

AMENDED IN SENATE JUNE 15, 2016

AMENDED IN SENATE SEPTEMBER 9, 2015

AMENDED IN SENATE SEPTEMBER 4, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 72

Introduced by Assembly ~~Member Bonta~~ Members *Bonta, Bonilla, Dahle, Gonzalez, Maienschein, and Wood*
(Coauthor: Senator Hancock)

December 18, 2014

An act to add and repeal Article 4 (commencing with Section 32250) of Chapter 3 of Division 23 of the Health and Safety Code, relating to health care districts, and declaring the urgency thereof, to take effect immediately. *Sections 1371.30, 1371.31, and 1371.9 to the Health and Safety Code, and to add Sections 10112.8, 10112.81, and 10112.82 to the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 72, as amended, Bonta. ~~Eden Township Healthcare District special taxes authorization.~~ *Health care coverage: out-of-network coverage.*

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. A willful violation of the act is a crime. Existing law requires a health care service plan to reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee. Existing law prohibits a health care service plan from requiring a provider to obtain authorization prior to the provision of emergency services and

care necessary to stabilize the enrollee's emergency medical care, as specified.

Existing law also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires a health insurance policy issued, amended, or renewed on or after January 1, 2014, that provides or covers benefits with respect to services in an emergency department of a hospital to cover emergency services without the need for prior authorization, regardless of whether the provider is a participating provider, and subject to the same cost sharing required if the services were provided by a participating provider, as specified.

This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2017, to provide that if an enrollee or insured receives covered services from a contracting health facility, as defined, at which, or as a result of which, the enrollee or insured receives covered services provided by a noncontracting individual health professional, as defined, the enrollee or insured would be required to pay the noncontracting individual health professional only the same cost sharing required if the services were provided by a contracting individual health professional, which would be referred to as the "in-network cost-sharing amount." The bill would require the in-network cost-sharing amount to be collected by the health care service plan or health insurer, as specified. The bill would prohibit an enrollee or insured from owing the noncontracting individual health professional at the contracting health facility more than the in-network cost-sharing amount if the noncontracting individual health professional receives reimbursement for services provided to the enrollee or insured at a contracting health facility from the health care service plan or health insurer. However, the bill would make an exception from this prohibition if the enrollee or insured provides written consent that satisfies specified criteria. The bill would require a noncontracting individual health professional who collects any amount from the enrollee or insured to refund the amount to the enrollee or insured, as specified, and would provide that interest on any amount not refunded to the enrollee or insured shall accrue at 15% per annum, as specified.

Existing law requires a contract between a health care service plan and a provider, or a contract between an insurer and a provider, to contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan or insurer. Existing law requires that dispute resolution

mechanism also be made accessible to a noncontracting provider for the purpose of resolving billing and claims disputes.

This bill would require the department and the commissioner to each establish an independent dispute resolution process that would allow a noncontracting individual health professional who rendered services at a contracting health facility, or a plan or insurer, to appeal a claim payment dispute, as specified. The bill would authorize the department and the commissioner to contract with one or more independent dispute resolution organizations to conduct the independent dispute resolution process, as specified. The bill would provide that the decision of the organization would be binding on the parties. The bill would require a plan or insurer to base reimbursement for covered services on the amount the individual health professional would have been reimbursed by Medicare for the same or similar services in the general geographic area in which the services were rendered. The plan or insurer would be required to provide specified information relating to the determination of the average contracted rate by July 1, 2017, and to adjust the rate each year thereafter, as prescribed. The bill would require the department and the commissioner to report the above information to the Governor and other specified recipients by January 1, 2020. The bill would require a noncontracting individual health professional who disputes that claim reimbursement to utilize the independent dispute resolution process. The bill would provide that these provisions do not apply to emergency services and care, as defined.

Because a willful violation of the bill's provisions relative to a health care service plan would be 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 law provides for the formation of local health care districts and specifies district powers. The California Constitution prohibits the Legislature from imposing taxes for local purposes, but allows the Legislature to authorize local governments to impose them.~~

~~This bill, until January 1, 2026, would authorize the Eden Township Healthcare District to impose special taxes, as provided.~~

~~This bill would make legislative findings and declarations as to the necessity of a special statute for the Eden Township Healthcare District.~~

~~This bill would declare that it is to take effect immediately as an urgency statute.~~

Vote: $\frac{2}{3}$ -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. Section 1371.30 is added to the Health and Safety
2 Code, immediately following Section 1371.3, to read:

3 1371.30. (a) (1) The department shall establish an independent
4 dispute resolution process for the purpose of processing and
5 resolving a claim dispute between a health care service plan and
6 a noncontracting individual health professional for services subject
7 to subdivision (a) of Section 1371.9.

8 (2) Prior to initiating the independent dispute resolution process,
9 the parties shall exhaust the plan’s internal process.

10 (3) If either the noncontracting individual health professional
11 or the plan appeals a claim to the department’s independent dispute
12 resolution process, the other party shall participate in the appeal
13 process as described in this section.

