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CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 72

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

December 18, 2014

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~~ *establish, by September 1, 2017,* 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. *Contracts entered into pursuant to these provisions would be exempt from specified statutory provisions and related state agency review and approval requirements.* 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 pursuant to a specified ~~methodology.~~ *methodology and would specify, among other responsibilities, the duties of health care service plans, their delegated entities, and health insurers in identifying and calculating the applicable reimbursement rates, as well as various related duties of the department and the commissioner.* The bill would require the department and the commissioner to report ~~the above information~~ *on the data and information provided in the independent dispute resolution process* to the Governor and other specified recipients by January 1, ~~2020.~~ *2019.* The bill would require a noncontracting individual health ~~professional who~~ *professional, health care service plan or delegated entity, or health insurer that* 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:

SECTION 1. Section 1371.30 is added to the Health and Safety Code, immediately following Section 1371.3, to read:

1371.30. (a) (1) ~~The~~ *By September 1, 2017, the* department shall establish an independent dispute resolution process for the purpose of processing and resolving a claim dispute between a health care service plan and a noncontracting individual health professional for services subject to subdivision (a) of Section 1371.9.

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

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

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

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

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

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

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

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

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

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

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

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

(6) Contracts entered into pursuant to the authority in this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code and shall be exempt from the review or approval of any division of the Department of General Services.

(d) The decision obtained through the department's independent dispute resolution process shall be binding on both parties. The plan shall implement the decision obtained through the independent dispute resolution process. If dissatisfied, either party may pursue any right, remedy, or penalty established under any other applicable law.

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

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

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

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

(i) This section shall not be construed to alter a health care service plan's obligations pursuant to Sections 1371 and 1371.4.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-plan letters or similar instructions, without taking regulatory action, until the time regulations are adopted.

(k) By January 1, 2019, the department shall provide a report to the Governor, the President pro Tempore of the Senate, the Speaker of the Assembly, and the Senate and Assembly Committees on Health of the data and information provided in the independent dispute resolution process in a manner and format specified by the Legislature.

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

1371.31. (a) (1) For services rendered subject to Section 1371.9, *effective July 1, 2017,* unless otherwise agreed to by the noncontracting individual health professional and the plan, the plan shall reimburse the greater of the average contracted rate or 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered. For the purposes of this section, "average contracted rate" means the average of the contracted commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region.

This subdivision does not apply to subdivision (c) of Section 1371.9 or subdivision (b) of this section.

(2) (A) By July 1, 2017, each health care service plan and its delegated entities shall provide to the department all of the following:

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

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

(iii) The policies and procedures used to determine the average contracted rates under this subdivision.

(B) For each calendar year after the plan's initial submission of the average contracted rate as specified in subparagraph (A) and until the standardized methodology under paragraph (3) is specified, a health care service plan and the plan's delegated entities shall adjust the rate initially established pursuant to this subdivision by the Consumer Price Index for Medical Care Services, as published by the United States Bureau of Labor Statistics.

~~(2) (A) The~~

(3) (A) By January 1, 2019, the department shall specify a methodology that plans and delegated entities shall use to determine the average contracted rates for services most frequently subject to Section 1371.9. This methodology shall take into account, at a minimum, *information from the independent dispute resolution process,* the specialty of the individual health ~~professional~~ *professional,* and the geographic region in which the services are rendered. The methodology to determine an average contracted rate shall ensure that the plan includes the highest and lowest contracted rates.

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

(C) If, based on the health care service plan's model, a health care service plan does not pay a statistically significant number or dollar amount of claims for services covered under Section 1371.9, the health care service plan shall demonstrate to the department that it has access to a statistically credible database reflecting rates paid to noncontracting individual health professionals for services provided in a geographic ~~region.~~ *region and shall use that database to determine an average contracted rate required pursuant to paragraph (1).*

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

~~(E)~~

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

~~(F)~~

(E) The average contracted rate data submitted pursuant to this ~~paragraph~~ *section* shall be confidential and not subject to disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

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

(F) In developing the standardized methodology under this subdivision, the department shall consult with interested parties throughout the process of developing the standards, including the Department of Insurance, representatives of health plans, insurers, health care providers, hospitals, consumer advocates, and other stakeholders it deems appropriate. The department shall hold the first stakeholder meeting no later than July 1, 2017.

~~(3)~~

(4) A health care service plan shall include in its reports submitted to the department pursuant to Section 1367.035 and

regulations adopted pursuant to that section, in a manner specified by the department, the number of ~~out-of-network payments made for services subject to Section 1371.9, as well as other data sufficient to determine the prevalence of out-of-network individual health professionals at specific facilities for the types of facilities listed in subdivision (f) of Section 1371.9.~~ *payments made to noncontracting individual health professionals for services at a contracting health facility and subject to Section 1371.9, as well as other data sufficient to determine the proportion of noncontracting individual health professionals to contracting individual health professionals at contracting health facilities, as defined in subdivision (f) of Section 1371.9. The department shall include a summary of this information in its January 1, 2019, report required pursuant to subdivision (k) of Section 1371.30 and its findings regarding the impact of the act that added this section on health care service plan contracting and network adequacy.*

(5) A health care service plan that provides services subject to Section 1371.9 shall meet the network adequacy requirements set forth in subdivisions (d) and (e) of Section 1367 of this code and in Exhibits (H) and (I) of subdivision (d) of Section 1300.51 of, and Section 1300.67.2 of, Title 28 of the California Code of Regulations, including, but not limited to, inpatient hospital services and specialist physician services, and if necessary, the department may adopt additional regulations related to those services.

