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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, 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 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 on the data and information provided in the independent dispute resolution process to the Governor and other specified recipients by January 1, 2019. The bill would require a noncontracting individual health 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:

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) By September 1, 2017, the department shall
4 establish an independent dispute resolution process for the purpose
5 of processing and resolving a claim dispute between a health care
6 service plan and a noncontracting individual health professional
7 for services subject 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.

(5) In deciding the dispute, the independent organization shall base its decision regarding the appropriate reimbursement on all relevant 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.

1 (e) This section shall not apply to a Medi-Cal managed health
2 care service plan or any entity that enters into a contract with the
3 State Department of Health Care Services pursuant to Chapter 7
4 (commencing with Section 14000), Chapter 8 (commencing with
5 Section 14200), and Chapter 8.75 (commencing with Section
6 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.
7 (f) If a health care service plan delegates payment functions to
8 a contracted entity, including, but not limited to, a medical group
9 or independent practice association, then the delegated entity shall
10 comply with this section.
11 (g) This section shall not apply to emergency services and care,
12 as defined in Section 1317.1.
13 (h) The definitions in subdivision (f) of Section 1371.9 shall
14 apply for purposes of this section.
15 (i) This section shall not be construed to alter a health care
16 service plan's obligations pursuant to Sections 1371 and 1371.4.
17 (j) Notwithstanding Chapter 3.5 (commencing with Section
18 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
19 the department may implement, interpret, or make specific this
20 section by means of all-plan letters or similar instructions, without
21 taking regulatory action, until the time regulations are adopted.
22 (k) By January 1, 2019, the department shall provide a report
23 to the Governor, the President pro Tempore of the Senate, the
24 Speaker of the Assembly, and the Senate and Assembly
25 Committees on Health of the data and information provided in the
26 independent dispute resolution process in a manner and format
27 specified by the Legislature.
28 SEC. 2. Section 1371.31 is added to the Health and Safety
29 Code, to read:
30 1371.31. (a) (1) For services rendered subject to Section
31 1371.9, effective July 1, 2017, unless otherwise agreed to by the
32 noncontracting individual health professional and the plan, the
33 plan shall reimburse the greater of the average contracted rate or
34 125 percent of the amount Medicare reimburses on a fee-for-service
35 basis for the same or similar services in the general geographic
36 region in which the services were rendered. For the purposes of
37 this section, "average contracted rate" means the average of the
38 contracted commercial rates paid by the health plan or delegated
39 entity for the same or similar services in the geographic region.

1 This subdivision does not apply to subdivision (c) of Section
2 1371.9 or subdivision (b) of this section.
3 (2) (A) By July 1, 2017, each health care service plan and its
4 delegated entities shall provide to the department all of the
5 following:
6 (i) Data listing its average contracted rates for the plan for
7 services most frequently subject to Section 1371.9 in each
8 geographic region in which the services are rendered for the
9 calendar year 2015.
10 (ii) Its methodology for determining the average contracted rate
11 for the plan for services subject to Section 1371.9. The
12 methodology to determine an average contracted rate shall ensure
13 that the plan includes the highest and lowest contracted rates for
14 the calendar year 2015.
15 (iii) The policies and procedures used to determine the average
16 contracted rates under this subdivision.
17 (B) For each calendar year after the plan's initial submission of
18 the average contracted rate as specified in subparagraph (A) and
19 until the standardized methodology under paragraph (3) is
20 specified, a health care service plan and the plan's delegated entities
21 shall adjust the rate initially established pursuant to this subdivision
22 by the Consumer Price Index for Medical Care Services, as
23 published by the United States Bureau of Labor Statistics.
24 (3) (A) By January 1, 2019, the department shall specify a
25 methodology that plans and delegated entities shall use to
26 determine the average contracted rates for services most frequently
27 subject to Section 1371.9. This methodology shall take into
28 account, at a minimum, information from the independent dispute
29 resolution process, the specialty of the individual health
30 professional, and the geographic region in which the services are
31 rendered. The methodology to determine an average contracted
32 rate shall ensure that the plan includes the highest and lowest
33 contracted rates.
34 (B) Health care service plans and delegated entities shall provide
35 to the department the policies and procedures used to determine
36 the average contracted rates in compliance with subparagraph (A).
37 (C) If, based on the health care service plan's model, a health
38 care service plan does not pay a statistically significant number or
39 dollar amount of claims for services covered under Section 1371.9,
40 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 and shall use that database to determine an average contracted rate required pursuant to paragraph (1).

