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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**

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**Introduced by Assembly Members Bonta, Bonilla, Dahle, Gonzalez,  
Maienschein, *Santiago*, and Wood**

December 18, 2014

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An act to add 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. 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 more than the in-network cost-sharing amount~~ from the enrollee or insured to refund ~~the amount~~ *any overpayment* 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.

*Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.*

*This bill would make legislative findings to that effect.*

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.

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: 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~~ *complete* 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~~ *shall* permit the bundling of claims submitted  
23 to the same plan or the same delegated entity for the same or  
24 similar services by the same noncontracting individual health  
25 professional.

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

30 (c) (1) The department may contract with one or more  
31 independent organizations to conduct the proceedings. The  
32 independent organization handling a dispute shall be independent  
33 of either party to the dispute.

34 (2) The department shall establish conflict-of-interest standards,  
35 consistent with the purposes of this section, that an organization  
36 shall meet in order to qualify to administer the independent dispute  
37 resolution program. The conflict-of-interest standards shall be

1 consistent with the standards pursuant to subdivisions (c) and (d)  
2 of Section 1374.32.

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

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

13 (d) ~~(1)~~—The determination obtained through the department’s  
14 independent dispute resolution process shall be binding on both  
15 parties. *The plan shall implement the determination obtained*  
16 *through the independent dispute resolution process. If dissatisfied,*  
17 *either party may pursue any right, remedy, or penalty established*  
18 *under any other applicable law.*

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

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

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

32 (g) This section shall not apply to emergency services and care,  
33 as defined in Section ~~1317.4~~. *1317.1, or services required to be*  
34 *covered by a health care service plan pursuant to Section 1371.4.*

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

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

39 1371.31. (a) (1) For services rendered subject to Section  
40 1371.9, unless otherwise agreed to by the noncontracting individual

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

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

14 (i) Data listing its average contracted rates for services most  
15 frequently subject to Section 1371.9 in each geographic region in  
16 which the services are rendered, ~~including the average contracted~~  
17 ~~rates paid by the plan’s delegated entities. rendered for the year~~  
18 *2015.*

19 (ii) Its methodology for determining the average contracted rate  
20 for services subject to Section 1371.9. The methodology to  
21 determine an average contracted rate shall assure that the plan  
22 includes the highest and lowest contracted ~~rates. rates for the year~~  
23 *2015.*

24 (B) ~~Each~~ *In a manner and format specified by the department,*  
25 *by July 1, 2017, each* health care service plan’s delegated entities  
26 shall provide to the department ~~data listing its average contracted~~  
27 ~~rates for services most frequently subject to Section 1371.9 in each~~  
28 ~~geographic region in which the services are rendered. both of the~~  
29 *following:*

30 (i) *Data listing its average contracted rates for services most*  
31 *frequently subject to Section 1371.9 in each geographic region in*  
32 *which the services are rendered for the year 2015.*

33 (ii) *Its methodology for determining the average contracted rate*  
34 *for services subject to Section 1371.9. The methodology to*  
35 *determine the average contracted rate shall ensure that the plan*  
36 *includes the highest and lowest contracted rates for the year 2015.*

37 (C) For each year ~~thereafter, after 2015~~, the health care service  
38 plan and the plan’s delegated entities shall adjust the rate initially  
39 established pursuant to this subdivision by the Consumer Price

1 Index for Medical Care Services, as published by the United States  
2 Bureau of Labor Statistics.

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

5 (E) *The data submitted pursuant to clause (i) of subparagraph*  
6 *(A) and clause (i) of subparagraph (B) shall be confidential and*  
7 *not subject to disclosure under the California Public Records Act*  
8 *(Chapter 3.5 (commencing with Section 6250) of Division 7 of*  
9 *Title 1 of the Government Code).*

10 ~~(E)~~

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

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

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

26 (5) A noncontracting individual health professional who disputes  
27 the claim reimbursement under this section shall utilize the  
28 independent dispute resolution process described in Section  
29 1371.30.

30 (b) If nonemergency services are provided by a noncontracting  
31 individual health professional consistent with subdivision (c) of  
32 Section 1371.9, to an enrollee who has voluntarily chosen to use  
33 his or her out-of-network benefit for services covered by a preferred  
34 provider organization or a point-of-service plan, unless otherwise  
35 agreed to by the plan and the noncontracting individual health  
36 professional, the amount paid *by the health care service plan* shall  
37 be the amount set forth in the enrollee's evidence of coverage.  
38 This payment is not subject to the independent dispute resolution  
39 process described in Section 1371.30.

