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AMENDED IN ASSEMBLY APRIL 23, 2015
AMENDED IN ASSEMBLY APRIL 15, 2015
CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 533

Introduced by Assembly Member Bonta

February 23, 2015

An act to add ~~Section~~ *Sections 1371.30, 1371.31, and 1371.9* to the Health and Safety Code, and to add ~~Section 10112.8~~ *Sections 10112.8, 10112.81, and 10112.82* to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 533, 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 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 January 1, 2016, to provide that if an enrollee or insured obtains care 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 is 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. 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 plan or health insurer. The bill would require a noncontracting individual health professional who collects more than the in-network ~~cost sharing~~ *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 overpaid by, and not refunded to, the enrollee or insured shall accrue at 15% per annum, as specified. ~~Because a willful violation of the bill's provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.~~

Existing law requires a contract between a health care service plan and a provider, or a contract between an insurer and a provider, to contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan or insurer. Existing law requires that dispute resolution mechanism also be made accessible to a noncontracting provider for the purpose of resolving billing and claims disputes.

This bill would require the department and the commissioner to each establish an independent dispute resolution process that would allow a noncontracting individual health professional who rendered services at a contracting health facility to appeal a claim payment dispute that has completed the plan's or the insurer's internal dispute resolution mechanism, as specified. The bill would authorize the department and the commissioner to contract with one or more independent dispute

resolution organizations to conduct the independent dispute resolution process, as specified. The bill would provide that the decision of the organization would be binding on the parties. The bill would require a health care service plan or an insurer to base reimbursement of a claim by a noncontracting individual health professional on statistically credible information with regard to the amount paid to providers who provide similar services, are not capitated, and practice in the same or a similar geographic region, as specified.

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.

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.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

State-mandated local program: yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 1371.30 is added to the Health and Safety
- 2 Code, immediately following Section 1371.3, to read:
- 3 1371.30. (a) (1) The department shall establish an independent
- 4 dispute resolution process for the purpose of processing and
- 5 resolving a claim dispute between a health care service plan and
- 6 a noncontracting individual health professional for services subject
- 7 to Section 1371.9.
- 8 (2) A noncontracting individual health professional may appeal
- 9 a claim to the independent dispute resolution process established
- 10 pursuant to this section after the noncontracting individual health
- 11 professional has completed the plan’s internal dispute resolution
- 12 mechanism, as defined in subdivision (h) of Section 1367, or if 30
- 13 days have elapsed since the noncontracting individual health

1 professional initiated the plan's internal dispute resolution
2 mechanism.

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

7 (4) The disputed claim is limited to covered services rendered
8 by a noncontracting individual health professional, as defined by
9 paragraph (3) of subdivision (c) of Section 1371.9, at a contracting
10 health facility, as defined by paragraph (2) of subdivision (c) of
11 Section 1371.9.

12 (b) The department and the Department of Insurance shall
13 jointly establish uniform written procedures for the submission,
14 receipt, processing, and resolution of claim payment disputes
15 pursuant to this section.

16 (1) A noncontracting individual health professional appealing
17 to the independent dispute resolution process shall provide the
18 department with a written justification for the appeal, which shall
19 not exceed two pages.

20 (2) The department shall respond to an appeal by a
21 noncontracting individual health professional within 30 days of
22 receipt of the written document described in paragraph (1).

23 (3) The plan shall provide all documents submitted to the
24 department for the independent dispute resolution process to the
25 individual health professional appealing the claim. The statistically
26 credible information on the average payments described in
27 subdivision (b) of Section 1371.31 shall be exempt from public
28 disclosure.

29 (c) A noncontracting individual health professional may dispute
30 a claim for either of the following reasons:

31 (1) The noncontracting individual health professional disputes
32 that the payment received from the plan is the plan's average
33 contracted rate pursuant to Section 1371.31.

34 (2) The noncontracting individual health professional seeks to
35 be paid more than 150 percent of the amount that the plan
36 otherwise would pay pursuant to Section 1371.31.

