AMENDED IN SENATE APRIL 23, 2013

SENATE BILL No. 351

Introduced by Senator Hernandez

February 20, 2013

An act *to add Chapter 3.5 (commencing with Section 127601) to Part 2 of Division 107 of the Health and Safety Code,* relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 351, as amended, Hernandez. Health care coverage: ~~emergency care.~~ *hospital billing.*

Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health. 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. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care.

This bill would, until January 1, 2019, require a diagnosis and billing outlier hospital, as defined, and a hospital that is part of a diagnosis and billing outlier health system, as defined, to notify the patient and all payers of that status and that the hospital's total billed charges may be subject to adjustment as described below. The bill would make a failure to provide that notification a felony or a misdemeanor. By

expanding the definition of a crime, this bill would impose a state-mandated local program.

The bill would require the Office of Statewide Health Planning and Development, until January 1, 2019, to assign each hospital, as defined, a separate diagnosis and billing indicator rate for 4 specified disorders and to calculate a hospital's diagnosis and billing indicator rate for each of those disorders, as specified. The bill would require the office to post specified information on its Internet Web site by January 15, 2014, including those diagnosis and billing indicator rates and a list of diagnosis and billing outlier hospitals.

The bill would require the State Department of Public Health, by July 1, 2014, and until January 1, 2019, to contract with one or more independent medical review organizations, or the Department of Managed Health Care, to conduct reviews that a patient or payer could request within one year of receiving a bill from a diagnosis and billing outlier hospital or a hospital in a diagnosis and billing outlier health system, on and after January 15, 2014. The bill would require the review, among other things, to address the appropriateness of diagnostic codes, whether the billed services were actually provided to the patient, whether provided services were medically necessary or appropriate, and what adjustments, if any, should be made to the bills to decrease the total charges. The bill would require, upon receipt of the final report, the State Public Health Officer to immediately adopt the findings of the independent medical review organization, and promptly issue a written decision to the patient, other payers, and the hospital that would be binding on the hospital. The bill would require a hospital to adjust any charges necessary in accordance with the written decision within 30 days. The bill would subject a hospital that fails to provide the above-described adjusted bill or reimbursement of excess charges to a $100 civil penalty each day until it complies. The bill would authorize the State Department of Public Health to adopt regulations to implement these provisions.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms~~

~~that take effect January 1, 2014. Among other things, PPACA generally prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from establishing lifetime limits or annual limits on the dollar value of benefits for any participant or beneficiary.~~

~~Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health insurers annually to submit to the Department of Insurance a summary explanation of any lifetime and annual maximums for health benefits offered pursuant to specified provisions of law.~~

~~This bill would declare the intent of the Legislature to enact legislation that would establish limits on out-of-network hospital emergency care billing practices.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

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

SECTION 1. Chapter 3.5 (commencing with Section 127601) is added to Part 2 of Division 107 of the Health and Safety Code, to read:

CHAPTER 3.5. DIAGNOSIS AND BILLING OUTLIER HOSPITAL BILLING

127601. (a) It is the intent of the Legislature to encourage responsible hospital service and billing practices by mandating the right to an independent review of patients' medical bills submitted by hospitals or health systems that have unusually high rates of certain medical diagnoses or other indications of suspect billing practices.

(b) The Office of Statewide Health Planning and Development shall make recommendations to the Legislature biennially, beginning on September 1, 2016, regarding possible modifications to Section 127603 that would further the legislative intent stated in subdivision (a).

127602. For the purposes of this chapter, the following definitions shall apply:

(a) "Acute care inpatient admission" means a formal admission of a patient to the hospital, with the expectation of remaining overnight or longer, for acute care, as defined in paragraph (1) of subdivision (a) of Section 12501.1.

(b) "Bill" means a bill, statement, or other demand for payment for medical services and care provided.

(c) "Department" means the State Department of Public Health.

(d) "Diagnosis and billing outlier hospital" means any hospital that has a percentile ranking of 90 percent or higher for three or more of its four diagnosis and billing indicator rates if each of those three or more diagnosis and billing indicator rates is at least 150 percent of the statewide average for that diagnosis and billing indicator rate.

(e) "Health system" means a group of three or more hospitals in this state that are owned, operated, or substantially controlled by the same person or persons or other legal entity or entities, including, but not limited to, by a shared corporate parent.

(f) "Hospital" means a hospital licensed under subdivision (a) of Section 1250, provided that "hospital" shall not include either of the following:

(1) A hospital that had fewer than 250 acute care inpatient admissions of patients who were 65 years of age or older at the time of admission, during the 2011 calendar year.