14 (b) (1) The department shall establish uniform written
15 procedures for the submission, receipt, processing, and resolution
16 of claim payment disputes pursuant to this section and any other
17 guidelines for implementing this section.

18 (2) The department shall establish reasonable and necessary
19 fees for the purpose of administering this section, to be paid by
20 both parties.

21 (3) In establishing the independent dispute resolution process,
22 the department may permit the bundling of claims submitted to the
23 same plan or the same delegated entity for the same or similar
24 services by the same noncontracting individual health professional.

25 (4) The department shall permit a physician group, independent
26 practice association, or other entity authorized to act on behalf of
27 a noncontracting individual health professional to participate in
28 the independent dispute resolution process.

29 (c) (1) The department may contract with one or more
30 independent organizations to conduct the proceedings. The

1 independent organization handling a dispute shall be independent
2 of either party to the dispute.

3 (2) The department shall establish conflict-of-interest standards,
4 consistent with the purposes of this section, that an organization
5 shall meet in order to qualify to administer the independent dispute
6 resolution program. The conflict-of-interest standards shall be
7 consistent with the standards pursuant to subdivisions (c) and (d)
8 of Section 1374.32.

9 (3) The department may contract with the same independent
10 organization or organizations as the Department of Insurance.

11 (4) The department shall provide, upon the request of an
12 interested person, a copy of all nonproprietary information, as
13 determined by the director, filed with the department by an
14 independent organization seeking to contract with the department
15 to administer the independent dispute resolution process pursuant
16 to this section. The department may charge a nominal fee to cover
17 the costs of providing a copy of the information pursuant to this
18 paragraph.

19 (d) (1) The determination obtained through the department's
20 independent dispute resolution process shall be binding on both
21 parties.

22 (2) Notwithstanding paragraph (1), this section does not
23 preclude a dissatisfied party from pursuing any right, remedy, or
24 penalty established under any other applicable law.

25 (e) This section shall not apply to a Medi-Cal managed health
26 care service plan or any entity that enters into a contract with the
27 State Department of Health Care Services pursuant to Chapter 7
28 (commencing with Section 14000), Chapter 8 (commencing with
29 Section 14200), and Chapter 8.75 (commencing with Section
30 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

31 (f) If a health care service plan delegates payment functions to
32 a contracted entity, including, but not limited to, a medical group
33 or independent practice association, then the delegated entity shall
34 comply with this section.

35 (g) This section shall not apply to emergency services and care,
36 as defined in Section 1317.1.

37 (h) The definitions in subdivision (f) of Section 1371.9 shall
38 apply for purposes of this section.

39 SEC. 2. Section 1371.31 is added to the Health and Safety
40 Code, to read:

1 1371.31. (a) (1) For services rendered subject to Section
2 1371.9, unless otherwise agreed to by the noncontracting individual
3 health professional and the plan, the plan shall reimburse the
4 greater of the average contracted rate or 125 percent of the amount
5 Medicare reimburses on a fee-for-service basis for the same or
6 similar services in the general geographic region in which the
7 services were rendered. For the purposes of this section, “average
8 contracted rate” means the average of the contracted rates paid
9 by the health plan or delegated entity for the same or similar
10 services in the geographic region. This subdivision does not apply
11 to subdivision (c) of Section 1371.9 or subdivision (b) of this
12 section.

13 (2) (A) In a manner and format specified by the department,
14 by July 1, 2017, each health care service plan shall provide to the
15 department both of the following:

16 (i) Data listing its average contracted rates for services most
17 frequently subject to Section 1371.9 in each geographic region in
18 which the services are rendered, including the average contracted
19 rates paid by the plan’s delegated entities.

20 (ii) Its methodology for determining the average contracted rate
21 for services subject to Section 1371.9. The methodology to
22 determine an average contracted rate shall assure that the plan
23 includes the highest and lowest contracted rates.

24 (B) Each health care service plan’s delegated entities shall
25 provide to the department data listing its average contracted rates
26 for services most frequently subject to Section 1371.9 in each
27 geographic region in which the services are rendered.

28 (C) For each year thereafter, the health care service plan and
29 the plan’s delegated entities shall adjust the rate initially
30 established pursuant to this subdivision by the Consumer Price
31 Index for Medical Care Services, as published by the United States
32 Bureau of Labor Statistics.

33 (D) The department shall audit the accuracy of the information
34 required under subparagraphs (A) and (B).

35 (E) By January 1, 2020, the department shall provide a report
36 to the Governor, the President pro Tempore of the Senate, the
37 Speaker of the Assembly, and the Senate and Assembly Committees
38 on Health of the data provided in subparagraphs (A) and (B) in a
39 manner and format specified by the Legislature.

1 (3) For purposes of this section for Medicare fee for service
2 reimbursement, geographic regions shall be the geographic regions
3 specified for physician reimbursement for Medicare fee for service
4 by the United States Department of Health and Human Services.