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

6 (d) (1) A payment made by the health care service plan to the  
7 noncontracting health care professional for nonemergency services  
8 as required by Section 1371.9 and this section, in addition to the  
9 applicable cost sharing owed by the enrollee, shall constitute  
10 payment in full for nonemergency services ~~rendered~~. *rendered*  
11 *unless either party uses the independent dispute resolution process*  
12 *or other lawful means pursuant to Section 1371.30.*

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

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

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

25 (f) This section shall not apply to emergency services and care,  
26 as defined in Section ~~1317.4~~. *1317.1, or to those services required*  
27 *to be covered by a health care service plan pursuant to Section*  
28 *1371.4.*

29 (g) The definitions in subdivision (f) of Section 1371.9 shall  
30 apply for purposes of this section.

31 SEC. 3. Section 1371.9 is added to the Health and Safety Code,  
32 to read:

33 1371.9. (a) (1) Except as provided in subdivision (c), a health  
34 care service plan contract issued, amended, or renewed on or after  
35 July 1, 2017, shall provide that if an enrollee receives covered  
36 services from a contracting health facility at which, or as a result  
37 of which, the enrollee receives services provided by a  
38 noncontracting individual health professional, the enrollee shall  
39 pay no more than the same cost sharing that the enrollee would  
40 pay for the same covered services received from a contracting



1 individual health professional. This amount shall be referred to as  
2 the “in-network cost-sharing amount.”

3 (2) An enrollee shall not owe *the noncontracting individual*  
4 *health professional* more than the in-network cost-sharing amount  
5 for services subject to this section. ~~The health care service plan~~  
6 ~~shall collect the in-network cost-sharing amount from the enrollee.~~  
7 *At the time of payment by the plan to the noncontracting individual*  
8 *health professional, the plan shall inform the noncontracting*  
9 *individual health professional of the in-network cost-sharing*  
10 *amount owed by the enrollee.*

11 (3) A noncontracting individual health professional shall not  
12 bill or collect any amount from the enrollee for services subject  
13 to this ~~section.~~ *section except for the in-network cost-sharing*  
14 *amount.* Any communication from the noncontracting individual  
15 health professional to the enrollee *prior to the receipt of*  
16 *information about the in-network cost-sharing amount pursuant*  
17 *to paragraph (2)* shall include a notice in 12-point bold type stating  
18 that the communication is not a ~~bill.~~ *bill and informing the enrollee*  
19 *that the enrollee shall not pay until he or she is informed of any*  
20 *applicable cost sharing.*

21 (4) In submitting a claim to the plan, the noncontracting  
22 individual health professional shall affirm ~~in writing~~ to the plan  
23 that he or she has not attempted to collect any payment from the  
24 enrollee.

25 (5) (A) If the noncontracting individual health professional has  
26 received ~~any more than the in-network cost-sharing~~ amount from  
27 the enrollee for services subject to this section, the noncontracting  
28 individual health professional shall refund ~~the amount any~~  
29 ~~overpayment~~ to the enrollee ~~after receiving payment from the plan.~~  
30 *within 30 calendar days after receiving notice from the plan of the*  
31 *in-network cost-sharing amount owed by the enrollee pursuant to*  
32 *paragraph (2).*

33 (B) If the noncontracting individual health professional does  
34 not refund ~~the amount collected from the enrollee after receiving~~  
35 ~~payment from the plan,~~ *any overpayment to the enrollee within 30*  
36 *business days after being informed of the enrollee’s in-network*  
37 *cost-sharing amount,* interest shall accrue at the rate of 15 percent  
38 per annum beginning with the date payment was received from  
39 the enrollee.

1 (C) A noncontracting individual health professional shall  
2 automatically include in his or her refund to the enrollee all interest  
3 that has accrued pursuant to this section without requiring the  
4 enrollee to submit a request for the interest amount.

5 (b) Except for services subject to subdivision (c), the following  
6 shall apply:

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

11 (2) Cost sharing arising from services received by a  
12 noncontracting individual health professional at a contracting  
13 health facility shall be counted toward any deductible in the same  
14 manner as cost sharing would be attributed to a contracting  
15 individual health professional.

16 (3) The cost sharing paid by the enrollee pursuant to this section  
17 shall satisfy the enrollee's obligation to pay cost sharing for the  
18 health service and shall constitute "applicable cost sharing owed  
19 by the enrollee" for the purpose of subdivision (e) of Section  
20 1371.31.