(2) A hospital at which the average length of an acute care inpatient admission of a patient who was 65 years of age or older at the time of admission was 10 days or greater, during the 2011 calendar year.

(g) "ICD-9-CM" means the International Classification of Diseases, 9th Revision, Clinical Modification, published by the United States Department of Health and Human Services.

(h) "Office" means the Office of Statewide Health Planning and Development.

(i) "Payer" means any person or entity, including the patient, legally required or responsible to make payment with respect to a health care item or service, or any portion thereof.

127603. (a) Each hospital subject to this chapter shall be assigned a separate diagnosis and billing indicator rate for each of the following four disorders:

(1) Kwashiorkor or other forms of severe malnutrition, classified as ICD-9-CM code 260, 261, or 262.

(2) Acute heart failure, classified as ICD-9-CM code 428.21, 428.23, 428.31, 428.33, 428.41, or 428.43.

(3) Encephalopathy, classified as ICD-9-CM code 348.30, 348.31, 348.39, or 349.82.

(4) Autonomic nerve disorder, classified as ICD-9-CM code 337.9.

(b) The office shall calculate a hospital's diagnosis and billing indicator rate for each of the four disorders identified in paragraphs (1) to (4), inclusive, of subdivision (a) by dividing the number of all acute care inpatient admissions during the 2011 calendar year of patients who were 65 years of age or older at the time of admission and who were diagnosed with any one or more of the ICD-9-CM codes reflecting the disorder in question, by the total number of acute care inpatient admissions during the 2011 calendar year of patients who were 65 years of age or older at the time of admission. A hospital diagnosis and billing indicator rate shall not be calculated for a disorder identified in paragraphs (1) to (4), inclusive, of subdivision (a) if a hospital has less than 10 acute care inpatient admissions for that disorder.

(c) The office shall publish on its Internet Web site the following information regarding all hospitals' diagnosis and billing indicator rates by no later than January 15, 2014:

(1) Each hospital's diagnosis and billing indicator rates for each of the four disorders identified in paragraphs (1) to (4), inclusive, of subdivision (a).

(2) A list of each hospital's percentile ranking for each diagnosis and billing indicator rate. A hospital's percentile ranking for a diagnosis and billing indicator rate shall be calculated by dividing the number of hospitals subject to this chapter that have diagnosis and billing indicator rates for the disorder in question that are lower than the diagnosis and billing indicator rate of the hospital being ranked, by the total number of hospitals subject to this chapter.

(3) A list of diagnosis and billing outlier hospitals.

(d) The statewide average of a diagnosis and billing indicator rate shall be calculated for each of the disorders identified in paragraphs (1) to (4), inclusive, of subdivision (a) by dividing the number of all acute care inpatient admissions at all hospitals in

the state during the 2011 calendar year of patients who were 65 years of age or older at the time of admission and who were diagnosed with any one or more of the ICD-9-CM codes reflecting the disorder in question, by the total number of acute care inpatient admissions at all hospitals in the state during the 2011 calendar year of patients who were 65 years of age at the time of admission.

127604. (a) Any health system that, during the 2011 calendar year, included three or more diagnosis and billing outlier hospitals shall be deemed a diagnosis and billing outlier health system.

(b) (1) No person or entity listed in paragraph (2) shall be permitted to purchase or operate a hospital in California that is not already owned, operated, or substantially controlled by that person or entity, and shall not be permitted to receive any license for such a hospital pursuant to Chapter 2 (commencing with Section 1250) of Division 2.

(2) This subdivision applies to any diagnosis and billing outlier hospital, diagnosis and billing outlier health system, hospital that is part of a diagnosis and billing outlier health system, or person or persons or other legal entity or entities that own, operate, or substantially control any diagnosis and billing outlier hospital or any hospital that is part of a diagnosis and billing outlier health system.

(c) Every diagnosis and billing outlier hospital and every hospital in a diagnosis and billing outlier health system shall notify the patient and all payers at the time it submits a bill for any provided services and care of the following:

(1) The hospital is a diagnosis and billing outlier hospital or is part of a diagnosis and billing outlier health system.

(2) Its total billed charges may be subject to adjustment pursuant to Section 127605.