5 (4) A health care service plan shall authorize and permit
6 assignment of the enrollee's right, if any, to any reimbursement
7 for health care services covered under the plan contract to a
8 noncontracting individual health professional who furnishes the
9 health care services rendered subject to Section 1371.9. The plan
10 shall provide a form approved by the department for this purpose.

11 (5) A noncontracting individual health professional who disputes
12 the claim reimbursement under this section shall utilize the
13 independent dispute resolution process described in Section
14 1371.30.

15 (b) If nonemergency services are provided by a noncontracting
16 individual health professional consistent with subdivision (c) of
17 Section 1371.9, to an enrollee who has voluntarily chosen to use
18 his or her out-of-network benefit for services covered by a
19 preferred provider organization or a point-of-service plan, unless
20 otherwise agreed to by the plan and the noncontracting individual
21 health professional, the amount paid shall be the amount set forth
22 in the enrollee's evidence of coverage. This payment is not subject
23 to the independent dispute resolution process described in Section
24 1371.30.

25 (c) If a health care service plan delegates the responsibility for
26 payment of claims to a contracted entity, including, but not limited
27 to, a medical group or independent practice association, then the
28 entity to which that responsibility is delegated shall comply with
29 the requirements of this section.

30 (d) (1) A payment made by the health care service plan to the
31 noncontracting health care professional for nonemergency services
32 as required by Section 1371.9 and this section, in addition to the
33 applicable cost sharing owed by the enrollee, shall constitute
34 payment in full for nonemergency services rendered.

35 (2) Notwithstanding any other law, the amounts paid by a plan
36 for services under this section shall not constitute the prevailing
37 or customary charges, the usual fees to the general public, or other
38 charges for other payers for an individual health professional.

39 (3) This subdivision shall not preclude the use of the independent
40 dispute resolution process pursuant to Section 1371.30.

1 (e) *This section shall not apply to a Medi-Cal managed health*
2 *care service plan or any other entity that enters into a contract*
3 *with the State Department of Health Care Services pursuant to*
4 *Chapter 7 (commencing with Section 14000), Chapter 8*
5 *(commencing with Section 14200), and Chapter 8.75 (commencing*
6 *with Section 14591) of Part 3 of Division 9 of the Welfare and*
7 *Institutions Code.*

8 (f) *This section shall not apply to emergency services and care,*
9 *as defined in Section 1317.1.*

10 (g) *The definitions in subdivision (f) of Section 1371.9 shall*
11 *apply for purposes of this section.*

12 SEC. 3. *Section 1371.9 is added to the Health and Safety Code,*
13 *to read:*

14 1371.9. (a) (1) *Except as provided in subdivision (c), a health*
15 *care service plan contract issued, amended, or renewed on or after*
16 *July 1, 2017, shall provide that if an enrollee receives covered*
17 *services from a contracting health facility at which, or as a result*
18 *of which, the enrollee receives services provided by a*
19 *noncontracting individual health professional, the enrollee shall*
20 *pay no more than the same cost sharing that the enrollee would*
21 *pay for the same covered services received from a contracting*
22 *individual health professional. This amount shall be referred to*
23 *as the “in-network cost-sharing amount.”*

24 (2) *An enrollee shall not owe more than the in-network*
25 *cost-sharing amount for services subject to this section. The health*
26 *care service plan shall collect the in-network cost-sharing amount*
27 *from the enrollee.*

28 (3) *A noncontracting individual health professional shall not*
29 *bill or collect any amount from the enrollee for services subject*
30 *to this section. Any communication from the noncontracting*
31 *individual health professional to the enrollee shall include a notice*
32 *in 12-point bold type stating that the communication is not a bill.*

33 (4) *In submitting a claim to the plan, the noncontracting*
34 *individual health professional shall affirm in writing to the plan*
35 *that he or she has not attempted to collect any payment from the*
36 *enrollee.*

37 (5) (A) *If the noncontracting individual health professional has*
38 *received any amount from the enrollee for services subject to this*
39 *section, the noncontracting individual health professional shall*

1 *refund the amount to the enrollee after receiving payment from*
2 *the plan.*

3 *(B) If the noncontracting individual health professional does*
4 *not refund the amount collected from the enrollee after receiving*
5 *payment from the plan, interest shall accrue at the rate of 15*
6 *percent per annum beginning with the date payment was received*
7 *from the enrollee.*

8 *(C) A noncontracting individual health professional shall*
9 *automatically include in his or her refund to the enrollee all*
10 *interest that has accrued pursuant to this section without requiring*
11 *the enrollee to submit a request for the interest amount.*

12 *(b) Except for services subject to subdivision (c), the following*
13 *shall apply:*

14 *(1) Any cost sharing paid by the enrollee for the services*
15 *provided by a noncontracting individual health professional at*
16 *the contracting health facility shall count toward the limit on*
17 *annual out-of-pocket expenses established under Section 1367.006.*

