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AMENDED IN SENATE AUGUST 1, 2016  
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 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 more than the in-network cost-sharing amount from the enrollee or insured to refund 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.~~ *rendered pursuant to a specified methodology.* 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 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 shall permit the bundling of claims submitted to  
23 the 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 initiate and  
28 participate in the independent dispute resolution process.

29 (5) *In deciding the dispute, the independent organization shall*  
30 *base its decision regarding the appropriate reimbursement on all*  
31 *relevant information, including, but not limited to, the*  
32 *reimbursement amount suggested by either party.*

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

37 (2) The department shall establish conflict-of-interest standards,  
38 consistent with the purposes of this section, that an organization

1 shall meet in order to qualify to administer the independent dispute  
2 resolution program. The conflict-of-interest standards shall be  
3 consistent with the standards pursuant to subdivisions (c) and (d)  
4 of Section 1374.32.

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

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

15 (5) *The independent organization retained to conduct*  
16 *proceedings shall be deemed to be consultants for purposes of*  
17 *Section 43.98 of the Civil Code.*

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

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

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

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

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 commercial  
9 rates paid by the health plan or delegated entity for the same or  
10 similar services in the geographic region. This subdivision does  
11 not apply to subdivision (c) of Section 1371.9 or subdivision (b)  
12 of this 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 for the year 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 for the year 2015.~~

23 ~~(B) In a manner and format specified by the department, by July~~  
24 ~~1, 2017, each health care service plan’s delegated entities shall~~  
25 ~~provide to the department both of the following:~~

26 ~~(i) Data listing its average contracted rates for services most~~  
27 ~~frequently subject to Section 1371.9 in each geographic region in~~  
28 ~~which the services are rendered for the year 2015.~~

29 ~~(ii) Its methodology for determining the average contracted rate~~  
30 ~~for services subject to Section 1371.9. The methodology to~~  
31 ~~determine the average contracted rate shall ensure that the plan~~  
32 ~~includes the highest and lowest contracted rates for the year 2015.~~

33 *(2) (A) The department shall specify a methodology that plans*  
34 *and delegated entities shall use to determine the average*  
35 *contracted rates for services most frequently subject to Section*  
36 *1371.9. This methodology shall take into account, at a minimum,*  
37 *the specialty of the individual health professional and the*  
38 *geographic region in which the services are rendered. The*  
39 *methodology to determine an average contracted rate shall ensure*  
40 *that the plan includes the highest and lowest contracted rates.*

1 (B) Health care service plans and delegated entities shall  
2 annually provide to the department the policies and procedures  
3 used to determine the average contracted rates in compliance with  
4 subparagraph (A).

5 (C) If, based on the health care service plan's model, a health  
6 care service plan does not pay a statistically significant number  
7 or dollar amount of claims for services covered under Section  
8 1371.9, the health care service plan shall demonstrate to the  
9 department that it has access to a statistically credible database  
10 reflecting rates paid to noncontracting individual health  
11 professionals for services provided in a geographic region.

12 ~~(C)~~

13 (D) For each year after 2015, the health care service plan and  
14 the plan's delegated entities shall adjust the rate initially established  
15 pursuant to this subdivision by the Consumer Price Index for  
16 Medical Care Services, as published by the United States Bureau  
17 of Labor Statistics.

18 ~~(D) The department shall audit the accuracy of the information  
19 required under subparagraphs (A) and (B).~~

20 (E) The department shall review the information filed pursuant  
21 to this subdivision as part of its examination of fiscal and  
22 administrative affairs pursuant to Section 1382.

23 ~~(E)~~

24 (F) The average contracted rate data submitted pursuant to  
25 clause (i) of subparagraph (A) and clause (i) of subparagraph (B)  
26 this paragraph shall be confidential and not subject to disclosure  
27 under the California Public Records Act (Chapter 3.5 (commencing  
28 with Section 6250) of Division 7 of Title 1 of the Government  
29 Code).

30 ~~(F)~~

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

37 (3) A health care service plan shall include in its reports  
38 submitted to the department pursuant to Section 1367.035 and  
39 regulations adopted pursuant to that section, in a manner specified  
40 by the department, the number of out-of-network payments made

1 for services subject to Section 1371.9, as well as other data  
2 sufficient to determine the prevalence of out-of-network individual  
3 health professionals at specific facilities for the types of facilities  
4 listed in subdivision (f) of Section 1371.9.