(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.

(E) The average contracted rate data submitted pursuant to this 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).

(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.

(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 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 *this chapter, including, but not limited to,* 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~~ *Sections 1300.67.2 and 1300.67.2.1* of, Title 28 of the California Code of Regulations, including, but not limited to, inpatient

1 hospital services and specialist physician services, and if necessary,
2 the department may adopt additional regulations related to those
3 services. *This section shall not be construed to limit the director's*
4 *authority under this chapter.*
5 (6) For purposes of this section for Medicare fee-for-service
6 reimbursement, geographic regions shall be the geographic regions
7 specified for physician reimbursement for Medicare fee-for-service
8 by the United States Department of Health and Human Services.
9 (7) A health care service plan shall authorize and permit
10 assignment of the enrollee's right, if any, to any reimbursement
11 for health care services covered under the plan contract to a
12 noncontracting individual health professional who furnishes the
13 health care services rendered subject to Section 1371.9. Lack of
14 assignment pursuant to this paragraph shall not be construed to
15 limit the applicability of this section, Section 1371.30, or Section
16 1371.9.
17 (8) A noncontracting individual health professional, health care
18 service plan, or health care service plan's delegated entity who
19 disputes the claim reimbursement under this section shall utilize
20 the independent dispute resolution process described in Section
21 1371.30.
22 (b) If nonemergency services are provided by a noncontracting
23 individual health professional consistent with subdivision (c) of
24 Section 1371.9 to an enrollee who has voluntarily chosen to use
25 his or her out-of-network benefit for services covered by a plan
26 that includes coverage for out-of-network benefits, unless otherwise
27 agreed to by the plan and the noncontracting individual health
28 professional, the amount paid by the health care service plan shall
29 be the amount set forth in the enrollee's evidence of coverage.
30 This payment is not subject to the independent dispute resolution
31 process described in Section 1371.30.
32 (c) If a health care service plan delegates the responsibility for
33 payment of claims to a contracted entity, including, but not limited
34 to, a medical group or independent practice association, then the
35 entity to which that responsibility is delegated shall comply with
36 the requirements of this section.
37 (d) (1) A payment made by the health care service plan to the
38 noncontracting health care professional for nonemergency services
39 as required by Section 1371.9 and this section, in addition to the
40 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.

(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.

1 (3) A noncontracting individual health professional shall not
2 bill or collect any amount from the enrollee for services subject
3 to this section except for the in-network cost-sharing amount. Any
4 communication from the noncontracting individual health
5 professional to the enrollee prior to the receipt of information about
6 the in-network cost-sharing amount pursuant to paragraph (2) shall
7 include a notice in 12-point bold type stating that the
8 communication is not a bill and informing the enrollee that the
9 enrollee shall not pay until he or she is informed by his or her
10 health care service plan of any applicable cost sharing.
11 (4) (A) If the noncontracting individual health professional has
12 received more than the in-network cost-sharing amount from the
13 enrollee for services subject to this section, the noncontracting
14 individual health professional shall refund any overpayment to the
15 enrollee within 30 calendar days after receiving payment from the
16 enrollee.
17 (B) If the noncontracting individual health professional does
18 not refund any overpayment to the enrollee within 30 calendar
19 days after being informed of the enrollee's in-network cost-sharing
20 amount, interest shall accrue at the rate of 15 percent per annum
21 beginning with the date payment was received from the enrollee.
22 (C) A noncontracting individual health professional shall
23 automatically include in his or her refund to the enrollee all interest
24 that has accrued pursuant to this section without requiring the
25 enrollee to submit a request for the interest amount.
26 (b) Except for services subject to subdivision (c), the following
27 shall apply:
28 (1) Any cost sharing paid by the enrollee for the services subject
29 to this section shall count toward the limit on annual out-of-pocket
30 expenses established under Section 1367.006.
31 (2) Cost sharing arising from services subject to this section
32 shall be counted toward any deductible in the same manner as cost
33 sharing would be attributed to a contracting individual health
34 professional.
35 (3) The cost sharing paid by the enrollee pursuant to this section
36 shall satisfy the enrollee's obligation to pay cost sharing for the
37 health service and shall constitute "applicable cost sharing owed
38 by the enrollee."
39 (c) For services subject to this section, if an enrollee has a health
40 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.