37 (d) If the disputed claim is appealed pursuant to paragraph (1)
38 of subdivision (c), the department shall determine whether the
39 payment provided to the noncontracting individual health
40 professional is the plan's average contracted rate as defined in

1 *paragraph (1) of subdivision (c) of Section 1371.31. If the*
2 *department determines that the payment is lower than the plan's*
3 *average contracted rate, the plan shall correct the statistically*
4 *credible information required by Section 1371.31 and provide*
5 *payment to the noncontracting individual health professional,*
6 *consistent with subdivision (j).*

7 *(e) If the disputed claim is appealed pursuant to paragraph (2)*
8 *of subdivision (c), the department shall determine payment based*
9 *on all of the following:*

10 *(1) The provider's training, qualifications, and length of time*
11 *in practice.*

12 *(2) The nature of the services provided.*

13 *(3) The fees usually charged by or paid to the provider.*

14 *(4) Prevailing provider rates charged or paid in the general*
15 *geographic area in which the services were rendered.*

16 *(5) Other aspects of the economics of the medical provider's*
17 *practice that are relevant.*

18 *(6) Any unusual circumstances in the case.*

19 *(f) An eligible claim does not include any of the following:*

20 *(1) A dispute concerning a claim that has completed the plan's*
21 *internal dispute resolution mechanism established pursuant to*
22 *subdivision (h) of Section 1367, or a claim for which fewer than*
23 *30 days have elapsed since the individual health professional*
24 *initiated the plan's internal dispute resolution mechanism.*

25 *(2) A dispute concerning a claim that is currently in arbitration*
26 *or litigation in state or federal court.*

27 *(3) A dispute concerning a late payment.*

28 *(4) A dispute concerning an interest payment.*

29 *(5) A claim dispute that is not subject to the department's*
30 *jurisdiction.*

31 *(6) A claim dispute with a health plan licensed or regulated by*
32 *another entity or state.*

33 *(7) A dispute regarding a claim that does not involve covered*
34 *benefits.*

35 *(8) A claim denied on the basis that the services were not*
36 *medically necessary or were experimental or investigational in*
37 *nature.*

38 *(g) (1) A noncontracting individual health professional may*
39 *initiate an appeal to the department's independent dispute*
40 *resolution process by following the procedures specified by the*

1 department. A noncontracting individual health professional or
2 group of noncontracting individual health professionals may
3 aggregate disputed claim amounts. An aggregated claim shall
4 involve the same or similar services and the same health care
5 service plan.

6 (2) A health care service plan subject to a claim or claims
7 appealed by a noncontracting individual health professional shall
8 provide information requested by the department according to the
9 department's policies and procedures. If the requested information
10 is not received in a timely manner, the department shall make a
11 determination based on the information available to it.

12 (h) The department may contract with one or more independent
13 organizations that specialize in dispute resolution to conduct the
14 proceedings. The independent organization handling a dispute
15 shall be independent of either party to the dispute. The department
16 may establish additional requirements, including
17 conflict-of-interest standards, consistent with the purposes of this
18 section, that an organization shall meet in order to qualify for
19 participation in the independent dispute resolution program. The
20 department may contract with the same independent organization
21 or organizations as the Department of Insurance.

22 (i) The independent dispute resolution organization shall issue
23 a decision within 60 days of the receipt of required documentation,
24 according to the department's written policies and procedures.

25 (j) The determination obtained through the department's
26 independent dispute resolution process shall be binding on both
27 parties. When making a decision, the independent dispute
28 resolution organization shall prepare in writing and provide to
29 the parties an award, including factual findings and the reasons
30 on which the decision is based. If additional payment is awarded
31 to a noncontracting individual health professional, it shall be made
32 consistent with Section 1371.35.

33 (k) Each party shall bear its own costs and expenses, and an
34 equal share of the administrative fees for the independent dispute
35 resolution process. The department shall establish fees to cover
36 the actual cost of processing claims disputes pursuant to this
37 section.