18 *(2) Cost sharing arising from services received by a*
19 *noncontracting individual health professional at a contracting*
20 *health facility shall be counted toward any deductible in the same*
21 *manner as cost sharing would be attributed to a contracting*
22 *individual health professional.*

23 *(3) The cost sharing paid by the enrollee pursuant to this section*
24 *shall satisfy the enrollee's obligation to pay cost sharing for the*
25 *health service and shall constitute "applicable cost sharing owed*
26 *by the enrollee" for the purpose of subdivision (e) of Section*
27 *1371.31.*

28 *(c) For services subject to this section, if an enrollee has a*
29 *health care service plan that includes coverage for out-of-network*
30 *benefits, a noncontracting individual health professional may bill*
31 *or collect from the enrollee the out-of-network cost sharing, if*
32 *applicable, only when the enrollee consents in writing and that*
33 *written consent satisfies all the following criteria:*

34 *(1) At least 24 hours in advance of care, the enrollee shall*
35 *consent in writing to receive services from the identified*
36 *noncontracting individual health professional.*

37 *(2) The consent shall be obtained by the noncontracting*
38 *individual health professional separately from the consent for any*
39 *other part of the care or procedure. The consent shall not be*
40 *obtained by the facility or any representative of the facility. The*

1 consent shall not be obtained at the time of admission or at any
2 time when the enrollee is being prepared for surgery or any other
3 procedure.

4 (3) At the time consent is provided, the noncontracting individual
5 health professional shall give the enrollee a written estimate of
6 the enrollee's total out-of-pocket cost of care. The written estimate
7 shall be based on the professional's billed charges for the service
8 to be provided. The noncontracting individual health professional
9 shall not attempt to collect more than the estimated amount without
10 receiving separate written consent from the enrollee or the
11 enrollee's authorized representative.

12 (4) The consent shall advise the enrollee that he or she may
13 elect to seek care from a contracted provider or may contact the
14 enrollee's health care service plan in order to arrange to receive
15 the health service from a contracted provider for
16 lower-out-of-pocket costs.

17 (5) The consent and estimate shall be provided to the enrollee
18 in the language spoken by the enrollee.

19 (6) The consent shall also advise the enrollee that any costs
20 incurred as a result of the enrollee's use of the out-of-network
21 benefit shall be in addition to in-network cost-sharing amounts
22 and may not count toward the annual out-of-pocket maximum on
23 in-network benefits or a deductible, if any, for in-network benefits.

24 (d) A noncontracting individual health professional who fails
25 to comply with the requirements of subdivision (c) has not obtained
26 written consent for purposes of this section. Under those
27 circumstances, subdivisions (a) and (b) shall apply and subdivision
28 (c) shall not apply.

29 (e) (1) A noncontracting individual health professional may
30 advance to collections only the in-network cost-sharing amount,
31 as determined by the plan pursuant to subdivision (a) or the
32 out-of-network cost-sharing amount owed pursuant to subdivision
33 (c), that the enrollee has failed to pay.

34 (2) The noncontracting individual health professional, or any
35 entity acting on his or her behalf, including any assignee of the
36 debt, shall not report adverse information to a consumer credit
37 reporting agency or commence civil action against the enrollee
38 for 150 days after the initial billing regarding amounts owed by
39 the enrollee under subdivision (a) or (c).

1 (3) *With respect to an enrollee, the noncontracting individual*
2 *health professional, or any entity acting on his or her behalf,*
3 *including any assignee of the debt, shall not use wage garnishments*
4 *or liens on primary residences as a means of collecting unpaid*
5 *bills under this section.*

6 (f) *For purposes of this section and Sections 1371.30 and*
7 *1371.31, the following definitions shall apply:*

8 (1) *“Contracting health facility” means a health facility that is*
9 *contracted with the enrollee’s health care service plan to provide*
10 *services under the enrollee’s plan contract. A contracting health*
11 *care facility includes, but is not limited to, the following providers:*

12 (A) *A licensed hospital.*

13 (B) *An ambulatory surgery or other outpatient setting, as*
14 *described in subdivision (a), (d), (e), (g), or (h) of Section 1248.1.*

15 (C) *A laboratory.*

16 (D) *A radiology or imaging center.*

17 (E) *Any other similar provider as the department may define,*
18 *by regulation, as a health facility for purposes of this section.*

19 (2) *“Cost sharing” includes any copayment, coinsurance, or*
20 *deductible, or any other form of cost sharing paid by the enrollee*
21 *other than premium or share of premium.*

22 (3) *“Individual health professional” means a physician and*
23 *surgeon or other professional who is licensed by this state to*
24 *deliver or furnish health care services. For this purpose, an*
25 *“individual health professional” shall not include a dentist,*
26 *licensed pursuant to the Dental Practice Act (Chapter 4*
27 *(commencing with Section 1600) of Division 2 of the Business and*
28 *Professions Code).*

29 (4) *“In-network cost-sharing amount” means an amount no*
30 *more than the same cost sharing the enrollee would pay for the*
31 *same covered service received from a contracting health*
32 *professional. The in-network cost-sharing amount with respect to*
33 *an enrollee with coinsurance shall be based on the amount paid*
34 *by the plan pursuant to paragraph (1) of subdivision (a) of Section*
35 *1371.31.*

36 (5) *“Noncontracting individual health professional” means a*
37 *physician and surgeon or other professional who is licensed by*
38 *the state to deliver or furnish health care services and who is not*
39 *contracted with the enrollee’s health care service plan. For this*
40 *purpose, a “noncontracting individual health professional” shall*

1 not include a dentist, licensed pursuant to the Dental Practice Act
2 (Chapter 4 (commencing with Section 1600) of Division 2 of the
3 Business and Professions Code).