1 (d) A noncontracting individual health professional who fails
2 to comply with the requirements of subdivision (c) has not obtained
3 written consent for purposes of this section. Under those
4 circumstances, subdivisions (a) and (b) shall apply and subdivision
5 (c) shall not apply.
6 (e) (1) A noncontracting individual health professional may
7 advance to collections only the in-network cost-sharing amount,
8 as determined by the plan pursuant to subdivision (a) or the
9 out-of-network cost-sharing amount owed pursuant to subdivision
10 (c), that the enrollee has failed to pay.
11 (2) The noncontracting individual health professional, or any
12 entity acting on his or her behalf, including any assignee of the
13 debt, shall not report adverse information to a consumer credit
14 reporting agency or commence civil action against the enrollee for
15 a minimum of 150 days after the initial billing regarding amounts
16 owed by the enrollee under subdivision (a) or (c).
17 (3) With respect to an enrollee, the noncontracting individual
18 health professional, or any entity acting on his or her behalf,
19 including any assignee of the debt, shall not use wage garnishments
20 or liens on primary residences as a means of collecting unpaid bills
21 under this section.
22 (f) For purposes of this section and Sections 1371.30 and
23 1371.31, the following definitions shall apply:
24 (1) "Contracting health facility" means a health facility that is
25 contracted with the enrollee's health care service plan to provide
26 services under the enrollee's plan contract. A contracting health
27 care facility includes, but is not limited to, the following providers:
28 (A) A licensed hospital.
29 (B) An ambulatory surgery or other outpatient setting, as
30 described in subdivision (a), (d), (e), (g), or (h) of Section 1248.1.
31 (C) A laboratory.
32 (D) A radiology or imaging center.
33 (2) "Cost sharing" includes any copayment, coinsurance, or
34 deductible, or any other form of cost sharing paid by the enrollee
35 other than premium or share of premium.
36 (3) "Individual health professional" means a physician and
37 surgeon or other professional who is licensed by this state to deliver
38 or furnish health care services. For this purpose, an "individual
39 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.

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

1 10112.8. (a) (1) Except as provided in subdivision (c), a health
2 insurance policy issued, amended, or renewed on or after July 1,
3 2017, that provides benefits through contracts with providers at
4 alternative rates of payment pursuant to Section 10133, shall
5 provide that if an insured receives covered services from a
6 contracting health facility at which, or as a result of which, the
7 insured receives services provided by a noncontracting individual
8 health professional, the insured shall pay no more than the same
9 cost sharing that the insured would pay for the same covered
10 services received from a contracting individual health professional.
11 This amount shall be referred to as the "in-network cost-sharing
12 amount."
13 (2) Except as provided in subdivision (c), an insured shall not
14 owe the noncontracting individual health professional more than
15 the in-network cost-sharing amount for services subject to this
16 section. At the time of payment by the insurer to the noncontracting
17 individual health professional, the insurer shall inform the insured
18 and the noncontracting individual health professional of the
19 in-network cost-sharing amount owed by the insured.
20 (3) A noncontracting individual health professional shall not
21 bill or collect any amount from the insured for services subject to
22 this section except the in-network cost-sharing amount. Any
23 communication from the noncontracting individual health
24 professional to the insured prior to the receipt of information about
25 the in-network cost-sharing amount pursuant to paragraph (2) shall
26 include a notice in 12-point bold type stating that the
27 communication is not a bill and informing the insured that the
28 insured shall not pay until he or she is informed by his or her
29 insurer of any applicable cost sharing.
30 (4) (A) If the noncontracting individual health professional has
31 received more than the in-network cost-sharing amount from the
32 insured for services subject to this section, the noncontracting
33 individual health professional shall refund any overpayment to the
34 insured within 30 calendar days after receiving payment from the
35 insured.
36 (B) If the noncontracting individual health professional does
37 not refund any overpayment to the insured within 30 calendar days
38 after being informed of the insured's in-network cost-sharing
39 amount, interest shall accrue at the rate of 15 percent per annum
40 beginning with the 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