5 ~~(3)~~

6 (4) For purposes of this section for Medicare-fee-for-service  
7 fee-for-service reimbursement, geographic regions shall be the  
8 geographic regions specified for physician reimbursement for  
9 Medicare-fee-for-service fee-for-service by the United States  
10 Department of Health and Human Services.

11 ~~(4)~~

12 (5) A health care service plan shall authorize and permit  
13 assignment of the enrollee's right, if any, to any reimbursement  
14 for health care services covered under the plan contract to a  
15 noncontracting individual health professional who furnishes the  
16 health care services rendered subject to Section 1371.9. ~~The plan~~  
17 ~~shall provide a form approved by the department for this purpose.~~  
18 *Lack of assignment pursuant to this paragraph shall not be*  
19 *construed to limit the applicability of this section, Section 1371.30,*  
20 *or Section 1371.9.*

21 ~~(5)~~

22 (6) A noncontracting individual health professional who disputes  
23 the claim reimbursement under this section shall utilize the  
24 independent dispute resolution process described in Section  
25 1371.30.

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

37 (c) If a health care service plan delegates the responsibility for  
38 payment of claims to a contracted entity, including, but not limited  
39 to, a medical group or independent practice association, then the

1 entity to which that responsibility is delegated shall comply with  
2 the requirements of this section.

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

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

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

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

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

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

29 1371.9. (a) (1) Except as provided in subdivision (c), a health  
30 care service plan contract issued, amended, or renewed on or after  
31 July 1, 2017, shall provide that if an enrollee receives covered  
32 services from a contracting health facility at which, or as a result  
33 of which, the enrollee receives services provided by a  
34 noncontracting individual health professional, the enrollee shall  
35 pay no more than the same cost sharing that the enrollee would  
36 pay for the same covered services received from a contracting  
37 individual health professional. This amount shall be referred to as  
38 the “in-network cost-sharing amount.”

39 (2) An enrollee shall not owe the noncontracting individual  
40 health professional more than the in-network cost-sharing amount

1 for services subject to this section. At the time of payment by the  
2 plan to the noncontracting individual health professional, the plan  
3 shall inform the *enrollee and the* noncontracting individual health  
4 professional of the in-network cost-sharing amount owed by the  
5 enrollee.

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

16 (4) In submitting a claim to the plan, the noncontracting  
17 individual health professional shall affirm to the plan that he or  
18 she has not attempted to collect any payment from the enrollee.

19 (5) (A) If the noncontracting individual health professional has  
20 received more than the in-network cost-sharing amount from the  
21 enrollee for services subject to this section, the noncontracting  
22 individual health professional shall refund any overpayment to the  
23 enrollee within 30 calendar days after receiving notice from the  
24 plan of the in-network cost-sharing amount owed by the enrollee  
25 pursuant to paragraph (2).

26 (B) If the noncontracting individual health professional does  
27 not refund any overpayment to the enrollee within 30 business  
28 days after being informed of the enrollee's in-network cost-sharing  
29 amount, interest shall accrue at the rate of 15 percent per annum  
30 beginning with the ~~date payment was received from the enrollee.~~  
31 *first day after the 30-business-day period has elapsed.*

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

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

38 (1) Any cost sharing paid by the enrollee for the services  
39 ~~provided by a noncontracting individual health professional at the~~  
40 ~~contracting health facility~~ *subject to this section* shall count toward

1 the limit on annual out-of-pocket expenses established under  
2 Section 1367.006.

3 (2) Cost sharing arising from services ~~received by a~~  
4 ~~noncontracting individual health professional at a contracting~~  
5 ~~health facility~~ *subject to this section* shall be counted toward any  
6 deductible in the same manner as cost sharing would be attributed  
7 to a contracting individual health professional.