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

27 (1) At least 24 hours in advance of care, the enrollee shall  
28 consent in writing to receive services from the identified  
29 noncontracting individual health professional.

30 (2) The consent shall be obtained by the noncontracting  
31 individual health professional ~~separately from~~ *in a document that*  
32 *is separate from the document used to obtain* the consent for any  
33 other part of the care or procedure. The consent shall not be  
34 obtained by the facility or any representative of the facility. The  
35 consent shall not be obtained at the time of admission or at any  
36 time when the enrollee is being prepared for surgery or any other  
37 procedure.

38 (3) At the time consent is provided, the noncontracting  
39 individual health professional shall give the enrollee a written  
40 estimate of the enrollee's total out-of-pocket cost of care. The

1 written estimate shall be based on the professional's billed charges  
2 for the service to be provided. The noncontracting individual health  
3 professional shall not attempt to collect more than the estimated  
4 amount without receiving separate written consent from the  
5 enrollee or the enrollee's authorized ~~representative~~: *representative,*  
6 *unless circumstances arise during delivery of services that were*  
7 *unforeseen at the time the estimate was given that would require*  
8 *the provider to change the estimate.*

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

14 (5) The consent and estimate shall be provided to the enrollee  
15 in the language spoken by the ~~enrollee~~: *enrollee, if the language*  
16 *is a Medi-Cal threshold language, as defined in subdivision (d) of*  
17 *Section 128552.*

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

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

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

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

39 (3) With respect to an enrollee, the noncontracting individual  
40 health professional, or any entity acting on his or her behalf,

1 including any assignee of the debt, shall not use wage garnishments  
2 or liens on primary residences as a means of collecting unpaid bills  
3 under this section.

4 (f) For purposes of this section and Sections 1371.30 and  
5 1371.31, the following definitions shall apply:

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

10 (A) A licensed hospital.

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

13 (C) A laboratory.

14 (D) A radiology or imaging center.

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

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

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

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

32 (5) “Noncontracting individual health professional” means a  
33 physician and surgeon or other professional who is licensed by the  
34 state to deliver or furnish health care services and who is not  
35 contracted with the enrollee’s health care service ~~plan~~ *product*.  
36 For this purpose, a “noncontracting individual health professional”  
37 shall not include a dentist, licensed pursuant to the Dental Practice  
38 Act (Chapter 4 (commencing with Section 1600) of Division 2 of  
39 the Business and Professions Code).

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

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

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

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

22 (k) This section shall not apply to emergency services and care,  
23 as defined in Section ~~1317.1~~. 1317.1, *or to those services required*  
24 *to be covered by a health care service plan pursuant to Section*  
25 *1371.4.*

26 SEC. 4. Section 10112.8 is added to the Insurance Code, to  
27 read:

28 10112.8. (a) (1) Except as provided in subdivision (c), a health  
29 insurance policy issued, amended, or renewed on or after July 1,  
30 2017, *that provides benefits through contracts with providers at*  
31 *alternative rates of payment pursuant to Section 10133*, shall  
32 provide that if an insured receives covered services from a  
33 contracting health facility at which, or as a result of which, the  
34 insured receives services provided by a noncontracting individual  
35 health professional, the insured shall pay no more than the same  
36 cost sharing that the insured would pay for the same covered  
37 services received from a contracting individual health professional.  
38 This amount shall be referred to as the “in-network cost-sharing  
39 amount.”

1 (2) Except as provided in subdivision (c), an insured shall not  
2 owe *the noncontracting individual health professional* more than  
3 the in-network cost-sharing amount for services subject to this  
4 section. ~~The insurer shall collect the in-network cost-sharing~~  
5 ~~amount from the insured. At the time of payment by the insurer to~~  
6 ~~the noncontracting individual health professional, the insurer shall~~  
7 ~~inform the noncontracting individual health professional of the~~  
8 ~~in-network cost-sharing amount owed by the insured.~~

9 (3) A noncontracting individual health professional shall not  
10 bill or collect any amount from the insured for services subject to  
11 ~~this section. section except the in-network cost-sharing amount.~~  
12 Any communication from the noncontracting individual health  
13 professional to the insured *prior to the receipt of information about*  
14 *the in-network cost-sharing amount pursuant to paragraph (2)*  
15 shall include a notice in 12-point bold type stating that the  
16 communication is not a ~~bill. bill and informing the insured that~~  
17 ~~the insured shall not pay until he or she is informed of any~~  
18 ~~applicable cost sharing.~~

19 (4) In submitting a claim to the insurer, the noncontracting  
20 individual health professional shall affirm ~~in writing~~ to the insurer  
21 that he or she has not attempted to collect any payment from the  
22 insured.