38 (l) In determining what constitutes an "unfair payment pattern"
39 as defined in Section 1371.37, the department shall take into
40 consideration determinations of the independent dispute resolution

1 *process in order to determine whether a plan has engaged in an*
2 *unfair payment pattern.*

3 *(m) If a noncontracting individual health professional files*
4 *multiple appeals pursuant to paragraph (2) of subdivision (c) and*
5 *loses more than one third of those appeals within a one year*
6 *period, he or she shall be prohibited from appealing to the*
7 *department's independent dispute resolution process pursuant to*
8 *paragraph (2) of subdivision (c) for one year from the first appeal.*
9 *For the purposes of this section, a noncontracting individual health*
10 *professional shall be deemed to have lost an appeal when the*
11 *department's independent dispute resolution process awards the*
12 *noncontracting individual health professional less than the amount*
13 *sought by the noncontracting individual health professional.*

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

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

24 *SEC. 2. Section 1371.31 is added to the Health and Safety*
25 *Code, immediately following Section 1371.30, to read:*

26 *1371.31. (a) This section shall apply to claim disputes between*
27 *a noncontracting individual health professional subject to Section*
28 *1371.9 and a health care service plan. Claim disputes shall be*
29 *limited to circumstances in which either of the following occurs:*

30 *(1) The noncontracting individual health professional disputes*
31 *that the payment received from the plan is the plan's average*
32 *contracted rate pursuant to paragraph (1) of subdivision (c) of*
33 *Section 1371.30.*

34 *(2) The noncontracting individual health professional seeks to*
35 *be paid more than 150 percent of the amount that the plan would*
36 *otherwise pay pursuant to paragraph (2) of subdivision (c) of*
37 *Section 1371.30.*

38 *(b) (1) The health care service plan shall maintain statistically*
39 *credible information, updated at least annually, regarding rates*
40 *paid to currently contracting individual health professionals who*

1 provide similar services, are not capitated, and are practicing in
2 the same or a similar geographic area as the noncontracting
3 individual health professional.

4 (2) The statistically credible information required by paragraph
5 (1) shall take into consideration the determinations of the
6 independent dispute resolution process for claims filed pursuant
7 to paragraph (1) of subdivision (c) of 1371.30.

8 (c) (1) Unless otherwise provided in this section or otherwise
9 agreed by the noncontracting individual health professional and
10 the plan, the plan shall base reimbursement of noncontracted
11 claims for services rendered according to Section 1371.9 on the
12 average rates based on the statistically credible information with
13 regard to the amount paid to contracted individual health
14 professionals who are providing similar services, are not capitated,
15 and practicing in the same or similar geographic area.

16 (2) For nonemergency services provided by the noncontracting
17 individual health professional to an enrollee covered by a preferred
18 provider organization or a point of service plan, unless otherwise
19 agreed to by the plan and the noncontracting individual health
20 professional, the amount paid shall be the amount set forth in the
21 enrollee’s evidence of coverage.

22 (d) (1) A health care service plan’s failure to pay a
23 noncontracting individual health professional pursuant to this
24 section shall constitute an “unfair payment pattern” within the
25 meaning of Section 1371.37.

26 (2) In determining whether a plan has engaged in an “unfair
27 payment pattern” as defined in Section 1371.37, the department
28 shall take into consideration decisions of the independent dispute
29 resolution process.

30 **SECTION 1.**

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

33 1371.9. (a) (1) A health care service plan contract issued,
34 amended, or renewed on or after January 1, 2016, shall provide
35 that if an enrollee obtains care from a contracting health facility
36 at which, or as a result of which, the enrollee receives services
37 provided by a noncontracting individual health professional, the
38 enrollee shall pay the noncontracting individual health professional
39 no more than the same cost sharing that the enrollee would have
40 paid for the same covered benefits received from a contracting

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

3 (2) At the time of payment by the plan to the noncontracting
4 individual health professional, the plan shall inform the
5 noncontracting individual health professional of the in-network
6 cost sharing owed by the enrollee. If a noncontracting individual
7 health professional receives reimbursement for services provided
8 to the enrollee at a contracting health facility from the plan, an
9 enrollee shall not owe the noncontracting individual health
10 professional at the contracting health facility more than the
11 in-network cost sharing.