8 (3) The cost sharing paid by the enrollee pursuant to this section  
9 shall satisfy the enrollee's obligation to pay cost sharing for the  
10 health service and shall constitute "applicable cost sharing owed  
11 by the enrollee" ~~for the purpose of subdivision (e) of Section~~  
12 ~~1371.31.~~ *enrollee.*"

13 (c) For services subject to this section, if an enrollee has a health  
14 care service plan that includes coverage for out-of-network benefits,  
15 a noncontracting individual health professional may bill or collect  
16 from the enrollee the out-of-network cost sharing, if applicable,  
17 only when the enrollee consents in writing and that written consent  
18 ~~satisfies~~ *demonstrates satisfaction of* all the following criteria:

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

22 (2) The consent shall be obtained by the noncontracting  
23 individual health professional in a document that is separate from  
24 the document used to obtain the consent for any other part of the  
25 care or procedure. The consent shall not be obtained by the facility  
26 or any representative of the facility. The consent shall not be  
27 obtained at the time of admission or at any time when the enrollee  
28 is being prepared for surgery or any other procedure.

29 (3) At the time consent is provided, the noncontracting  
30 individual health professional shall give the enrollee a written  
31 estimate of the enrollee's total out-of-pocket cost of care. The  
32 written estimate shall be based on the professional's billed charges  
33 for the service to be provided. The noncontracting individual health  
34 professional shall not attempt to collect more than the estimated  
35 amount without receiving separate written consent from the  
36 enrollee or the enrollee's authorized representative, unless  
37 circumstances arise during delivery of services that were  
38 ~~unforeseen~~ *unforeseeable* at the time the estimate was given that  
39 would require the provider to change the estimate.

1 (4) The consent shall advise the enrollee that he or she may  
2 elect to seek care from a contracted provider or may contact the  
3 enrollee's health care service plan in order to arrange to receive  
4 the health service from a contracted provider for  
5 ~~lower-out-of-pocket~~ *lower out-of-pocket* costs.

6 (5) The consent and estimate shall be provided to the enrollee  
7 in the language spoken by the enrollee, if the language is a  
8 Medi-Cal threshold language, as defined in subdivision (d) of  
9 Section 128552.

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

15 (d) A noncontracting individual health professional who fails  
16 to comply with the requirements of subdivision (c) has not obtained  
17 written consent for purposes of this section. Under those  
18 circumstances, subdivisions (a) and (b) shall apply and subdivision  
19 (c) shall not apply.

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

25 (2) The noncontracting individual health professional, or any  
26 entity acting on his or her behalf, including any assignee of the  
27 debt, shall not report adverse information to a consumer credit  
28 reporting agency or commence civil action against the enrollee for  
29 *a minimum of* 150 days after the initial billing regarding amounts  
30 owed by the enrollee under subdivision (a) or (c).

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

36 (f) For purposes of this section and Sections 1371.30 and  
37 1371.31, the following definitions shall apply:

38 (1) "Contracting health facility" means a health facility that is  
39 contracted with the enrollee's health care service plan to provide

1 services under the enrollee’s plan contract. A contracting health  
2 care facility includes, but is not limited to, the following providers:

- 3 (A) A licensed hospital.
- 4 (B) An ambulatory surgery or other outpatient setting, as  
5 described in subdivision (a), (d), (e), (g), or (h) of Section 1248.1.
- 6 (C) A laboratory.
- 7 (D) A radiology or imaging center.

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

11 (3) “Individual health professional” means a physician and  
12 surgeon or other professional who is licensed by this state to deliver  
13 or furnish health care services. For this purpose, an “individual  
14 health professional” shall not include a dentist, licensed pursuant  
15 to the Dental Practice Act (Chapter 4 (commencing with Section  
16 1600) of Division 2 of the Business and Professions Code).

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

23 (5) “Noncontracting individual health professional” means a  
24 physician and surgeon or other professional who is licensed by the  
25 state to deliver or furnish health care services and who is not  
26 contracted with the enrollee’s health care service product. For this  
27 purpose, a “noncontracting individual health professional” shall  
28 not include a dentist, licensed pursuant to the Dental Practice Act  
29 (Chapter 4 (commencing with Section 1600) of Division 2 of the  
30 Business and Professions Code). *Application of this definition is*  
31 *not precluded by a noncontracting individual health professional’s*  
32 *affiliation with a group.*

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

36 (h) This section shall not be construed to exempt a plan or  
37 provider from the requirements under Section 1371.4 or 1373.96,  
38 nor abrogate the holding in *Prospect Medical Group, Inc. v.*  
39 *Northridge Emergency Medical Group* (2009) 45 Cal.4th 497.