(d) A hospital that fails to notify a patient or payer in accordance with the requirements of subdivision (c) shall be punished by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for two, three, or five years, or by a fine not exceeding fifty thousand dollars ($50,000) or, if the bill is found to have excess charges, the amount of the excess charges or fifty thousand dollars ($50,000), whichever is greater, or by both that imprisonment and fine, or by imprisonment in a county jail not to exceed one year, or by a fine of not more than ten thousand dollars ($10,000), or by both that imprisonment and fine.

127605. (a) By July 1, 2014, the department shall contract with one or more independent medical review organizations in the state to conduct reviews for the purposes of this section. The independent medical review organizations shall satisfy the requirements set forth in Section 1374.32 for organizations with which the Department of Managed Health Care may contract. The department director may contract with the Department of Managed Health Care to administer the independent medical review process.

(b) Any patient or payer who receives a bill from a diagnosis and billing outlier hospital or a hospital in a diagnosis and billing outlier health system for services and care provided at that hospital may, on or after January 15, 2014, and within one year of receiving the bill, apply to the department for an independent medical review of the hospital's bill and any other bills for service and care for the same patient submitted by the hospital or any other hospital in the same diagnosis and billing outlier health system. Within 45 days of receiving an application, or by August 15, 2014, whichever is later, the department shall assign an independent medical review organization. The patient or payer shall pay no application or processing fees of any kind.

(c) A patient or payer who notifies a hospital that the patient or payer has applied to the department for an independent medical review of the hospital's bills shall have no obligation to make any payments for any charges on any of the hospital's bills covered by the application until no earlier than 30 days after the patient or payer receives the decision of the department director pursuant to subdivision (f).

(d) An independent medical review organization assigned by the department to review an application made pursuant to subdivision (b) shall do the following:

(1) Review the bills and request any medical records from the hospital that would aid its review. Upon receipt of such a request and any necessary patient authorization, the hospital shall promptly provide to the independent medical review organization all the patient's medical records in the possession of the hospital, its agents, or its contracting providers relevant to the patient's medical condition, the services being provided to the patient for the condition, and the services and care on the bill under review.

(2) Determine whether each charge was for a service that was actually provided to the patient and whether each service was

medically necessary or appropriate based on the specific medical needs of the patient or the patient's instructions, and any of the following:

(A) Peer-reviewed scientific and medical evidence regarding the effectiveness of the service.

(B) Nationally recognized professional standards.

(C) Expert opinion.

(D) Generally accepted standards of medical practice.

(3) Prepare a draft report setting forth its findings.

(4) Submit copies of the draft report to the patient and all other payers and the hospital or hospitals that submitted the bills, and provide the patient, other payers, and the hospitals 30 days to submit comments, arguments, and evidence.

(5) Consider any comments, arguments, and evidence submitted pursuant to paragraph (4) and make any appropriate modifications to its draft report.

(6) Deliver to the patient, all other payers, the hospitals, and the department a final report within 30 days of receiving any comments, arguments, or evidence submitted pursuant to paragraph (4).

(e) The draft and final reports prepared by the independent medical review organization shall include specific findings regarding the appropriateness of the hospital's use of diagnostic codes, whether services indicated on the bills were actually provided to the patient, whether the services provided were medically necessary or appropriate, and whether and what adjustments should be made to the bills that would decrease the total billed charges on the bills.

(f) Upon receipt of the final report, the State Public Health Officer shall immediately adopt the findings of the independent medical review organization, and shall promptly issue a written decision to the patient, other payers, and the hospital that shall be binding on the hospital.

(g) Within 30 days of receiving a decision pursuant to subdivision (f) that identifies adjustments that would decrease the total billed charges on the hospital's bills, a hospital shall adjust those charges in accordance with the decision and send a revised bill to the patient and other payers. If a patient or other payer has already paid for billed charges that, in accordance with the decision, should not have been billed, the hospital shall provide

appropriate reimbursement within 30 days of receipt of the decision.

(h) A hospital that does not comply with subdivision (g) shall not seek or accept any payments for any charges that the department director has determined should be adjusted, and shall be subject to a civil penalty to be assessed by the department of one hundred dollars ($100) for each day the hospital does not send any revised bill or provide appropriate reimbursement, as required by subdivision (g).

(i) The reasonable cost of each independent review and the associated reasonable costs to the department of administering the independent medical review system established by this section shall be borne by the hospital whose bill is subject to the review pursuant to an assessment fee system established by the department director.

127606. The department may adopt regulations to implement this chapter.

127607. This chapter shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 3. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

~~SECTION 1. It is the intent of the Legislature to enact legislation to establish limits on out-of-network hospital emergency care billing practices.~~

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