12 (3) Except as provided in subdivision (d), if the noncontracting
13 individual health professional collects more than the in-network
14 cost sharing from the enrollee, the noncontracting individual health
15 professional shall refund any overpayment to the enrollee within
16 30 working days of receiving notice from the plan of the in-network
17 cost sharing amount owed by the enrollee pursuant to paragraph
18 (2). If the noncontracting individual health professional does not
19 refund any overpayment within 30 working days after being
20 informed of the enrollee’s in-network cost sharing, interest shall
21 accrue at the rate of 15 percent per annum beginning with the first
22 calendar day after the 30-working day period. A noncontracting
23 individual health professional shall automatically include in his
24 or her refund of the overpayment all interest that has accrued
25 pursuant to this section without requiring the enrollee to submit a
26 request for the interest amount.

27 (4) If the noncontracting individual health professional has
28 advanced to collections any amount owed by the enrollee, the plan
29 shall not reimburse the noncontracting individual health
30 professional for services provided to the enrollee by the
31 noncontracting individual health professional at a contracting
32 health facility. In submitting a claim to the plan, the noncontracting
33 individual health professional at a contracting health facility shall
34 affirm in writing that he or she has not advanced to collections any
35 payment owed by the enrollee. A noncontracting individual health
36 professional shall not attempt to collect more than the in-network
37 cost sharing from the enrollee after receiving payment from the
38 plan. Once the noncontracting individual health professional
39 receives payment from the plan, the noncontracting individual
40 health professional may advance to collections any in-network

1 cost sharing owed by the enrollee if the enrollee fails to pay the
2 in-network cost sharing after the plan has informed the
3 noncontracting individual health professional of the amount owed
4 by the enrollee pursuant to paragraph (2).

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

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

14 (c) For purposes of this section, the following definitions shall
15 apply:

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

19 (2) “Health facility” means a health facility provider who is
20 licensed by this state to deliver or furnish health care services. A
21 health facility shall include the following providers:

22 (A) Licensed hospital.

23 (B) Skilled nursing facility.

24 (C) Ambulatory surgery.

25 (D) Laboratory.

26 (E) Radiology or imaging.

27 (F) Facilities providing mental health or substance abuse
28 treatment.

29 (G) Any other provider as the department may by regulation
30 define as a health facility for purposes of this section.

31 (3) “Individual health professional” means a physician or
32 surgeon or other professional who is licensed by this state to deliver
33 or furnish health care services.

34 (d) An enrollee may voluntarily consent to the use of a
35 noncontracting individual health professional. For purposes of this
36 section, consent shall be voluntary if at least 24 hours in advance
37 of the receipt of services, the enrollee is provided a written estimate
38 of the cost of care by the noncontracting individual health
39 professional and the enrollee consents in writing to both the use
40 of a noncontracting individual health professional and payment of

1 the estimated additional cost for the services to be provided by the
2 noncontracting individual health professional. The consent shall
3 inform the enrollee that the cost of the services of the
4 noncontracting individual health professional will not accrue to
5 the limit on annual out-of-pocket expenses or the enrollee's
6 deductible, if any.

7 (e) This section shall not be construed to require a plan to cover
8 services or provide benefits that are not otherwise covered under
9 the terms and conditions of the plan contract.

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

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

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

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

31 ~~SEC. 2.~~

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

34 10112.8. (a) (1) A health insurance policy issued, amended,
35 or renewed on or after January 1, 2016, shall provide that if an
36 insured obtains care from a contracting health facility at which, or
37 as a result of which, the insured receives services provided by a
38 noncontracting individual health professional, the insured shall
39 pay the noncontracting individual health professional no more than
40 the same cost sharing that the insured would have paid for the

1 same covered benefits received from a contracting individual health
2 professional. This amount shall be referred to as the “in-network
3 cost sharing.”