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

5 (j) This section shall not apply to a Medi-Cal managed health  
6 care service plan or any other entity that enters into a contract with  
7 the State Department of Health Care Services pursuant to Chapter  
8 7 (commencing with Section 14000), Chapter 8 (commencing with  
9 Section 14200), and Chapter 8.75 (commencing with Section  
10 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

11 (k) This section shall not apply to emergency services and care,  
12 as defined in Section 1317.1, or to those services required to be  
13 covered by a health care service plan pursuant to Section 1371.4.

14 SEC. 4. Section 10112.8 is added to the Insurance Code, to  
15 read:

16 10112.8. (a) (1) Except as provided in subdivision (c), a health  
17 insurance policy issued, amended, or renewed on or after July 1,  
18 2017, that provides benefits through contracts with providers at  
19 alternative rates of payment pursuant to Section 10133, shall  
20 provide that if an insured receives covered services from a  
21 contracting health facility at which, or as a result of which, the  
22 insured receives services provided by a noncontracting individual  
23 health professional, the insured shall pay no more than the same  
24 cost sharing that the insured would pay for the same covered  
25 services received from a contracting individual health professional.  
26 This amount shall be referred to as the “in-network cost-sharing  
27 amount.”

28 (2) Except as provided in subdivision (c), an insured shall not  
29 owe the noncontracting individual health professional more than  
30 the in-network cost-sharing amount for services subject to this  
31 section. At the time of payment by the insurer to the noncontracting  
32 individual health professional, the insurer shall inform the *insured*  
33 *and the* noncontracting individual health professional of the  
34 in-network cost-sharing amount owed by the insured.

35 (3) A noncontracting individual health professional shall not  
36 bill or collect any amount from the insured for services subject to  
37 this section except the in-network cost-sharing amount. Any  
38 communication from the noncontracting individual health  
39 professional to the insured prior to the receipt of information about  
40 the in-network cost-sharing amount pursuant to paragraph (2) shall

1 include a notice in 12-point bold type stating that the  
2 communication is not a bill and informing the insured that the  
3 insured shall not pay until he or she is informed *by his or her*  
4 *insurer* of any applicable cost sharing.

5 (4) In submitting a claim to the insurer, the noncontracting  
6 individual health professional shall affirm to the insurer that he or  
7 she has not attempted to collect any payment from the insured.

8 (5) (A) If the noncontracting individual health professional has  
9 received more than the in-network cost-sharing amount from the  
10 insured for services subject to this section, the noncontracting  
11 individual health professional shall refund any overpayment to the  
12 insured within 30 calendar days after receiving notice from the  
13 insurer of the in-network cost-sharing amount owed by the insured  
14 pursuant to paragraph (2).

15 (B) If the noncontracting individual health professional does  
16 not refund any overpayment to the insured within 30 business days  
17 after being informed of the insured's in-network cost-sharing  
18 amount, interest shall accrue at the rate of 15 percent per annum  
19 beginning with the ~~date payment was received from the insured.~~  
20 *first day after the 30-business-day period has elapsed.*

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

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

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

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

37 (3) The cost sharing paid by the insured pursuant to this section  
38 shall satisfy the insured's obligation to pay cost sharing for the  
39 health service and shall constitute "applicable cost sharing owed

1 by the insured” for the purpose of subdivision (e) of Section  
2 10112.82: *insured.*”

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

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

13 (2) The consent shall be obtained by the noncontracting  
14 individual health professional in a document that is separate from  
15 the document used to obtain the consent for any other part of the  
16 care or procedure. The consent shall not be obtained by the facility  
17 or any representative of the facility. The consent shall not be  
18 obtained at the time of admission or at any time when the enrollee  
19 is being prepared for surgery or any other 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, unless circumstances arise during  
28 delivery of services that were ~~unforeseen~~ *unforeseeable* at the time  
29 the estimate was given that would require the provider to change  
30 the estimate.

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

36 (5) The consent and estimate shall be provided to the insured  
37 in the language spoken by the insured, if the language is a Medi-Cal  
38 threshold language, as defined in subdivision (d) of Section 128552  
39 of the Health and Safety Code.

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

6 (d) A noncontracting individual health professional who fails  
7 to comply with provisions of this subdivision has not obtained  
8 written consent for purposes of this section. Under those  
9 circumstances, subdivisions (a) and (b) shall apply and subdivision  
10 (c) shall not apply.