4 (g) This section shall not be construed to require a health care
5 service plan to cover services not required by law or by the terms
6 and conditions of the health care service plan contract.

7 (h) This section shall not be construed to exempt a plan or
8 provider from the requirements under Section 1371.4 or 1373.96,
9 nor abrogate the holding in *Prospect Medical Group, Inc. v.*
10 *Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, that
11 an emergency room physician is prohibited from billing an enrollee
12 of a health care service plan directly for sums that the health care
13 service plan has failed to pay for the enrollee's emergency room
14 treatment.

15 (i) If a health care service plan delegates payment functions to
16 a contracted entity, including, but not limited to, a medical group
17 or independent practice association, the delegated entity shall
18 comply with this section.

19 (j) This section shall not apply to a Medi-Cal managed health
20 care service plan or any other entity that enters into a contract
21 with the State Department of Health Care Services pursuant to
22 Chapter 7 (commencing with Section 14000), Chapter 8
23 (commencing with Section 14200), and Chapter 8.75 (commencing
24 with Section 14591) of Part 3 of Division 9 of the Welfare and
25 Institutions Code.

26 (k) This section shall not apply to emergency services and care,
27 as defined in Section 1317.1.

28 SEC. 4. Section 10112.8 is added to the Insurance Code, to
29 read:

30 10112.8. (a) (1) Except as provided in subdivision (c), a health
31 insurance policy issued, amended, or renewed on or after July 1,
32 2017, shall provide that if an insured receives covered services
33 from a contracting health facility at which, or as a result of which,
34 the insured receives services provided by a noncontracting
35 individual health professional, the insured shall pay no more than
36 the same cost sharing that the insured would pay for the same
37 covered services received from a contracting individual health
38 professional. This amount shall be referred to as the "in-network
39 cost-sharing amount."

1 (2) *Except as provided in subdivision (c), an insured shall not*
2 *owe more than the in-network cost-sharing amount for services*
3 *subject to this section. The insurer shall collect the in-network*
4 *cost-sharing amount from the insured.*

5 (3) *A noncontracting individual health professional shall not*
6 *bill or collect any amount from the insured for services subject to*
7 *this section. Any communication from the noncontracting individual*
8 *health professional to the insured shall include a notice in 12-point*
9 *bold type stating that the communication is not a bill.*

10 (4) *In submitting a claim to the insurer, the noncontracting*
11 *individual health professional shall affirm in writing to the insurer*
12 *that he or she has not attempted to collect any payment from the*
13 *insured.*

14 (5) (A) *If the noncontracting individual health professional has*
15 *received any amount from the insured for services subject to this*
16 *section, the noncontracting individual health professional shall*
17 *refund the amount to the insured after receiving payment from the*
18 *insurer.*

19 (B) *If the noncontracting individual health professional does*
20 *not refund the amount collected from the insured after receiving*
21 *payment from the insurer, interest shall accrue at the rate of 15*
22 *percent per annum beginning with the date payment was received*
23 *from the insured.*

24 (C) *A noncontracting individual health professional shall*
25 *automatically include in his or her refund to the insured all interest*
26 *that has accrued pursuant to this section without requiring the*
27 *insured to submit a request for the interest amount.*

28 (b) *Except for services subject to subdivision (c), the following*
29 *shall apply:*

30 (1) *Any cost sharing paid by the insured for the services*
31 *provided by a noncontracting individual health professional at*
32 *the contracting health facility shall count toward the limit on*
33 *annual out-of-pocket expenses established under Section 10112.28.*

34 (2) *Cost sharing arising from services received by a*
35 *noncontracting individual health professional at a contracting*
36 *health facility shall be counted toward any deductible in the same*
37 *manner as cost sharing would be attributed to a contracting*
38 *individual health professional.*

39 (3) *The cost sharing paid by the insured pursuant to this section*
40 *shall satisfy the insured's obligation to pay cost sharing for the*

1 health service and shall constitute “applicable cost sharing owed
2 by the insured” for the purpose of subdivision (e) of Section
3 10112.82.

4 (c) For services subject to this section, if an insured has an
5 insurance contract that includes coverage for out-of-network
6 benefits, a noncontracting individual health professional may bill
7 or collect from the insured the out-of-network cost sharing, if
8 applicable, only when the insured consents in writing and that
9 written consent satisfies all the following criteria:

10 (1) At least 24 hours in advance of care, the insured shall
11 consent in writing to receive services from the identified
12 noncontracting individual health professional.