4 (2) At the time of payment by the health insurer to the
5 noncontracting individual health professional, the health insurer
6 shall inform the noncontracting individual health professional of
7 the in-network cost sharing owed by the insured. If a
8 noncontracting individual health professional receives
9 reimbursement for services provided to the insured at a contracting
10 health facility from the health insurer, an insured shall not owe the
11 noncontracting individual health professional at the contracting
12 health facility more than the in-network cost sharing.

13 (3) Except as provided in subdivision (d), if the noncontracting
14 individual health professional collects more than the in-network
15 cost sharing from the insured, the noncontracting individual health
16 professional shall refund any overpayment to the insured within
17 30 working days of receiving notice from the health insurer of the
18 in-network cost sharing amount owed by the insured pursuant to
19 paragraph (2). If the noncontracting individual health professional
20 does not refund any overpayment within 30 working days after
21 being informed of the insured’s in-network cost sharing, interest
22 shall accrue at the rate of 15 percent per annum beginning with
23 the first calendar day after the 30-working day period. A
24 noncontracting individual health professional shall automatically
25 include in his or her refund of the overpayment all interest that has
26 accrued pursuant to this section without requiring the insured to
27 submit a request for the interest amount.

28 (4) If the noncontracting individual health professional has
29 advanced to collections any amount owed by the insured, the health
30 insurer shall not reimburse the noncontracting individual health
31 professional for services provided to the insured by the
32 noncontracting individual health professional at a contracting
33 health facility. In submitting a claim to the health insurer, the
34 noncontracting individual health professional at a contracting
35 health facility shall affirm in writing that he or she has not
36 advanced to collections any payment owed by the insured. A
37 noncontracting individual health professional shall not attempt to
38 collect more than the in-network cost sharing from the insured
39 after receiving payment from the health insurer. Once the
40 noncontracting individual health professional receives payment

1 from the health insurer, the noncontracting individual health
2 professional may advance to collections any in-network cost
3 sharing owed by the insured if the insured fails to pay the
4 in-network cost sharing after the health insurer has informed the
5 noncontracting individual health professional of the amount owed
6 by the insured pursuant to paragraph (2).

7 (5) This section shall only apply to a health insurer that enters
8 into a contract with a professional or institutional provider to
9 provide services at alternative rates of payment pursuant to Section
10 10133.

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

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

20 (c) For purposes of this section, the following definitions shall
21 apply:

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

25 (2) “Health facility” means a health facility provider who is
26 licensed by this state to deliver or furnish health care services. A
27 health facility shall include the following providers:

28 (A) Licensed hospital.

29 (B) Skilled nursing facility.

30 (C) Ambulatory surgery.

31 (D) Laboratory.

32 (E) Radiology or imaging.

33 (F) Facilities providing mental health or substance abuse
34 treatment.

35 (G) Any other provider as the commissioner may by regulation
36 define as a health facility for purposes of this section.

37 (3) “Individual health professional” means a physician or
38 surgeon or other professional who is licensed by this state to deliver
39 or furnish health care services.

1 (d) An insured may voluntarily consent to the use of a
2 noncontracting individual health professional. For purposes of this
3 section, consent shall be voluntary if at least 24 hours in advance
4 of the receipt of services, the insured is provided a written estimate
5 of the cost of care by the noncontracting individual health
6 professional and the insured consents in writing to both the use of
7 a noncontracting individual health professional and payment of
8 the estimated additional cost for the services to be provided by the
9 noncontracting individual health professional. The consent shall
10 inform the insured that the cost of the services of the
11 noncontracting individual health professional will not accrue to
12 the limit on annual out-of-pocket expenses or the insured's
13 deductible, if any.