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

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

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

27 (f) For purposes of this section and Sections 10112.81 and  
28 10112.82, the following definitions shall apply:

29 (1) "Contracting health facility" means a health facility that is  
30 contracted with the insured's health insurer to provide services  
31 under the insured's policy. A contracting health care facility  
32 includes, but is not limited to, the following providers:

33 (A) A licensed hospital.

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

37 (C) A laboratory.

38 (D) A radiology or imaging center.

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

4 (3) “Individual health professional” means a physician and  
5 surgeon or other professional who is licensed by the state to deliver  
6 or furnish health care services. For this purpose, an “individual  
7 health professional” shall not include a dentist, licensed pursuant  
8 to the Dental Practice Act (Chapter 4 (commencing with Section  
9 1600) of Division 2 of the Business and Professions Code).

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

16 (5) “Noncontracting individual health professional” means a  
17 physician and surgeon or other professional who is licensed by the  
18 state to deliver or furnish health care services and who is not  
19 contracted with the insured’s health insurance product. For this  
20 purpose, a “noncontracting individual health professional” shall  
21 not include a dentist, licensed pursuant to the Dental Practice Act  
22 (Chapter 4 (commencing with Section 1600) of Division 2 of the  
23 Business and Professions Code). *Application of this definition is*  
24 *not precluded by a noncontracting individual health professional’s*  
25 *affiliation with a group.*

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

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

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

35 SEC. 5. Section 10112.81 is added to the Insurance Code, to  
36 read:

37 10112.81. (a) (1) The commissioner shall establish an  
38 independent dispute resolution process for the purpose of  
39 processing and resolving a claim dispute between a health insurer

1 and a noncontracting individual health professional for services  
2 subject to subdivision (a) of Section 10112.8.

3 (2) Prior to initiating the independent dispute resolution process,  
4 the parties shall complete the insurer's internal process.

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

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

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

16 (3) In establishing the independent dispute resolution process,  
17 the commissioner shall permit the bundling of claims submitted  
18 to the same insurer or the same delegated entity for the same or  
19 similar services by the same noncontracting individual health  
20 professional.

21 (4) The commissioner shall permit a physician group,  
22 independent practice association, or other entity authorized to act  
23 on behalf of a noncontracting individual health professional to  
24 initiate and participate in the independent dispute resolution  
25 process.

26 (5) *In deciding the dispute, the independent organization shall*  
27 *base its decision regarding the appropriate reimbursement on all*  
28 *relevant information, including, but not limited to, the*  
29 *reimbursement amount suggested by either party.*

30 (c) (1) The commissioner 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 commissioner shall establish conflict-of-interest  
35 standards, consistent with the purposes of this section, that an  
36 organization shall meet in order to qualify to administer the  
37 independent dispute resolution program. The conflict-of-interest  
38 standards shall be consistent with the standards pursuant to  
39 subdivisions (c) and (d) of Section 10169.2.

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

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

12 (5) *The independent organization retained to conduct*  
13 *proceedings shall be deemed to be consultants for purposes of*  
14 *Section 43.98 of the Civil Code.*

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

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

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

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

30 SEC. 6. Section 10112.82 is added to the Insurance Code, to  
31 read:

32 10112.82. (a) (1) For services rendered subject to Section  
33 10112.8, unless otherwise agreed to by the noncontracting  
34 individual health professional and the insurer, the insurer shall  
35 reimburse the greater of the average contracted rate or 125 percent  
36 of the amount Medicare reimburses on a fee-for-service basis for  
37 the same or similar services in the general geographic region in  
38 which the services were rendered. For the purposes of this section,  
39 "average contracted rate" means the average of the contracted  
40 commercial rates paid by the health insurer for the same or similar

1 services in the geographic region. This subdivision does not apply  
2 to subdivision (c) of Section 10112.8 or subdivision (b) of this  
3 section.