23 (5) (A) If the noncontracting individual health professional has  
24 received ~~any more than the in-network cost-sharing~~ amount from  
25 the insured for services subject to this section, the noncontracting  
26 individual health professional shall refund ~~the amount any~~  
27 ~~overpayment to the insured after receiving payment from the~~  
28 ~~insurer. within 30 calendar days after receiving notice from the~~  
29 ~~insurer of the in-network cost-sharing amount owed by the insured~~  
30 ~~pursuant to paragraph (2).~~

31 (B) If the noncontracting individual health professional does  
32 not refund ~~the amount collected from the insured after receiving~~  
33 ~~payment from the insurer, any overpayment to the insured within~~  
34 ~~30 business days after being informed of the insured's in-network~~  
35 ~~cost-sharing amount, interest shall accrue at the rate of 15 percent~~  
36 ~~per annum beginning with the date payment was received from~~  
37 ~~the insured.~~

38 (C) A noncontracting individual health professional shall  
39 automatically include in his or her refund to the insured all interest

1 that has accrued pursuant to this section without requiring the  
2 insured to submit a request for the interest amount.

3 (b) Except for services subject to subdivision (c), the following  
4 shall apply:

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

9 (2) Cost sharing arising from services received by a  
10 noncontracting individual health professional at a contracting  
11 health facility shall be counted toward any deductible in the same  
12 manner as cost sharing would be attributed to a contracting  
13 individual health professional.

14 (3) The cost sharing paid by the insured pursuant to this section  
15 shall satisfy the insured's obligation to pay cost sharing for the  
16 health service and shall constitute "applicable cost sharing owed  
17 by the insured" for the purpose of subdivision (e) of Section  
18 10112.82.

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

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

28 (2) The consent shall be obtained by the noncontracting  
29 individual health professional ~~separately from~~ *in a document that*  
30 *is separate from the document used to obtain* the consent for any  
31 other part of the care or procedure. The consent shall not be  
32 obtained by the facility or any representative of the facility. The  
33 consent shall not be obtained at the time of admission or at any  
34 time when the enrollee is being prepared for surgery or any other  
35 procedure.

36 (3) At the time consent is provided the noncontracting individual  
37 health professional shall give the insured a written estimate of the  
38 insured's total out-of-pocket cost of care. The written estimate  
39 shall be based on the professional's billed charges for the service  
40 to be provided. The noncontracting individual health professional

1 shall not attempt to collect more than the estimated amount without  
2 receiving separate written consent from the insured or the insured's  
3 authorized ~~representative~~. *representative, unless circumstances*  
4 *arise during delivery of services that were unforeseen at the time*  
5 *the estimate was given that would require the provider to change*  
6 *the estimate.*

7 (4) The consent shall advise the insured that he or she may elect  
8 to seek care from a contracted provider or may contact the insured's  
9 health care service plan in order to arrange to receive the health  
10 service from a contracted provider for lower-out-of-pocket costs.

11 (5) The consent and estimate shall be provided to the insured  
12 in the language spoken by the ~~insured~~. *insured, if the language is*  
13 *a Medi-Cal threshold language, as defined in subdivision (d) of*  
14 *Section 128552 of the Health and Safety Code.*

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

20 (d) A noncontracting individual health professional who fails  
21 to comply with provisions of this subdivision has not obtained  
22 written consent for purposes of this section. Under those  
23 circumstances, subdivisions (a) and (b) shall apply and subdivision  
24 (c) shall not apply.

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

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

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



1 (f) For purposes of this section and Sections 10112.81 and  
2 10112.82, the following definitions shall apply:

3 (1) “Contracting health facility” means a health facility that is  
4 contracted with the insured’s health ~~care service plan~~ *insurer* to  
5 provide services under the insured’s policy. A contracting health  
6 care facility includes, but is not limited to, the following providers:

7 (A) A licensed hospital.

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

11 (C) A laboratory.

12 (D) A radiology or imaging center.

