

AMENDED IN SENATE MARCH 24, 2014

SENATE BILL

No. 1215

Introduced by Senator Hernandez

February 20, 2014

An act to amend Section ~~1367.006~~ of the Health and Safety Code, and to amend Section ~~10112.28~~ of the Insurance Code, relating to health care coverage 650.02 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1215, as amended, Hernandez. ~~Health care coverage. Healing arts licensees: referrals.~~

Existing law provides for the licensure and regulation of healing arts professionals by boards within the Department of Consumer Affairs. Existing law makes it a crime for licensed healing arts professionals to receive money or other consideration for, or to engage in various related activities with respect to, the referral of patients, clients, or customers to any person, with specified exceptions.

Existing law also makes it a crime for a licensed healing arts professional to refer patients for specified services if the licensee or his or her immediate family has a financial interest, as defined, with the person or entity. Existing law provides that, among other exceptions, this prohibition does not apply to services for a specific patient that are performed within, or goods that are supplied by, a licensee's office or the office of a group practice.

This bill would provide that this exception does not apply to advanced imaging, anatomic pathology, radiation therapy, or physical therapy for a specific patient that is performed within a licensee's office or the

office of a group practice. By expanding the scope of a crime, the bill would impose a state-mandated local program.

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 establishes annual limits on deductibles for employer-sponsored plans and defines bronze, silver, gold, and platinum levels of coverage for the nongrandfathered individual and small group markets.~~

~~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 that nongrandfathered care service plan and health insurance contracts that are issued, amended, or renewed on or after January 1, 2015, provide for a limit on annual out-of-pocket expenses for covered benefits, as specified.~~

~~This bill would correct erroneous references in those provisions.~~

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:

- 1 SECTION 1. *The Legislature finds and declares all of the*
- 2 *following:*
- 3 (a) *Recent studies by the Government Accountability Office*
- 4 *(GAO) examining self-referral practices in advanced diagnostic*
- 5 *imaging and anatomic pathology determined that financial*
- 6 *incentives were the most likely cause of increases in self-referrals.*
- 7 (b) *For advanced diagnostic imaging, the GAO stated that*
- 8 *“providers who self-referred made 400,000 more referrals for*
- 9 *advanced imaging services than they would have if they were not*
- 10 *self-referring,” at a cost of “more than \$100 million” in 2010.*

1 (c) For anatomic pathology, the GAO found that “self-referring
2 providers likely referred over 918,000 more anatomic pathology
3 services” than they would have if they were not self-referring,
4 costing Medicare approximately \$69 million more in 2010 than if
5 self-referral was not permitted.

6 (d) In November 2012, Bloomberg News released an
7 investigative report that scrutinized ordeals faced by California
8 prostate cancer patients treated by a urology clinic that owns
9 radiation therapy equipment. The report found that physician
10 self-referral resulted in a detrimental impact on patient care and
11 drove up health care costs in the Medicare Program. The Wall
12 Street Journal, the Washington Post, and the Baltimore Sun have
13 also published investigations showing that urology groups owning
14 radiation therapy machines have utilization rates that rise quickly
15 and are well above national norms for radiation therapy treatment
16 of prostate cancer.

17 SEC. 2. Section 650.02 of the Business and Professions Code
18 is amended to read:

19 650.02. The prohibition of Section 650.01 shall not apply to
20 or restrict any of the following:

21 (a) A licensee may refer a patient for a good or service otherwise
22 prohibited by subdivision (a) of Section 650.01 if the licensee’s
23 regular practice is located where there is no alternative provider
24 of the service within either 25 miles or 40 minutes traveling time,
25 via the shortest route on a paved road. If an alternative provider
26 commences furnishing the good or service for which a patient was
27 referred pursuant to this subdivision, the licensee shall cease
28 referrals under this subdivision within six months of the time at
29 which the licensee knew or should have known that the alternative
30 provider is furnishing the good or service. A licensee who refers
31 to or seeks consultation from an organization in which the licensee
32 has a financial interest under this subdivision shall disclose this
33 interest to the patient or the patient’s parents or legal guardian in
34 writing at the time of referral.