1 receiving separate written consent from the insured or the insured's
2 authorized representative, unless circumstances arise during
3 delivery of services that were unforeseeable at the time the estimate
4 was given that would require the provider to change the estimate.
5 (4) The consent shall advise the insured that he or she may elect
6 to seek care from a contracted provider or may contact the insured's
7 insurer in order to arrange to receive the health service from a
8 contracted provider for lower out-of-pocket costs.
9 (5) The consent and estimate shall be provided to the insured
10 in the language spoken by the insured, if the language is a Medi-Cal
11 threshold language, as defined in subdivision (d) of Section 128552
12 of the Health and Safety Code.
13 (6) The consent shall also advise the insured that any costs
14 incurred as a result of the insured's use of the out-of-network
15 benefit shall be in addition to in-network cost-sharing amounts
16 and may not count toward the annual out-of-pocket maximum on
17 in-network benefits or a deductible, if any, for in-network benefits.
18 (d) A noncontracting individual health professional who fails
19 to comply with provisions of this subdivision has not obtained
20 written consent for purposes of this section. Under those
21 circumstances, subdivisions (a) and (b) shall apply and subdivision
22 (c) shall not apply.
23 (e) (1) A noncontracting individual health professional may
24 advance to collections only the in-network cost-sharing amount,
25 as determined by the insurer pursuant to subdivision (a) or the
26 out-of-network cost-sharing amount owed pursuant to subdivision
27 (c), that the insured has failed to pay.
28 (2) The noncontracting individual health professional, or any
29 entity acting on his or her behalf, including any assignee of the
30 debt, shall not report adverse information to a consumer credit
31 reporting agency or commence civil action against the insured for
32 a minimum of 150 days after the initial billing regarding amounts
33 owed by the insured under subdivision (a) or (c).
34 (3) With respect to an insured, a noncontracting individual health
35 professional, or any entity acting on his or her behalf, including
36 any assignee of the debt, shall not use wage garnishments or liens
37 on primary residences as a means of collecting unpaid bills under
38 this section.
39 (f) For purposes of this section and Sections 10112.81 and
40 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

1 independent practice association, the delegated entity shall comply
2 with this section.
3 (i) This section shall not apply to emergency services and care,
4 as defined in Section 1317.1 of the Health and Safety Code.
5 SEC. 5. Section 10112.81 is added to the Insurance Code, to
6 read:
7 10112.81. (a) (1) By September 1, 2017, the commissioner
8 shall establish an independent dispute resolution process for the
9 purpose of processing and resolving a claim dispute between a
10 health insurer and a noncontracting individual health professional
11 for services subject to subdivision (a) of Section 10112.8.
12 (2) Prior to initiating the independent dispute resolution process,
13 the parties shall complete the insurer's internal process.
14 (3) If either the noncontracting individual health professional
15 or the insurer appeals a claim to the department's independent
16 dispute resolution process, the other party shall participate in the
17 appeal process as described in this section.
18 (b) (1) The commissioner shall establish uniform written
19 procedures for the submission, receipt, processing, and resolution
20 of claim payment disputes pursuant to this section and any other
21 guidelines for implementing this section.
22 (2) The commissioner shall establish reasonable and necessary
23 fees for the purpose of administering this section, to be paid by
24 both parties.
25 (3) In establishing the independent dispute resolution process,
26 the commissioner shall permit the bundling of claims submitted
27 to the same insurer or the same delegated entity for the same or
28 similar services by the same noncontracting individual health
29 professional.
30 (4) The commissioner shall permit a physician group,
31 independent practice association, or other entity authorized to act
32 on behalf of a noncontracting individual health professional to
33 initiate and participate in the independent dispute resolution
34 process.
35 (5) In deciding the dispute, the independent organization shall
36 base its decision regarding the appropriate reimbursement on all
37 relevant information.
38 (c) (1) The commissioner may contract with one or more
39 independent organizations to conduct the proceedings. The