~~(4)~~

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

~~(5)~~

(7) A health care service plan shall authorize and permit assignment of the enrollee's right, if any, to any reimbursement for health care services covered under the plan contract to a noncontracting individual health professional who furnishes the health care services rendered subject to Section 1371.9. Lack of assignment pursuant to this paragraph shall not be construed to limit the applicability of this section, Section 1371.30, or Section 1371.9.

~~(6)~~

(8) A noncontracting individual health ~~professional~~ *professional, health care service plan, or health care service plan's delegated entity* who disputes the claim reimbursement under this section shall utilize the independent dispute resolution process described in Section 1371.30.

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

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

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

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

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

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

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

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

(h) This section shall not be construed to alter a health care service plan's obligations pursuant to Sections 1371 and 1371.4.

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

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

(2) An enrollee shall not owe the noncontracting individual health professional more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the noncontracting individual health professional, the plan shall inform the enrollee and the noncontracting individual health professional of the in-network cost-sharing amount owed by the enrollee.

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

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

~~(5)~~

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

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

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

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

(1) Any cost sharing paid by the enrollee for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting individual health professional.

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

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

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

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

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

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

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

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

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

(e) (1) A noncontracting individual health professional may advance to collections only the in-network cost-sharing amount, as determined by the plan pursuant to subdivision (a) or the

out-of-network cost-sharing amount owed pursuant to subdivision (c), that the enrollee has failed to pay.

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

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

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

(1) "Contracting health facility" means a health facility that is contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract. A contracting health care facility includes, but is not limited to, the following providers:

(A) A licensed hospital.

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

(C) A laboratory.

(D) A radiology or imaging center.

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

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

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

(5) "Noncontracting individual health professional" means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services and who is not contracted with the enrollee's health care service product. For this purpose, a "noncontracting individual health professional" shall not include a dentist, licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code). Application of this definition is not precluded by a noncontracting individual health professional's affiliation with a group.

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

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

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

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

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

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

10112.8. (a) (1) Except as provided in subdivision (c), a health insurance policy issued, amended, or renewed on or after July 1, 2017, that provides benefits through contracts with providers at alternative rates of payment pursuant to Section 10133, shall provide that if an insured receives covered services from a contracting health facility at which, or as a result of which, the insured receives services provided by a noncontracting individual

health professional, the insured shall pay no more than the same cost sharing that the insured would pay for the same covered services received from a contracting individual health professional. This amount shall be referred to as the "in-network cost-sharing amount."

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

(3) A noncontracting individual health professional shall not bill or collect any amount from the insured for services subject to this section except the in-network cost-sharing amount. Any communication from the noncontracting individual health professional to the insured prior to the receipt of information about the in-network cost-sharing amount pursuant to paragraph (2) shall include a notice in 12-point bold type stating that the communication is not a bill and informing the insured that the insured shall not pay until he or she is informed by his or her insurer of any applicable cost sharing.

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

~~(5)~~

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

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

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

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

(1) Any cost sharing paid by the insured for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting individual health professional.

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

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

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

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

(3) At the time consent is provided the noncontracting individual health professional shall give the insured a written estimate of the insured's total out-of-pocket cost of care. The written estimate shall be based on the professional's billed charges for the service to be provided. The noncontracting individual health professional shall not attempt to collect more than the estimated amount without

receiving separate written consent from the insured or the insured's authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate.

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

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

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

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

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

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

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

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

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

(A) A licensed hospital.

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

(C) A laboratory.

(D) A radiology or imaging center.

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

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

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

(5) "Noncontracting individual health professional" means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services and who is not contracted with the insured's health insurance product. For this purpose, a "noncontracting individual health professional" shall not include a dentist, licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code). Application of this definition is not precluded by a noncontracting individual health professional's affiliation with a group.

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

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

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

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

10112.81. (a) (1) ~~The~~ *By September 1, 2017, the* commissioner shall establish an independent dispute resolution process for the purpose of processing and resolving a claim dispute between a health insurer and a noncontracting individual health professional for services subject to subdivision (a) of Section 10112.8.

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

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

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

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

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

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

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

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

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

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

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

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

(5) Contracts entered into pursuant to the authority in this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code and shall be exempt from the review or approval of any division of the Department of General Services.

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

(e) If a health insurer delegates payment functions to a contracted entity, including, but not limited to, a medical group or

independent practice association, then the delegated entity shall comply with this section.

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

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

(h) This section shall not be construed to alter a health insurer's obligations pursuant to Section 10123.13.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the commissioner may implement, interpret, or make specific this section by issuing guidance, without taking regulatory action, until the time regulations are adopted.