35 (b) A licensee, when the licensee or his or her immediate family
36 has one or more of the following arrangements with another
37 licensee, a person, or an entity, is not prohibited from referring a
38 patient to the licensee, person, or entity because of the arrangement:

39 (1) A loan between a licensee and the recipient of the referral,
40 if the loan has commercially reasonable terms, bears interest at

1 the prime rate or a higher rate that does not constitute usury, is
2 adequately secured, and the loan terms are not affected by either
3 party's referral of any person or the volume of services provided
4 by either party.

5 (2) A lease of space or equipment between a licensee and the
6 recipient of the referral, if the lease is written, has commercially
7 reasonable terms, has a fixed periodic rent payment, has a term of
8 one year or more, and the lease payments are not affected by either
9 party's referral of any person or the volume of services provided
10 by either party.

11 (3) Ownership of corporate investment securities, including
12 shares, bonds, or other debt instruments that may be purchased on
13 terms generally available to the public and that are traded on a
14 licensed securities exchange or NASDAQ, do not base profit
15 distributions or other transfers of value on the licensee's referral
16 of persons to the corporation, do not have a separate class or
17 accounting for any persons or for any licensees who may refer
18 persons to the corporation, and are in a corporation that had, at the
19 end of the corporation's most recent fiscal year, or on average
20 during the previous three fiscal years, stockholder equity exceeding
21 seventy-five million dollars (\$75,000,000).

22 (4) Ownership of shares in a regulated investment company as
23 defined in Section 851(a) of the federal Internal Revenue Code, if
24 the company had, at the end of the company's most recent fiscal
25 year, or on average during the previous three fiscal years, total
26 assets exceeding seventy-five million dollars (\$75,000,000).

27 (5) A one-time sale or transfer of a practice or property or other
28 financial interest between a licensee and the recipient of the referral
29 if the sale or transfer is for commercially reasonable terms and the
30 consideration is not affected by either party's referral of any person
31 or the volume of services provided by either party.

32 (6) A personal services arrangement between a licensee or an
33 immediate family member of the licensee and the recipient of the
34 referral if the arrangement meets all of the following requirements:

35 (A) It is set out in writing and is signed by the parties.

36 (B) It specifies all of the services to be provided by the licensee
37 or an immediate family member of the licensee.

38 (C) The aggregate services contracted for do not exceed those
39 that are reasonable and necessary for the legitimate business
40 purposes of the arrangement.

1 (D) A person who is referred by a licensee or an immediate
2 family member of the licensee is informed in writing of the
3 personal services arrangement that includes information on where
4 a person may go to file a complaint against the licensee or the
5 immediate family member of the licensee.

6 (E) The term of the arrangement is for at least one year.

7 (F) The compensation to be paid over the term of the
8 arrangement is set in advance, does not exceed fair market value,
9 and is not determined in a manner that takes into account the
10 volume or value of any referrals or other business generated
11 between the parties.

12 (G) The services to be performed under the arrangement do not
13 involve the counseling or promotion of a business arrangement or
14 other activity that violates any state or federal law.

15 (c) (1) A licensee may refer a person to a health facility, as
16 defined in Section 1250 of the Health and Safety Code, or to any
17 facility owned or leased by a health facility, if the recipient of the
18 referral does not compensate the licensee for the patient referral,
19 and any equipment lease arrangement between the licensee and
20 the referral recipient complies with the requirements of paragraph
21 (2) of subdivision (b).

22 (2) Nothing shall preclude this subdivision from applying to a
23 licensee solely because the licensee has an ownership or leasehold
24 interest in an entire health facility or an entity that owns or leases
25 an entire health facility.

26 (3) A licensee may refer a person to a health facility for any
27 service classified as an emergency under subdivision (a) or (b) of
28 Section 1317.1 of the Health and Safety Code.