1 independent organization handling a dispute shall be independent
2 of either party to the dispute.
3 (2) The commissioner shall establish conflict-of-interest
4 standards, consistent with the purposes of this section, that an
5 organization shall meet in order to qualify to administer the
6 independent dispute resolution program. The conflict-of-interest
7 standards shall be consistent with the standards pursuant to
8 subdivisions (c) and (d) of Section 10169.2.
9 (3) The commissioner may contract with the same independent
10 organization or organizations as the State Department of Managed
11 Health Care.
12 (4) The commissioner shall provide, upon the request of an
13 interested person, a copy of all nonproprietary information, as
14 determined by the commissioner, filed with the department by an
15 independent organization seeking to contract with the department
16 to administer the independent dispute resolution process pursuant
17 to this section. The department may charge a nominal fee to cover
18 the costs of providing a copy of the information pursuant to this
19 paragraph.
20 (5) Contracts entered into pursuant to the authority in this
21 subdivision shall be exempt from Part 2 (commencing with Section
22 10100) of Division 2 of the Public Contract Code, Section 19130
23 of the Government Code, and Chapter 6 (commencing with Section
24 14825) of Part 5.5 of Division 3 of the Government Code and shall
25 be exempt from the review or approval of any division of the
26 Department of General Services.
27 (d) The decision obtained through the commissioner's
28 independent dispute resolution process shall be binding on both
29 parties. The insurer shall implement the decision obtained through
30 the independent dispute resolution process. If dissatisfied, either
31 party may pursue any right, remedy, or penalty established under
32 any other applicable law.
33 (e) If a health insurer delegates payment functions to a
34 contracted entity, including, but not limited to, a medical group or
35 independent practice association, then the delegated entity shall
36 comply with this section.
37 (f) This section shall not apply to emergency services and care,
38 as defined in Section 1317.1 of the Health and Safety Code.
39 (g) The definitions in subdivision (f) of Section 10112.8 shall
40 apply for purposes of this section.

1 (h) This section shall not be construed to alter a health insurer's
2 obligations pursuant to Section 10123.13.
3 (i) Notwithstanding Chapter 3.5 (commencing with Section
4 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
5 the commissioner may implement, interpret, or make specific this
6 section by issuing guidance, without taking regulatory action, until
7 the time regulations are adopted.
8 (j) By January 1, 2019, the commissioner shall provide a report
9 to the Governor, the President pro Tempore of the Senate, the
10 Speaker of the Assembly, and the Senate and Assembly
11 Committees on Health of the data and information provided in the
12 independent dispute resolution process in a manner and format
13 specified by the Legislature.
14 SEC. 6. Section 10112.82 is added to the Insurance Code, to
15 read:
16 10112.82. (a) (1) For services rendered subject to Section
17 10112.8, effective July 1, 2017, unless otherwise agreed to by the
18 noncontracting individual health professional and the insurer, the
19 insurer shall reimburse the greater of the average contracted rate
20 or 125 percent of the amount Medicare reimburses on a
21 fee-for-service basis for the same or similar services in the general
22 geographic region in which the services were rendered. For the
23 purposes of this section, "average contracted rate" means the
24 average of the contracted commercial rates paid by the health
25 insurer for the same or similar services in the geographic region.
26 This subdivision does not apply to subdivision (c) of Section
27 10112.8 or subdivision (b) of this section.
28 (2) (A) By July 1, 2017, each health insurer shall provide to
29 the commissioner all of the following:
30 (i) Data listing its average contracted rates for the insurer for
31 services most frequently subject to Section 10112.8 in each
32 geographic region in which the services are rendered for the
33 calendar year 2015.
34 (ii) Its methodology for determining the average contracted rate
35 for the insurer for services subject to Section 10112.8. The
36 methodology to determine an average contracted rate shall ensure
37 that the insurer includes the highest and lowest contracted rates
38 for the calendar year 2015.
39 (iii) The policies and procedures used to determine the average
40 contracted rates under this subdivision.