13 (2) The consent shall be obtained by the noncontracting
14 individual health professional separately from the consent for any
15 other part of the care or procedure. The consent shall not be
16 obtained by the facility or any representative of the facility. The
17 consent shall not be obtained at the time of admission or at any
18 time when the enrollee is being prepared for surgery or any other
19 procedure.

20 (3) At the time consent is provided the noncontracting individual
21 health professional shall give the insured a written estimate of the
22 insured’s total out-of-pocket cost of care. The written estimate
23 shall be based on the professional’s billed charges for the service
24 to be provided. The noncontracting individual health professional
25 shall not attempt to collect more than the estimated amount without
26 receiving separate written consent from the insured or the insured’s
27 authorized representative.

28 (4) The consent shall advise the insured that he or she may elect
29 to seek care from a contracted provider or may contact the
30 insured’s health care service plan in order to arrange to receive
31 the health service from a contracted provider for
32 lower-out-of-pocket costs.

33 (5) The consent and estimate shall be provided to the insured
34 in the language spoken by the insured.

35 (6) The consent shall also advise the insured that any costs
36 incurred as a result of the insured’s use of the out-of-network
37 benefit shall be in addition to in-network cost-sharing amounts
38 and may not count toward the annual out-of-pocket maximum on
39 in-network benefits or a deductible, if any, for in-network benefits.

1 (d) A noncontracting individual health professional who fails
2 to comply with provisions of this subdivision has not obtained
3 written consent for purposes of this section. Under those
4 circumstances, subdivisions (a) and (b) shall apply and subdivision
5 (c) shall not apply.

6 (e) (1) A noncontracting individual health professional may
7 advance to collections only the in-network cost-sharing amount,
8 as determined by the insurer pursuant to subdivision (a) or the
9 out-of-network cost-sharing amount owed pursuant to subdivision
10 (c), that the insured has failed to pay.

11 (2) The noncontracting individual health professional, or any
12 entity acting on his or her behalf, including any assignee of the
13 debt, shall not report adverse information to a consumer credit
14 reporting agency or commence civil action against the insured for
15 150 days after the initial billing regarding amounts owed by the
16 insured under subdivision (a) or (c).

17 (3) With respect to an insured, a noncontracting individual
18 health professional, or any entity acting on his or her behalf,
19 including any assignee of the debt, shall not use wage garnishments
20 or liens on primary residences as a means of collecting unpaid
21 bills under this section.

22 (f) For purposes of this section and Sections 10112.81 and
23 10112.82, the following definitions shall apply:

24 (1) “Contracting health facility” means a health facility that is
25 contracted with the insured’s health care service plan to provide
26 services under the insured’s policy. A contracting health care
27 facility includes, but is not limited to, the following providers:

28 (A) A licensed hospital.

29 (B) An ambulatory surgery or other outpatient setting, as
30 described in subdivision (a), (d), (e), (g), or (h) of Section 1248.1
31 of the Health and Safety Code.

32 (C) A laboratory.

33 (D) A radiology or imaging center.

34 (E) Any other provider as the department may define, by
35 regulation, as a health facility for purposes of this section.

36 (2) “Cost sharing” includes any copayment, coinsurance, or
37 deductible, or any other form of cost sharing paid by the insured
38 other than premium or share of premium.

39 (3) “Individual health professional” means a physician and
40 surgeon or other professional who is licensed by the state to deliver

1 or furnish health care services. For this purpose, an “individual
2 health professional” shall not include a dentist, licensed pursuant
3 to the Dental Practice Act (Chapter 4 (commencing with Section
4 1600) of Division 2 of the Business and Professions Code).

5 (4) “In-network cost-sharing amount” means an amount no
6 more than the same cost sharing the insured would pay for the
7 same covered service received from a contracting health
8 professional. The in-network cost-sharing amount with respect to
9 an insured with coinsurance shall be based on the amount paid
10 by the insurer pursuant to paragraph (1) of subdivision (a) of
11 Section 10112.82.

12 (5) “Noncontracting individual health professional” means a
13 physician and surgeon or other professional who is licensed by
14 the state to deliver or furnish health care services and who is not
15 contracted with the insured’s health insurer. For this purpose, a
16 “noncontracting individual health professional” shall not include
17 a dentist, licensed pursuant to the Dental Practice Act (Chapter
18 4 (commencing with Section 1600) of Division 2 of the Business
19 and Professions Code).

20 (g) This section shall not be construed to require an insurer to
21 cover services not required by law or by the terms and conditions
22 of the health insurance policy.

23 (h) If a health insurer delegates payment functions to a
24 contracted entity, including, but not limited to, a medical group
25 or independent practice association, the delegated entity shall
26 comply with this section.

27 (i) This section shall not apply to emergency services and care,
28 as defined in Section 1317.1 of the Health and Safety Code.