29 (4) A licensee may refer a person to any organization that owns
30 or leases a health facility licensed pursuant to subdivision (a), (b),
31 or (f) of Section 1250 of the Health and Safety Code if the licensee
32 is not compensated for the patient referral, the licensee does not
33 receive any payment from the recipient of the referral that is based
34 or determined on the number or value of any patient referrals, and
35 any equipment lease arrangement between the licensee and the
36 referral recipient complies with the requirements of paragraph (2)
37 of subdivision (b). For purposes of this paragraph, the ownership
38 may be through stock or membership, and may be represented by
39 a parent holding company that solely owns or controls both the
40 health facility organization and the affiliated organization.

1 (d) A licensee may refer a person to a nonprofit corporation that
2 provides physician services pursuant to subdivision (l) of Section
3 1206 of the Health and Safety Code if the nonprofit corporation
4 is controlled through membership by one or more health facilities
5 or health facility systems and the amount of compensation or other
6 transfer of funds from the health facility or nonprofit corporation
7 to the licensee is fixed annually, except for adjustments caused by
8 physicians joining or leaving the groups during the year, and is
9 not based on the number of persons utilizing goods or services
10 specified in Section 650.01.

11 (e) A licensee compensated or employed by a university may
12 refer a person for a physician service, to any facility owned or
13 operated by the university, or to another licensee employed by the
14 university, provided that the facility or university does not
15 compensate the referring licensee for the patient referral. In the
16 case of a facility that is totally or partially owned by an entity other
17 than the university, but that is staffed by university physicians,
18 those physicians may not refer patients to the facility if the facility
19 compensates the referring physicians for those referrals.

20 ~~(f) The~~

21 *(f) (1) Except as specified in paragraph (2), the prohibition of*
22 *Section 650.01 shall not apply to any service for a specific patient*
23 *that is performed within, or goods that are supplied by, a licensee's*
24 *office, or the office of a group practice. Further, the provisions of*
25 *Section 650.01 shall not alter, limit, or expand a licensee's ability*
26 *to deliver, or to direct or supervise the delivery of, in-office goods*
27 *or services according to the laws, rules, and regulations governing*
28 *his or her scope of practice.*

29 *(2) The prohibition of Section 650.01 shall apply to advanced*
30 *imaging, anatomic pathology, radiation therapy, or physical*
31 *therapy for a specific patient that is performed within a licensee's*
32 *office or the office of a group practice.*

33 (g) The prohibition of Section 650.01 shall not apply to cardiac
34 rehabilitation services provided by a licensee or by a suitably
35 trained individual under the direct or general supervision of a
36 licensee, if the services are provided to patients meeting the criteria
37 for Medicare reimbursement for the services.

38 (h) The prohibition of Section 650.01 shall not apply if a licensee
39 is in the office of a group practice and refers a person for services
40 or goods specified in Section 650.01 to a multispecialty clinic, as

1 defined in subdivision (l) of Section 1206 of the Health and Safety
2 Code.

3 (i) The prohibition of Section 650.01 shall not apply to health
4 care services provided to an enrollee of a health care service plan
5 licensed pursuant to the Knox-Keene Health Care Service Plan
6 Act of 1975 (Chapter 2.2 (commencing with Section 1340) of
7 Division 2 of the Health and Safety Code).

8 (j) The prohibition of Section 650.01 shall not apply to a request
9 by a pathologist for clinical diagnostic laboratory tests and
10 pathological examination services, a request by a radiologist for
11 diagnostic radiology services, or a request by a radiation oncologist
12 for radiation therapy if those services are furnished by, or under
13 the supervision of, the pathologist, radiologist, or radiation
14 oncologist pursuant to a consultation requested by another
15 physician.

16 (k) This section shall not apply to referrals for services that are
17 described in and covered by Sections 139.3 and 139.31 of the
18 Labor Code.