14 (e) This section shall not be construed to require an insurer to
15 cover services or provide benefits that are not otherwise covered
16 under the terms and conditions of the policy.

17 (f) This section shall not be construed to exempt a health insurer
18 from the requirements under Section 10112.7 or Section 10133.56.

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

21 *10112.81. (a) (1) The commissioner shall establish an*
22 *independent dispute resolution process for the purpose of*
23 *processing and resolving a claim dispute between an insurer and*
24 *a noncontracting individual health professional for services subject*
25 *to Section 10112.8.*

26 *(2) A noncontracting individual health professional may appeal*
27 *a claim to the independent dispute resolution process established*
28 *pursuant to this section after the noncontracting individual health*
29 *professional has completed the insurer's internal dispute resolution*
30 *process, as defined in subdivision (b) of Section 10123.137 or if*
31 *30 days have elapsed since the noncontracting individual health*
32 *professional initiated the insurer's internal dispute resolution*
33 *mechanism.*

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

38 *(4) The disputed claim is limited to covered services rendered*
39 *by a noncontracting individual health professional, as defined by*
40 *paragraph (3) of subdivision (c) of Section 10112.8, at a*

1 *contracting health facility, as defined by paragraph (2) of*
2 *subdivision (c) of Section 10112.8.*

3 *(b) The commissioner and the Department of Managed Health*
4 *Care shall jointly establish uniform written procedures for the*
5 *submission, receipt, processing, and resolution of claim payment*
6 *disputes pursuant to this section.*

7 *(1) A noncontracting individual health professional appealing*
8 *to the independent dispute resolution process shall provide the*
9 *commissioner with a written justification for the appeal, which*
10 *shall not exceed two pages.*

11 *(2) The commissioner shall respond to an appeal by a*
12 *noncontracting individual health professional within 30 days of*
13 *receipt of the written documentation described in paragraph (1).*

14 *(3) The insurer shall provide all documents submitted to the*
15 *commissioner for the independent dispute resolution process to*
16 *the individual health professional appealing the claim. The*
17 *statistically credible information on the average payments*
18 *described in subdivision (b) of Section 10112.82 shall be exempt*
19 *from the disclosure required by this paragraph.*

20 *(c) A noncontracting individual health professional may dispute*
21 *a claim for either of the following reasons:*

22 *(1) The noncontracting individual health professional disputes*
23 *that the payment received from the insurer is the insurer's average*
24 *contracted rate pursuant to Section 10112.82.*

25 *(2) The noncontracting individual health professional seeks to*
26 *be paid more than 150 percent of the amount that the insurer*
27 *otherwise would pay pursuant to Section 10112.82.*

28 *(d) If the disputed claim is appealed pursuant to paragraph (1)*
29 *of subdivision (c), the department shall determine whether the*
30 *payment provided to the noncontracting individual health*
31 *professional is the insurer's average contracted rate as defined*
32 *in paragraph (1) of subdivision (c) of Section 10112.82. If the*
33 *commissioner determines that the payment is lower than the*
34 *insurer's average contracted rate, the insurer shall correct the*
35 *statistically credible information required by Section 10112.82*
36 *and provide payment to the noncontracting individual health*
37 *professional, consistent with subdivision (j).*

38 *(e) If the disputed claim is appealed pursuant to paragraph (2)*
39 *of subdivision (c), the commissioner shall determine payment based*
40 *on all of the following:*