29 SEC. 5. Section 10112.81 is added to the Insurance Code, to
30 read:

31 10112.81. (a) (1) The commissioner shall establish an
32 independent dispute resolution process for the purpose of
33 processing and resolving a claim dispute between a health insurer
34 and a noncontracting individual health professional for services
35 subject to subdivision (a) of Section 10112.8.

36 (2) Prior to initiating the independent dispute resolution process,
37 the parties shall exhaust the insurer’s internal process.

38 (3) If either the noncontracting individual health professional
39 or the insurer appeals a claim to the department’s independent

1 *dispute resolution process, the other party shall participate in the*
2 *appeal process as described in this section.*

3 *(b) (1) The commissioner shall establish uniform written*
4 *procedures for the submission, receipt, processing, and resolution*
5 *of claim payment disputes pursuant to this section and any other*
6 *guidelines for implementing this section.*

7 *(2) The commissioner shall establish reasonable and necessary*
8 *fees for the purpose of administering this section, to be paid by*
9 *both parties.*

10 *(3) In establishing the independent dispute resolution process,*
11 *the commissioner may permit the bundling of claims submitted to*
12 *the same insurer or the same delegated entity for the same or*
13 *similar services by the same noncontracting individual health*
14 *professional.*

15 *(4) The commissioner shall permit a physician group,*
16 *independent practice association, or other entity authorized to act*
17 *on behalf of a noncontracting individual health professional to*
18 *participate in the independent dispute resolution process.*

19 *(c) (1) The commissioner may contract with one or more*
20 *independent organizations to conduct the proceedings. The*
21 *independent organization handling a dispute shall be independent*
22 *of either party to the dispute.*

23 *(2) The commissioner shall establish conflict-of-interest*
24 *standards, consistent with the purposes of this section, that an*
25 *organization shall meet in order to qualify to administer the*
26 *independent dispute resolution program. The conflict-of-interest*
27 *standards shall be consistent with the standards pursuant to*
28 *subdivisions (c) and (d) of Section 10169.2.*

29 *(3) The commissioner may contract with the same independent*
30 *organization or organizations as the State Department of Managed*
31 *Health Care.*

32 *(4) The commissioner shall provide, upon the request of an*
33 *interested person, a copy of all nonproprietary information, as*
34 *determined by the commissioner, filed with the department by an*
35 *independent organization seeking to contract with the department*
36 *to administer the independent dispute resolution process pursuant*
37 *to this section. The department may charge a nominal fee to cover*
38 *the costs of providing a copy of the information pursuant to this*
39 *paragraph.*

1 (d) (1) *The determination obtained through the commissioner’s*
2 *independent dispute resolution process shall be binding on both*
3 *parties.*

4 (2) *Notwithstanding paragraph (1), this section does not*
5 *preclude a dissatisfied party from pursuing any right, remedy, or*
6 *penalty established under any other applicable law.*

7 (e) *If a health insurer delegates payment functions to a*
8 *contracted entity, including, but not limited to, a medical group*
9 *or independent practice association, then the delegated entity shall*
10 *comply with this section.*

11 (f) *This section shall not apply to emergency services and care,*
12 *as defined in Section 1317.1 of the Health and Safety Code.*

13 (g) *The definitions in subdivision (f) of Section 10112.8 shall*
14 *apply for purposes of this section.*

15 SEC. 6. *Section 10112.82 is added to the Insurance Code, to*
16 *read:*

17 10112.82. (a) (1) *For services rendered subject to Section*
18 *10112.8, unless otherwise agreed to by the noncontracting*
19 *individual health professional and the insurer, the insurer shall*
20 *reimburse the greater of the average contracted rate or 125 percent*
21 *of the amount Medicare reimburses on a fee-for-service basis for*
22 *the same or similar services in the general geographic region in*
23 *which the services were rendered. For the purposes of this section,*
24 *“average contracted rate” means the average of the contracted*
25 *rates paid by the health insurer or delegated entity for the same*
26 *or similar services in the geographic region. This subdivision does*
27 *not apply to subdivision (c) of Section 10112.8 or subdivision (b)*
28 *of this section.*

29 (2) (A) *In a manner and format specified by the commissioner,*
30 *by July 1, 2017, each health insurer shall provide to the department*
31 *both of the following:*

32 (i) *Data listing its average contracted rates for services most*
33 *frequently subject to Section 10112.8 in each geographic region*
34 *in which the services are rendered, including the average*
35 *contracted rates paid by the insurer’s delegated entities.*

36 (ii) *Its methodology for determining the average contracted rate*
37 *for services subject to Section 10112.8. The methodology to*
38 *determine an average contracted rate shall assure that the insurer*
39 *includes the highest and lowest contracted rates.*

1 (B) Each health insurer's delegated entities shall provide to the
2 department data listing its average contracted rates for services
3 most frequently subject to Section 10112.8 in each geographic
4 region in which the services are rendered.