19 ~~(l) This section shall become operative on January 1, 1995.~~

20 *SEC. 3. No reimbursement is required by this act pursuant to*
21 *Section 6 of Article XIII B of the California Constitution because*
22 *the only costs that may be incurred by a local agency or school*
23 *district will be incurred because this act creates a new crime or*
24 *infraction, eliminates a crime or infraction, or changes the penalty*
25 *for a crime or infraction, within the meaning of Section 17556 of*
26 *the Government Code, or changes the definition of a crime within*
27 *the meaning of Section 6 of Article XIII B of the California*
28 *Constitution.*

29 ~~SECTION 1. Section 1367.006 of the Health and Safety Code~~
30 ~~is amended to read:~~

31 ~~1367.006. (a) This section shall apply to nongrandfathered~~
32 ~~individual and group health care service plan contracts that provide~~
33 ~~coverage for essential health benefits, as defined in Section~~
34 ~~1367.005, and that are issued, amended, or renewed on or after~~
35 ~~January 1, 2015.~~

36 ~~(b) (1) For nongrandfathered health care service plan contracts~~
37 ~~in the individual or small group markets, a health care service plan~~
38 ~~contract, except a specialized health care service plan contract,~~
39 ~~that is issued, amended, or renewed on or after January 1, 2015,~~
40 ~~shall provide for a limit on annual out-of-pocket expenses for all~~

1 covered benefits that meet the definition of essential health benefits
2 in Section 1367.005, including out-of-network emergency care
3 consistent with Section 1371.4.

4 ~~(2) For nongrandfathered health care service plan contracts in~~
5 ~~the large group market, a health care service plan contract, except~~
6 ~~a specialized health care service plan contract, that is issued,~~
7 ~~amended, or renewed on or after January 1, 2015, shall provide~~
8 ~~for a limit on annual out-of-pocket expenses for covered benefits;~~
9 ~~including out-of-network emergency care consistent with Section~~
10 ~~1371.4. This limit shall only apply to essential health benefits, as~~
11 ~~defined in Section 1367.005, that are covered under the plan to~~
12 ~~the extent that this provision does not conflict with federal law or~~
13 ~~guidance on out-of-pocket maximums for nongrandfathered health~~
14 ~~care service plan contracts in the large group market.~~

15 ~~(e) (1) The limit described in subdivision (b) shall not exceed~~
16 ~~the limit described in Section 1302(e) of PPACA, and any~~
17 ~~subsequent rules, regulations, or guidance issued under that section.~~

18 ~~(2) The limit described in subdivision (b) shall result in a total~~
19 ~~maximum out-of-pocket limit for all covered essential health~~
20 ~~benefits equal to the dollar amounts in effect under Section~~
21 ~~223(e)(2)(A)(ii) of the Internal Revenue Code of 1986 with the~~
22 ~~dollar amounts adjusted as specified in Section 1302(c)(1)(B) of~~
23 ~~PPACA.~~

24 ~~(d) Nothing in this section shall be construed to affect the~~
25 ~~reduction in cost sharing for eligible enrollees described in Section~~
26 ~~1402 of PPACA, and any subsequent rules, regulations, or guidance~~
27 ~~issued under that section.~~

28 ~~(e) If an essential health benefit is offered or provided by a~~
29 ~~specialized health care service plan, the total annual out-of-pocket~~
30 ~~maximum for all covered essential benefits shall not exceed the~~
31 ~~limit in subdivision (c). This section shall not apply to a specialized~~
32 ~~health care service plan that does not offer an essential health~~
33 ~~benefit as defined in Section 1367.005.~~

34 ~~(f) The maximum out-of-pocket limit shall apply to any~~
35 ~~copayment, coinsurance, deductible, and any other form of cost~~
36 ~~sharing for all covered benefits that meet the definition of essential~~
37 ~~health benefits in Section 1367.005.~~

38 ~~(g) For nongrandfathered health plan contracts in the group~~
39 ~~market, “plan year” has the meaning set forth in Section 144.103~~
40 ~~of Title 45 of the Code of Federal Regulations. For~~

1 nongrandfathered health plan contracts sold in the individual
2 market, “plan year” means the calendar year.