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

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

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

24 (4) “In-network cost-sharing amount” means an amount no more  
25 than the same cost sharing the insured would pay for the same  
26 covered service received from a contracting health professional.  
27 The in-network cost-sharing amount with respect to an insured  
28 with coinsurance shall be based on the amount paid by the insurer  
29 pursuant to paragraph (1) of subdivision (a) of Section 10112.82.

30 (5) “Noncontracting individual health professional” means a  
31 physician and surgeon or other professional who is licensed by the  
32 state to deliver or furnish health care services and who is not  
33 contracted with the insured’s health ~~insurer~~ *insurance product*.  
34 For this purpose, a “noncontracting individual health professional”  
35 shall not include a dentist, licensed pursuant to the Dental Practice  
36 Act (Chapter 4 (commencing with Section 1600) of Division 2 of  
37 the Business and Professions Code).

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

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

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

7 SEC. 5. Section 10112.81 is added to the Insurance Code, to  
8 read:

9 10112.81. (a) (1) The commissioner shall establish an  
10 independent dispute resolution process for the purpose of  
11 processing and resolving a claim dispute between a health insurer  
12 and a noncontracting individual health professional for services  
13 subject to subdivision (a) of Section 10112.8.

14 (2) Prior to initiating the independent dispute resolution process,  
15 the parties shall ~~exhaust~~ *complete* the insurer's internal process.

16 (3) If either the noncontracting individual health professional  
17 or the insurer appeals a claim to the department's independent  
18 dispute resolution process, the other party shall participate in the  
19 appeal process as described in this section.

20 (b) (1) The commissioner shall establish uniform written  
21 procedures for the submission, receipt, processing, and resolution  
22 of claim payment disputes pursuant to this section and any other  
23 guidelines for implementing this section.

24 (2) The commissioner shall establish reasonable and necessary  
25 fees for the purpose of administering this section, to be paid by  
26 both parties.

27 (3) In establishing the independent dispute resolution process,  
28 the commissioner ~~may~~ *shall* permit the bundling of claims  
29 submitted to the same insurer or the same delegated entity for the  
30 same or similar services by the same noncontracting individual  
31 health professional.

32 (4) The commissioner shall permit a physician group,  
33 independent practice association, or other entity authorized to act  
34 on behalf of a noncontracting individual health professional to  
35 *initiate and* participate in the independent dispute resolution  
36 process.

37 (c) (1) The commissioner may contract with one or more  
38 independent organizations to conduct the proceedings. The  
39 independent organization handling a dispute shall be independent  
40 of either party to the dispute.

1 (2) The commissioner shall establish conflict-of-interest  
2 standards, consistent with the purposes of this section, that an  
3 organization shall meet in order to qualify to administer the  
4 independent dispute resolution program. The conflict-of-interest  
5 standards shall be consistent with the standards pursuant to  
6 subdivisions (c) and (d) of Section 10169.2.

7 (3) The commissioner may contract with the same independent  
8 organization or organizations as the State Department of Managed  
9 Health Care.

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

18 (d) ~~(4)~~—The determination obtained through the commissioner’s  
19 independent dispute resolution process shall be binding on both  
20 parties. *The insurer shall implement the determination obtained*  
21 *through the independent dispute resolution process. If dissatisfied,*  
22 *either party may pursue any right, remedy, or penalty established*  
23 *under any other applicable law.*

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

27 (e) If a health insurer delegates payment functions to a  
28 contracted entity, including, but not limited to, a medical group or  
29 independent practice association, then the delegated entity shall  
30 comply with this section.

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

33 (g) The definitions in subdivision (f) of Section 10112.8 shall  
34 apply for purposes of this section.

35 SEC. 6. Section 10112.82 is added to the Insurance Code, to  
36 read:

37 10112.82. (a) (1) For services rendered subject to Section  
38 10112.8, unless otherwise agreed to by the noncontracting  
39 individual health professional and the insurer, the insurer shall  
40 reimburse the greater of the average contracted rate or 125 percent

1 of the amount Medicare reimburses on a fee-for-service basis for  
2 the same or similar services in the general geographic region in  
3 which the services were rendered. For the purposes of this section,  
4 “average contracted rate” means the average of the contracted  
5 *commercial* rates paid by the health insurer ~~or delegated entity~~ for  
6 the same or similar services in the geographic region. This  
7 subdivision does not apply to subdivision (c) of Section 10112.8  
8 or subdivision (b) of this section.

