that is affiliated with a health care service plan, and the hospital and affiliated health care service plan are owned, operated, or substantially controlled by the same person or persons or other legal entity or entities.

(7) A "local" patient is a patient whose residence meets both of the following requirements:

(A) Is in the same county as the hospital at which the patient receives services and care or is in a county adjacent to the county where the hospital at which the patient receives services and care is located.

(B) Has a five-digit ZIP Code that is the same as the five-digit ZIP Code associated with the residences of patients involved in at least 50 emergency department encounters during the most recently completed calendar year.

(8) An "emergency department encounter" means the patient has been registered in the emergency department for a period of five hours or longer, or has been admitted as an inpatient following registration and a stay of any length in the emergency department. An emergency department encounter does not include an encounter that results from the receipt of patient transfers pursuant to the transfer requirements of the federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. Sec. 1395dd) from another hospital that is not affiliated with, or owned, operated, or substantially controlled by, the same person or persons or other legal entity or entities as the hospital receiving the transfer.

(9) "Out-of-network" refers to care provided to a patient by a hospital that has not contracted with the patient's health care service plan or health insurer for reimbursement at a negotiated rate with respect to the care provided.

(10) "Out-of-network emergency utilization rate" means the percentage of all emergency department encounters at a hospital during the course of the rate reporting period that are out-of-network for local, privately insured patients. This rate shall be calculated by dividing a hospital's total number of emergency department encounters during the rate reporting period that involved local, privately insured patients for whom the emergency services and care provided were out-of-network by the hospital's total number of emergency department encounters that involved local, privately insured patients in the rate reporting period.

(11) "Primary payer" means the payer, other than the patient, who is or was legally required or responsible to make payment with respect to an item or service, or any portion thereof, before any other payer, other than the patient.

(12) (A) "Privately insured patient" means a patient for whom the primary payer is a health insurer, a health care service plan, or an employer plan sponsor, and is not Medicare, Medi-Cal, the Healthy Families Program, the Federal Temporary High Risk Pool, the Major Risk Medical Insurance Program, or any other government program of health benefits or managed care product provided pursuant to any government program of health benefits.

(B) "Privately insured patient" does not include any patient receiving emergency services and care prior to stabilization as treatment for an injury that is compensable for purposes of workers' compensation.

(13) "Rate reporting period" means, for the purposes of calculating the out-of-network emergency utilization rate, a three-year period, provided that if the most recent calendar year ended within the previous 90 days, then data for the three-year period used to calculate the out-of-network emergency utilization rate shall be taken from the three calendar years preceding the most recently completed calendar year.

(b) For purposes of this article, the following shall not be considered to be a government program of health benefits:

(1) A health care service plan, qualified health plan, or health insurance policy or product offered through the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(2) An employer-sponsored health benefit plan or contract providing health benefits or coverage for state, local, or other government employees, retirees, or their family members, including, but not limited to, a health benefit plan or contract entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code).

(c) The definitions of Section 1317.1, with the exception of the definition of "hospital," shall control the construction of this article, unless the context otherwise requires.

127466. (a) (1) A hospital with an out-of-network emergency utilization rate of 50 percent or greater shall notify payers at the time the hospital submits bills, statements, or other demands for payment for emergency services and care provided to a patient prior to stabilization, other than services and care described in paragraph (5), (6), (7), or (9), that the hospital's out-of-network emergency utilization rate is 50 percent or greater and therefore its total billed charges for emergency services and care provided to a patient prior to stabilization may be subject to adjustment in accordance with this section. This subdivision shall not apply to any hospital that has an out-of-network emergency utilization rate that is less than 50 percent, nor shall this subdivision apply to a

hospital if the hospital can establish that in the preceding six-month period the percentage of all emergency department encounters at the hospital that were out-of-network for local, privately insured patients was less than 50 percent.

(2) A hospital's total billed charges subject to adjustment under this subdivision shall not include charges billed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or any other licensed professional who is a member of the hospital medical staff.