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

7 ~~(i) Data listing its average contracted rates for services most  
8 frequently subject to Section 10112.8 in each geographic region  
9 in which the services are rendered for the year 2015.~~

10 ~~(ii) Its methodology for determining the average contracted rate  
11 for services subject to Section 10112.8. The methodology to  
12 determine an average contracted rate shall assure that the insurer  
13 includes the highest and lowest contracted rates for the year 2015.~~

14 ~~(B) In a manner and format specified by the commissioner, by  
15 July 1, 2017, each health insurer's delegated entities shall provide  
16 to the department both of the following:~~

17 ~~(i) Data listing its average contracted rates for services most  
18 frequently subject to Section 10112.8 in each geographic region  
19 in which the services are rendered for the year 2015.~~

20 ~~(ii) Its methodology for determining the average contracted rate  
21 for services subject to Section 10112.8. The methodology to  
22 determine the average contracted rate shall ensure that the insurer  
23 includes the highest and lowest contracted rates for the year 2015.~~

24 ~~(2) (A) The commissioner shall specify a methodology that  
25 insurers shall use to determine the average contracted rates for  
26 services most frequently subject to Section 10112.8. This  
27 methodology shall take into account, at a minimum, the specialty  
28 of the individual health professional and the geographic region  
29 in which the services are rendered. The methodology to determine  
30 an average contracted rate shall ensure that the insurer includes  
31 the highest and lowest contracted rates.~~

32 ~~(B) Insurers shall annually provide to the commissioner the  
33 policies and procedures used to determine the average contracted  
34 rates in compliance with subparagraph (A).~~

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

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

3 ~~(E)~~

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

10 ~~(F)~~

11 (E) 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 *and information* provided in  
15 subparagraphs (A) and (B) in a manner and format specified by  
16 the Legislature.

17 (3) For the purposes of this section, for average contracted rates  
18 for individual and small group coverage, geographic region shall  
19 be the geographic regions listed in subparagraph (A) of paragraph  
20 (2) of subdivision (a) of Section 1357.512 of the Health and Safety  
21 Code. For purposes of this section for Medicare fee-for-service  
22 reimbursement, geographic regions shall be the geographic regions  
23 specified for physician reimbursement for Medicare ~~fee-for-service~~  
24 *fee-for-service* by the United States Department of Health and  
25 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.~~ *Lack of assignment pursuant to this paragraph shall*  
33 *not be construed to limit the applicability of this section, Section*  
34 *10112.8, or Section 10112.81.*

35 (5) A noncontracting individual health professional who disputes  
36 the claim reimbursement under this section shall utilize the  
37 independent dispute resolution process described in Section  
38 10112.81.

39 (b) If nonemergency services are provided by a noncontracting  
40 individual health professional consistent with subdivision (c) of

1 Section 10112.8 to an insured who has voluntarily chosen to use  
2 his or her out-of-network benefit for services covered by a preferred  
3 provider organization or a point-of-service plan, *an insurer that*  
4 *includes coverage for out-of-network benefits*, unless otherwise  
5 agreed to by the insurer and the noncontracting individual health  
6 professional, the amount paid by the insurer shall be the amount  
7 set forth in the insured's evidence of coverage. This payment is  
8 not subject to the independent dispute resolution process described  
9 in Section 10112.81.

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

15 (d) (1) A payment made by the health insurer to the  
16 noncontracting health care professional for nonemergency services  
17 as required by Section 10112.8 and this section, in addition to the  
18 applicable cost sharing owed by the insured, shall constitute  
19 payment in full for nonemergency services rendered unless either  
20 party uses the dispute resolution process or other lawful means  
21 pursuant to Section 10112.81.

22 (2) Notwithstanding any other law, the amounts paid by an  
23 insurer for services under this section shall not constitute the  
24 prevailing or customary charges, the usual fees to the general  
25 public, or other charges for other payers for an individual health  
26 professional.

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

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

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

33 SEC. 7. The Legislature finds and declares that Sections 2 and  
34 6 of this act, which add Section 1371.31 to the Health and Safety  
35 Code and Section 10112.82 to the Insurance Code, respectively,  
36 impose a limitation on the public's right of access to the meetings  
37 of public bodies or the writings of public officials and agencies  
38 within the meaning of Section 3 of Article I of the California  
39 Constitution. Pursuant to that constitutional provision, the

1 Legislature makes the following findings to demonstrate the interest  
2 protected by this limitation and the need for protecting that interest:  
3 In order to protect confidential rate information used by health  
4 care service plans and health insurers and to protect the integrity  
5 of the competitive market, it is necessary that this act limit the  
6 public's right of access to that information.

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