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

12 (i) Data listing its average contracted rates for services most  
13 frequently subject to Section 10112.8 in each geographic region  
14 in which the services are rendered, ~~including the average contracted~~  
15 ~~rates paid by the insurer’s delegated entities.~~ *rendered for the year*  
16 *2015.*

17 (ii) Its methodology for determining the average contracted rate  
18 for services subject to Section 10112.8. The methodology to  
19 determine an average contracted rate shall assure that the insurer  
20 includes the highest and lowest contracted ~~rates.~~ *rates for the year*  
21 *2015.*

22 (B) ~~Each~~ *In a manner and format specified by the commissioner,*  
23 *by July 1, 2017, each* health insurer’s delegated entities shall  
24 provide to the department ~~data listing its average contracted rates~~  
25 ~~for services most frequently subject to Section 10112.8 in each~~  
26 ~~geographic region in which the services are rendered.~~ *both of the*  
27 *following:*

28 (i) *Data listing its average contracted rates for services most*  
29 *frequently subject to Section 10112.8 in each geographic region*  
30 *in which the services are rendered for the year 2015.*

31 (ii) *Its methodology for determining the average contracted rate*  
32 *for services subject to Section 10112.8. The methodology to*  
33 *determine the average contracted rate shall ensure that the insurer*  
34 *includes the highest and lowest contracted rates for the year 2015.*

35 (C) For each year ~~thereafter,~~ *after 2015,* the health insurer and  
36 its delegated entities shall adjust the rate initially established  
37 pursuant to this subdivision by the Consumer Price Index for  
38 Medical Care Services, as published by the United States Bureau  
39 of Labor Statistics.

1 (D) The commissioner shall audit the accuracy of ~~this~~  
2 ~~information~~. *the information required under subparagraphs (A)*  
3 *and (B).*

4 (E) *The data submitted pursuant to clause (i) of subparagraph*  
5 *(A) and clause (i) of subparagraph (B) shall be confidential and*  
6 *not subject to disclosure under the California Public Records Act*  
7 *(Chapter 3.5 (commencing with Section 6250) of Division 7 of*  
8 *Title 1 of the Government Code).*

9 ~~(E)~~

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

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

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

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

34 (b) If nonemergency services are provided by a noncontracting  
35 individual health professional consistent with subdivision (c) of  
36 Section 10112.8 to an insured who has voluntarily chosen to use  
37 his or her out-of-network benefit for services covered by a preferred  
38 provider organization or a point-of-service plan, unless otherwise  
39 agreed to by the insurer and the noncontracting individual health  
40 professional, the amount paid *by the insurer* shall be the amount

1 set forth in the insured's evidence of coverage. This payment is  
2 not subject to the independent dispute resolution process described  
3 in Section 10112.81.

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

9 (d) (1) A payment made by the health insurer to the  
10 noncontracting health care professional for nonemergency services  
11 as required by Section 10112.8 and this section, in addition to the  
12 applicable cost sharing owed by the insured, shall constitute  
13 payment in full for nonemergency services—~~rendered.~~ *rendered*  
14 *unless either party uses the dispute resolution process or other*  
15 *lawful means pursuant to Section 10112.81.*

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

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

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

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

27 *SEC. 7. The Legislature finds and declares that Sections 2 and*  
28 *6 of this act, which add Section 1371.31 to the Health and Safety*  
29 *Code and Section 10112.82 to the Insurance Code, respectively,*  
30 *impose a limitation on the public's right of access to the meetings*  
31 *of public bodies or the writings of public officials and agencies*  
32 *within the meaning of Section 3 of Article I of the California*  
33 *Constitution. Pursuant to that constitutional provision, the*  
34 *Legislature makes the following findings to demonstrate the interest*  
35 *protected by this limitation and the need for protecting that*  
36 *interest:*

37 *In order to protect confidential rate information used by health*  
38 *care service plans and health insurers and to protect the integrity*  
39 *of the competitive market, it is necessary that this act limit the*  
40 *public's right of access to that information.*

1     ~~SEC. 7.~~

2     *SEC. 8.* No reimbursement is required by this act pursuant to  
3 Section 6 of Article XIII B of the California Constitution because  
4 the only costs that may be incurred by a local agency or school  
5 district will be incurred because this act creates a new crime or  
6 infraction, eliminates a crime or infraction, or changes the penalty  
7 for a crime or infraction, within the meaning of Section 17556 of  
8 the Government Code, or changes the definition of a crime within  
9 the meaning of Section 6 of Article XIII B of the California  
10 Constitution.

O