3 (h) “PPACA” means the federal Patient Protection and
4 Affordable Care Act (Public Law 111-148), as amended by the
5 federal Health Care and Education Reconciliation Act of 2010
6 (Public Law 111-152), and any rules, regulations, or guidance
7 issued thereunder.

8 SEC. 2. Section 10112.28 of the Insurance Code is amended
9 to read:

10 10112.28. (a) This section shall apply to nongrandfathered
11 individual and group health insurance policies that provide
12 coverage for essential health benefits, as defined in Section
13 10112.27, and that are issued, amended, or renewed on or after
14 January 1, 2015.

15 (b) (1) For nongrandfathered health insurance policies in the
16 individual or small group markets, a health insurance policy, except
17 a specialized health insurance policy, that is issued, amended, or
18 renewed on or after January 1, 2015, shall provide for a limit on
19 annual out-of-pocket expenses for all covered benefits that meet
20 the definition of essential health benefits in Section 10112.27,
21 including out-of-network emergency care.

22 (2) For nongrandfathered health insurance policies in the large
23 group market, a health insurance policy, except a specialized health
24 insurance policy, that is issued, amended, or renewed on or after
25 January 1, 2015, shall provide for a limit on annual out-of-pocket
26 expenses for covered benefits, including out-of-network emergency
27 care. This limit shall apply only to essential health benefits, as
28 defined in Section 10112.27, that are covered under the policy to
29 the extent that this provision does not conflict with federal law or
30 guidance on out-of-pocket maximums for nongrandfathered health
31 insurance policies in the large group market.

32 (c) (1) The limit described in subdivision (b) shall not exceed
33 the limit described in Section 1302(c) of PPACA and any
34 subsequent rules, regulations, or guidance issued under that section.

35 (2) The limit described in subdivision (b) shall result in a total
36 maximum out-of-pocket limit for all covered essential health
37 benefits that shall equal the dollar amounts in effect under Section
38 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the
39 dollar amounts adjusted as specified in Section 1302(c)(1)(B) of
40 PPACA.

1 ~~(d) Nothing in this section shall be construed to affect the~~
2 ~~reduction in cost sharing for eligible insureds described in Section~~
3 ~~1402 of PPACA and any subsequent rules, regulations, or guidance~~
4 ~~issued under that section.~~

5 ~~(e) If an essential health benefit is offered or provided by a~~
6 ~~specialized health insurance policy, the total annual out-of-pocket~~
7 ~~maximum for all covered essential benefits shall not exceed the~~
8 ~~limit in subdivision (c). This section shall not apply to a specialized~~
9 ~~health insurance policy that does not offer an essential health~~
10 ~~benefit as defined in Section 10112.27.~~

11 ~~(f) The maximum out-of-pocket limit shall apply to any~~
12 ~~copayment, coinsurance, deductible, and any other form of cost~~
13 ~~sharing for all covered benefits that meet the definition of essential~~
14 ~~health benefits, as defined in Section 10112.27.~~

15 ~~(g) For nongrandfathered health insurance policies in the group~~
16 ~~market, “policy year” has the meaning set forth in Section 144.103~~
17 ~~of Title 45 of the Code of Federal Regulations. For~~
18 ~~nongrandfathered health insurance policies sold in the individual~~
19 ~~market, “policy year” means the calendar year.~~

20 ~~(h) “PPACA” means the federal Patient Protection and~~
21 ~~Affordable Care Act (Public Law 111-148), as amended by the~~
22 ~~federal Health Care and Education Reconciliation Act of 2010~~
23 ~~(Public Law 111-152), and any rules, regulations, or guidance~~
24 ~~issued thereunder.~~