(j) By January 1, 2019, the commissioner shall provide a report to the Governor, the President pro Tempore of the Senate, the Speaker of the Assembly, and the Senate and Assembly Committees on Health of the data and information provided in the independent dispute resolution process in a manner and format specified by the Legislature.

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

10112.82. (a) (1) For services rendered subject to Section 10112.8, *effective July 1, 2017,* unless otherwise agreed to by the noncontracting individual health professional and the insurer, the insurer shall reimburse the greater of the average contracted rate or 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered. For the purposes of this section, "average contracted rate" means the average of the contracted commercial rates paid by the health insurer for the same or similar services in the geographic region. This subdivision does not apply to subdivision (c) of Section 10112.8 or subdivision (b) of this section.

(2) (A) By July 1, 2017, each health insurer shall provide to the commissioner all of the following:

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

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

(iii) The policies and procedures used to determine the average contracted rates under this subdivision.

(B) For each calendar year after the health insurer's initial submission of the average contracted rate as specified in subparagraph (A) and until the standardized methodology under paragraph (3) is specified, a health insurer shall adjust the rate initially established pursuant to this subdivision by the Consumer Price Index for Medical Care Services, as published by the United States Bureau of Labor Statistics.

~~(2) (A) The~~

(3) (A) By January 1, 2019, the commissioner shall specify a methodology that insurers shall use to determine the average contracted rates for services most frequently subject to Section 10112.8. This methodology shall take into account, at a minimum, *information from the independent dispute resolution process,* the specialty of the individual health ~~professional~~ *professional,* and the geographic region in which the services are rendered. The methodology to determine an average contracted rate shall ensure that the insurer includes the highest and lowest contracted rates.

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

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

~~(D)~~

(C) The average contracted rate data submitted pursuant to this ~~paragraph~~ *section* shall be confidential and not subject to disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

~~(E) By January 1, 2020, the department shall provide a report to the Governor, the President pro Tempore of the Senate, the~~

~~Speaker of the Assembly, and the Senate and Assembly Committees on Health of the data and information provided in subparagraphs (A) and (B) in a manner and format specified by the Legislature.~~

(D) In developing the standardized methodology under this subdivision, the commissioner shall consult with interested parties throughout the process of developing the standards, including the Department of Managed Health Care, representatives of health plans, insurers, health care providers, hospitals, consumer advocates, and other stakeholders it deems appropriate. The commissioner shall hold the first stakeholder meeting no later than July 1, 2017.

(4) A health insurer shall include in its reports submitted to the commissioner pursuant to Section 10133.5 and regulations adopted pursuant to that section, in a manner specified by the department, the number of payments made to noncontracting individual health professionals for services at a contracting health facility and subject to Section 10112.8, as well as other data sufficient to determine the proportion of noncontracting individual health professionals to contracting individual health professionals at contracting health facilities, as defined in subdivision (f) of Section 10112.8. The commissioner shall include a summary of this information in its January 1, 2019, report required pursuant to subdivision (j) of Section 10112.81 and its findings regarding the impact of the act that added this section on health insurer contracting and network adequacy.

(5) A health insurer that provides services subject to Section 10112.8 shall meet the network adequacy requirements set forth in Section 10133.5 of the Insurance Code and Section 2240.1 of Title 10 of the California Code of Regulations, including, but not limited to, inpatient hospital services and specialist physician services, and if necessary, the commissioner may adopt additional regulations related to those services.

~~(3)~~

(6) For the purposes of this section, for average contracted rates for individual and small group coverage, geographic region shall be the geographic regions listed in subparagraph (A) of paragraph (2) of subdivision (a) of Section ~~1357.512 of the Health and Safety Code.~~ *10753.14.* For purposes of this section for Medicare fee-for-service reimbursement, geographic regions shall be the

geographic regions specified for physician reimbursement for Medicare fee-for-service by the United States Department of Health and Human Services.

~~(4)~~

(7) A health insurer shall authorize and permit assignment of the insured's right, if any, to any reimbursement for health care services covered under the health insurance policy to a noncontracting individual health professional who furnishes the health care services rendered subject to Section 10112.8. Lack of assignment pursuant to this paragraph shall not be construed to limit the applicability of this section, Section 10112.8, or Section 10112.81.

~~(5)~~

(8) A noncontracting individual health professional *or health insurer* who disputes the claim reimbursement under this section shall utilize the independent dispute resolution process described in Section 10112.81.

(b) If nonemergency services are provided by a noncontracting individual health professional consistent with subdivision (c) of Section 10112.8 to an insured who has voluntarily chosen to use his or her out-of-network benefit for services covered by an insurer that includes coverage for out-of-network benefits, unless otherwise agreed to by the insurer and the noncontracting individual health professional, the amount paid by the insurer shall be the amount set forth in the insured's ~~evidence of coverage.~~ *policy.* This payment is not subject to the independent dispute resolution process described in Section 10112.81.

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

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

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

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

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

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

(g) This section shall not be construed to alter a health insurer's obligations pursuant to Section 10123.13.

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

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

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

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