5 (C) For each year thereafter, the health insurer and its delegated
6 entities shall adjust the rate initially established pursuant to this
7 subdivision by the Consumer Price Index for Medical Care
8 Services, as published by the United States Bureau of Labor
9 Statistics.

10 (D) The commissioner shall audit the accuracy of this
11 information.

12 (E) By January 1, 2020, the department shall provide a report
13 to the Governor, the President pro Tempore of the Senate, the
14 Speaker of the Assembly, and the Senate and Assembly Committees
15 on Health of the data provided in subparagraphs (A) and (B) in a
16 manner and format specified by the Legislature.

17 (3) For the purposes of this section, for average contracted
18 rates for individual and small group coverage, geographic region
19 shall be the geographic regions listed in subparagraph (A) of
20 paragraph (2) of subdivision (a) of Section 1357.512 of the Health
21 and Safety Code. For purposes of this section for Medicare
22 fee-for-service reimbursement, geographic regions shall be the
23 geographic regions specified for physician reimbursement for
24 Medicare fee for service by the United States Department of Health
25 and Human Services.

26 (4) A health insurer shall authorize and permit assignment of
27 the insured's right, if any, to any reimbursement for health care
28 services covered under the health insurance policy to a
29 noncontracting individual health professional who furnishes the
30 health care services rendered subject to Section 10112.8. The
31 insurer shall provide a form approved by the commissioner for
32 this purpose.

33 (5) A noncontracting individual health professional who disputes
34 the claim reimbursement under this section shall utilize the
35 independent dispute resolution process described in Section
36 10112.81.

37 (b) If nonemergency services are provided by a noncontracting
38 individual health professional consistent with subdivision (c) of
39 Section 10112.8 to an insured who has voluntarily chosen to use
40 his or her out-of-network benefit for services covered by a

1 preferred provider organization or a point-of-service plan, unless
 2 otherwise agreed to by the insurer and the noncontracting
 3 individual health professional, the amount paid shall be the amount
 4 set forth in the insured’s evidence of coverage. This payment is
 5 not subject to the independent dispute resolution process described
 6 in Section 10112.81.

7 (c) If a health insurer delegates the responsibility for payment
 8 of claims to a contracted entity, including, but not limited to, a
 9 medical group or independent practice association, then the entity
 10 to which that responsibility is delegated shall comply with the
 11 requirements of this section.

12 (d) (1) A payment made by the health insurer to the
 13 noncontracting health care professional for nonemergency services
 14 as required by Section 10112.8 and this section, in addition to the
 15 applicable cost sharing owed by the insured, shall constitute
 16 payment in full for nonemergency services rendered.

17 (2) Notwithstanding any other law, the amounts paid by an
 18 insurer for services under this section shall not constitute the
 19 prevailing or customary charges, the usual fees to the general
 20 public, or other charges for other payers for an individual health
 21 professional.

22 (3) This subdivision shall not preclude the use of the independent
 23 dispute resolution process pursuant to Section 10112.81.

24 (e) This section shall not apply to emergency services and care,
 25 as defined in Section 1317.1 of the Health and Safety Code.

26 (f) The definitions in subdivision (f) of Section 10112.8 shall
 27 apply for purposes of this section.

28 SEC. 7. No reimbursement is required by this act pursuant to
 29 Section 6 of Article XIII B of the California Constitution because
 30 the only costs that may be incurred by a local agency or school
 31 district will be incurred because this act creates a new crime or
 32 infraction, eliminates a crime or infraction, or changes the penalty
 33 for a crime or infraction, within the meaning of Section 17556 of
 34 the Government Code, or changes the definition of a crime within
 35 the meaning of Section 6 of Article XIII B of the California
 36 Constitution.

37 SECTION 1. ~~Article 4 (commencing with Section 32250) is~~
 38 ~~added to Chapter 3 of Division 23 of the Health and Safety Code,~~
 39 ~~to read:~~

Article 4. ~~Special Taxes~~

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~~32250. (a) Subject to Section 4 of Article XIII A and Article XIII C of the California Constitution, the Eden Township Healthcare District may impose special taxes within the district pursuant to the procedures established in Article 3.5 (commencing with Section 50075) of Chapter 1 of Part 1 of Division 1 of Title 5 of the Government Code and any other applicable procedures provided by law. The board of directors shall determine the basis and nature of a special tax and its manner of collection.~~

~~(b) For purposes of this section, “special taxes” means special taxes that apply uniformly to all taxpayers or all real property within the district.~~

~~(c) It is the intent of the legislature that funds from a tax enacted pursuant to this section be used to support the purposes of the district, including support of nonprofit and public hospitals and other health care providers in the communities served by the district.~~

~~32251. This article shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2026, deletes or extends that date.~~

~~SEC. 2. The Legislature finds and declares that a special law is necessary and that a general law cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances of the Eden Township Healthcare District.~~

~~SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:~~

~~In order to ensure that the residents of the Eden Township Healthcare District have continued access to critical health care services, it is necessary that this measure take effect immediately.~~

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