- 1 (1) *The provider's training, qualifications, and length of time*
2 *in practice.*
- 3 (2) *The nature of the services provided.*
- 4 (3) *The fees usually charged by or paid to the provider.*
- 5 (4) *Prevailing provider rates charged or paid in the general*
6 *geographic area in which the services were rendered.*
- 7 (5) *Other aspects of the economics of the medical provider's*
8 *practice that are relevant.*
- 9 (6) *Any unusual circumstances in the case.*
- 10 (f) *An eligible claim does not include the following:*
- 11 (1) *A dispute concerning a claim that has not previously been*
12 *submitted to the insurer's dispute resolution mechanism established*
13 *pursuant to subdivision (b) of Section 10123.137, or a claim for*
14 *which fewer than 30 days have elapsed since the individual health*
15 *professional initiated the insurer's internal dispute resolution*
16 *process.*
- 17 (2) *A dispute concerning a claim that is currently in arbitration*
18 *or litigation in state or federal court.*
- 19 (3) *A dispute concerning a late payment.*
- 20 (4) *A dispute concerning an interest payment.*
- 21 (5) *A Medi-Cal claim dispute for which a fair hearing pursuant*
22 *to Chapter 7 (commencing with Section 10950) of Part 2 of*
23 *Division 9 of the Welfare and Institutions Code has commenced.*
- 24 (6) *A claim dispute that is not subject to the commissioner's*
25 *jurisdiction.*
- 26 (7) *A claim dispute with a health insurer licensed or regulated*
27 *by another entity or state.*
- 28 (8) *A dispute regarding a claim that does not involve covered*
29 *benefits.*
- 30 (9) *A claim denied on the basis that the services were not*
31 *medically necessary or were experimental or investigational in*
32 *nature.*
- 33 (g) (1) *A noncontracting individual health professional may*
34 *initiate an appeal to the independent dispute resolution process*
35 *established pursuant to this section by following the procedures*
36 *specified by the commissioner. A noncontracting individual health*
37 *professional may aggregate disputed claim amounts. An*
38 *aggregated claim shall involve the same or similar services and*
39 *the same insurer.*

1 (2) An insurer subject to a claim or claims appealed by a
2 noncontracting individual health professional shall provide
3 information requested by the commissioner according to the
4 commissioner's policies and procedures. If the requested
5 information is not received in a timely manner, the commissioner
6 shall make a determination based on the information available to
7 him or her.

8 (h) The commissioner may contract with one or more
9 independent organizations that specialize in dispute resolution to
10 conduct the proceedings. The independent organization handling
11 a dispute shall be independent of either party to the dispute. The
12 commissioner may establish additional requirements, including
13 conflict-of-interest standards, consistent with the purposes of this
14 section, that an organization shall meet in order to qualify for
15 participation in the independent dispute resolution program. The
16 commissioner may contract with the same independent
17 organization or organizations as the Department of Managed
18 Health Care.

19 (i) The independent dispute resolution organization shall issue
20 a decision within 60 days of receipt of required documentation,
21 according to the commissioner's written policies and procedures.

22 (j) The determination obtained through the independent dispute
23 resolution process shall be binding on both parties. When making
24 a decision, the independent dispute resolution organization shall
25 prepare in writing and provide to the parties an award including
26 factual findings and the reasons upon which the decision is based.
27 If additional payment is awarded to a noncontracting individual
28 health professional, it shall be made consistent with the
29 requirements of Section 10123.13.

30 (k) Each party shall bear its own costs and expenses and an
31 equal share of the administrative fees for the independent dispute
32 resolution process. The commissioner shall establish fees to cover
33 the actual cost of processing claims disputes pursuant to this
34 section.

35 (l) In determining what constitutes an "unfair payment pattern"
36 as defined in Section 1371.37 of the Health and Safety Code, the
37 commissioner shall take into consideration determinations of the
38 independent dispute resolution process established pursuant to
39 subdivision (a) in determining whether an insurer has engaged in
40 an unfair payment pattern.

1 (m) If a noncontracting individual health professional files
2 multiple appeals pursuant to paragraph (2) of subdivision (c) and
3 loses more than one third of those appeals within a one year
4 period, he or she shall be prohibited from appealing to the
5 commissioner's independent dispute resolution process pursuant
6 to paragraph (2) of subdivision (c) for one year from the first
7 appeal. For the purposes of this section, a noncontracting
8 individual health professional shall be deemed to have lost an
9 appeal when the commissioner's independent dispute resolution
10 process awards the noncontracting individual health professional
11 less than the amount sought by the noncontracting individual
12 health professional.