(3) The adjustment made pursuant to this subdivision shall be such that the hospital's total expected payment from a payer for emergency services and care prior to stabilization shall be 60 percent of the payer's average in-network payments, but shall in no event be less than 150 percent of the payment the hospital reasonably could expect to receive from Medicare for providing similar emergency services and care prior to stabilization. If the payer does not have average in-network payments for similar emergency services and care prior to stabilization, then the hospital's total expected payment shall be in accordance with existing law.

(4) A payer that receives the notification made by a hospital pursuant to paragraph (1) may adjust the reimbursement to the hospital pursuant to this section.

(5) If a contract, including a contract with a health insurer, health care service plan, or other health care coverage provider, governs the adjustment of the total billed charges for the emergency services and care provided to a patient prior to stabilization by the hospital, the contract shall control and the provisions of this subdivision shall not apply.

(6) The adjustment required by this subdivision shall not apply to a hospital's charges for emergency services and care provided to a patient prior to stabilization as treatment for an injury that is compensable for purposes of workers' compensation.

(7) The adjustment required by this subdivision shall not apply to a hospital's charges for emergency services and care provided to a patient prior to stabilization for whom Medicare, Medi-Cal, or any other government program of health benefits, excluding public employee benefit plans, is the primary payer for those services and care.

(8) The adjustment required by this subdivision shall not apply to a hospital's charges for emergency services and care provided to a patient prior to stabilization where all of the following conditions are met:

(A) The primary payer is a health insurer, health care service plan, or other health care coverage provider.

(B) As of January 1, 2013, the primary payer and the hospital are parties to a contract governing the adjustment of total billed charges for emergency services and care provided to patients prior to stabilization.

(C) On or after January 1, 2013, and before the provision of the emergency services and care to the patient prior to stabilization, the primary payer terminates the contract described in subparagraph (B), except where the termination is due to the hospital's breach of the contract, or the primary payer fails to timely renew the contract described in subparagraph (B) after the hospital makes a timely and binding offer to renew on substantially the same terms and including reasonable rate adjustments. The hospital shall have the burden of proving that it made a timely and binding renewal offer that met the requirements of this paragraph in any proceeding applying this subdivision.

(9) The adjustment required by this subdivision shall not apply if existing law, including Article 1 (commencing with Section 127400), requires a hospital to limit expected payment for emergency services and care provided to a patient prior to stabilization to an amount that is less than the hospital's total billed charges, as adjusted in accordance with paragraph (3). Nothing in this article shall prevent a hospital from adjusting its total billed charges to limit expected payments for emergency services and care prior to stabilization to amounts that are less than the total billed charges as adjusted in accordance with paragraph (3).

(b) If application of federal law, including Section 2719A of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19a), and its implementing regulations, requires that a health care service plan or health insurer provide payment for emergency services and care prior to stabilization in an amount greater than the hospital's total billed charges for those services and care as adjusted in accordance with subdivision (a), the hospital's total billed charges shall be adjusted such that its total expected payment for the emergency services and care prior to stabilization shall be the

minimum amount that will comply with the applicable federal law. Nothing in this subdivision shall be construed as confirming any federal obligation of a health insurer or health care service plan to provide payments of any particular amount for out-of-network emergency services provided to its policyholders or enrollees prior to stabilization.

127467. Nothing in this article shall be construed to require a hospital to modify its uniform schedule of charges or published rates, nor shall this article preclude the recognition of a hospital's established charge schedule or published rates for purposes of applying any payment limit, interim payment amount, or other payment calculation based upon a hospital's rates or charges under the Medi-Cal program, the Medicare Program, workers' compensation, or other federal, state, or local public program of health benefits.

127468. A hospital subject to Section 127466 shall provide reimbursement for any amount actually paid in excess of the amount due under this article, including interest. Interest owed by the hospital shall accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date payment is received by the hospital. However, a hospital is not required to provide a reimbursement if the amount due is less than five dollars ($5).

127469. Nothing in this article shall be construed to supersede or repeal Section 1371, 1371.35, 1371.36, 1371.37, 1371.38, or 1371.39.

127470. This article shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

Approved _____, 2012

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Governor