1 (B) For each calendar year after the health insurer's initial
2 submission of the average contracted rate as specified in
3 subparagraph (A) and until the standardized methodology under
4 paragraph (3) is specified, a health insurer shall adjust the rate
5 initially established pursuant to this subdivision by the Consumer
6 Price Index for Medical Care Services, as published by the United
7 States Bureau of Labor Statistics.
8 (3) (A) By January 1, 2019, the commissioner shall specify a
9 methodology that insurers shall use to determine the average
10 contracted rates for services most frequently subject to Section
11 10112.8. This methodology shall take into account, at a minimum,
12 information from the independent dispute resolution process, the
13 specialty of the individual health professional, and the geographic
14 region in which the services are rendered. The methodology to
15 determine an average contracted rate shall ensure that the insurer
16 includes the highest and lowest contracted rates.
17 (B) Insurers shall provide to the commissioner the policies and
18 procedures used to determine the average contracted rates in
19 compliance with subparagraph (A).
20 (C) The average contracted rate data submitted pursuant to this
21 section shall be confidential and not subject to disclosure under
22 the California Public Records Act (Chapter 3.5 (commencing with
23 Section 6250) of Division 7 of Title 1 of the Government Code).
24 (D) In developing the standardized methodology under this
25 subdivision, the commissioner shall consult with interested parties
26 throughout the process of developing the standards, including the
27 Department of Managed Health Care, representatives of health
28 plans, insurers, health care providers, hospitals, consumer
29 advocates, and other stakeholders it deems appropriate. The
30 commissioner shall hold the first stakeholder meeting no later than
31 July 1, 2017.
32 (4) A health insurer shall include in its reports submitted to the
33 commissioner pursuant to Section 10133.5 and regulations adopted
34 pursuant to that section, in a manner specified by the department,
35 the number of payments made to noncontracting individual health
36 professionals for services at a contracting health facility and subject
37 to Section 10112.8, as well as other data sufficient to determine
38 the proportion of noncontracting individual health professionals
39 to contracting individual health professionals at contracting health
40 facilities, as defined in subdivision (f) of Section 10112.8. The

1 commissioner shall include a summary of this information in its
2 January 1, 2019, report required pursuant to subdivision (j) of
3 Section 10112.81 and its findings regarding the impact of the act
4 that added this section on health insurer contracting and network
5 adequacy.
6 (5) A health insurer that provides services subject to Section
7 10112.8 shall meet the network adequacy requirements set forth
8 in *this chapter, including, but not limited to,* Section 10133.5 of
9 ~~the Insurance Code~~ *this code* and ~~Section 2240.1~~ *Sections 2240.1*
10 *and 2240.7* of Title 10 of the California Code of Regulations,
11 including, but not limited to, inpatient hospital services and
12 specialist physician services, and if necessary, the commissioner
13 may adopt additional regulations related to those services. *This*
14 *section shall not be construed to limit the commissioner's authority*
15 *under this chapter.*
16 (6) For the purposes of this section, for average contracted rates
17 for individual and small group coverage, geographic region shall
18 be the geographic regions listed in subparagraph (A) of paragraph
19 (2) of subdivision (a) of Section 10753.14. For purposes of this
20 section for Medicare fee-for-service reimbursement, geographic
21 regions shall be the geographic regions specified for physician
22 reimbursement for Medicare fee-for-service by the United States
23 Department of Health and Human Services.
24 (7) A health insurer shall authorize and permit assignment of
25 the insured's right, if any, to any reimbursement for health care
26 services covered under the health insurance policy to a
27 noncontracting individual health professional who furnishes the
28 health care services rendered subject to Section 10112.8. Lack of
29 assignment pursuant to this paragraph shall not be construed to
30 limit the applicability of this section, Section 10112.8, or Section
31 10112.81.
32 (8) A noncontracting individual health professional or health
33 insurer who disputes the claim reimbursement under this section
34 shall utilize the independent dispute resolution process described
35 in Section 10112.81.
36 (b) If nonemergency services are provided by a noncontracting
37 individual health professional consistent with subdivision (c) of
38 Section 10112.8 to an insured who has voluntarily chosen to use
39 his or her out-of-network benefit for services covered by an insurer
40 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 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:

1 In order to protect confidential rate information used by health
2 care service plans and health insurers and to protect the integrity
3 of the competitive market, it is necessary that this act limit the
4 public's right of access to that information.
5 SEC. 8. No reimbursement is required by this act pursuant to
6 Section 6 of Article XIII B of the California Constitution because
7 the only costs that may be incurred by a local agency or school
8 district will be incurred because this act creates a new crime or
9 infraction, eliminates a crime or infraction, or changes the penalty
10 for a crime or infraction, within the meaning of Section 17556 of
11 the Government Code, or changes the definition of a crime within
12 the meaning of Section 6 of Article XIII B of the California
13 Constitution.

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