13 (n) If an insurer delegates payment functions to a contracted
14 entity, including, but not limited to, a medical group of independent
15 practice association, then the delegated entity shall comply with
16 this section.

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

19 10112.82. (a) This section shall apply to a claim dispute
20 between a noncontracting individual health professional subject
21 to Section 10112.8 and a health insurer. Claim disputes shall be
22 limited to circumstances in which either of the following occurs:

23 (1) The noncontracting individual health professional disputes
24 that the payment received from the insurer is the insurer's average
25 contracted rate pursuant to paragraph (1) of subdivision (c) of
26 Section 10112.81.

27 (2) The noncontracting individual health professional seeks to
28 be paid more than 150 percent of the amount that the insurer
29 otherwise would pay pursuant to paragraph (2) of subdivision (c)
30 of Section 10112.81.

31 (b) (1) The insurer shall maintain statistically credible
32 information, updated at least annually, regarding rates paid to
33 currently contracting individual health professionals who provide
34 similar services, are not capitated, and are practicing in the same
35 or a similar geographic area as the noncontracting individual
36 health professional.

37 (2) The statistically credible information required by paragraph
38 (1) shall take into consideration the determinations of the
39 independent dispute resolution process for claims filed pursuant
40 to Section 10112.81.

1 (3) *The statistically credible information required by paragraph*
2 *(1) shall be confidential and shall be exempt from public*
3 *disclosure.*

4 (c) (1) *Unless otherwise provided in this section or otherwise*
5 *agreed to by the noncontracting individual health professional*
6 *and the insurer, the insurer shall base reimbursement of claims*
7 *on the statistically credible information with regard to the amount*
8 *paid to providers who are providing similar services, are not*
9 *capitated, and practicing in the same or similar geographic area.*

10 (2) *For nonemergency services provided by the noncontracting*
11 *individual health professional to an insured covered by a preferred*
12 *provider organization or a point-of-service plan, unless otherwise*
13 *agreed to by the insurer and the noncontracting individual health*
14 *professional, the amount paid shall be the amount set forth in the*
15 *insured’s evidence of coverage.*

16 (d) (1) *An insurer’s failure to pay a noncontracting individual*
17 *health professional consistent with this section shall constitute an*
18 *“unfair payment pattern” within the meaning of Section 1371.37*
19 *of the Health and Safety Code.*

20 (2) *In determining whether an insurer has engaged in an “unfair*
21 *payment pattern” as defined in Section 1371.37 of the Health and*
22 *Safety Code, the commissioner shall take into consideration*
23 *decisions of the independent dispute resolution process established*
24 *pursuant to subdivision (a) of Section 10112.81.*

25 SEC. 7. *The Legislature finds and declares that Sections 2 and*
26 *6 of this act, which add Section 1371.31 to the Health and Safety*
27 *Code and Section 10112.82 to the Insurance Code, impose a*
28 *limitation on the public’s right of access to the meetings of public*
29 *bodies or the writings of public officials and agencies within the*
30 *meaning of Section 3 of Article I of the California Constitution.*
31 *Pursuant to that constitutional provision, the Legislature makes*
32 *the following findings to demonstrate the interest protected by this*
33 *limitation and the need for protecting that interest:*

34 *In order to protect confidential and proprietary information, it*
35 *is necessary for that information to remain confidential.*

36 ~~SEC. 3.~~

37 SEC. 8. *No reimbursement is required by this act pursuant to*
38 *Section 6 of Article XIII B of the California Constitution because*
39 *the only costs that may be incurred by a local agency or school*
40 *district will be incurred because this act creates a new crime or*

1 infraction, eliminates a crime or infraction, or changes the penalty
2 for a crime or infraction, within the meaning of Section 17556 of
3 the Government Code, or changes the definition of a crime within
4 the meaning of Section 6 of Article XIII B of the California
5 Constitution.

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