AMENDED IN SENATE AUGUST 18, 2015

AMENDED IN SENATE JULY 7, 2015

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 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 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 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.

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,~~ *with a plan or insurer,* 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~~ *contracted individual health professionals* who provide similar services, are not capitated, and practice in the same or a similar geographic region, as specified. *The bill would require an insurer to base reimbursement of a claim by a noncontracting health professional on statistically credible information with regard to the amount paid to contracted individual health professionals who provide similar services and practice in the same or a similar geographic region, as specified. The bill would require a noncontracting individual health professional who disputes that claim reimbursement to utilize the independent dispute resolution process. The bill would provide that these provisions do not apply to emergency services and care, as defined.*

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:

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

1371.30. (a) (1) The department shall establish an independent dispute resolution process for the purpose of processing and

resolving a claim dispute between a health care service plan and a noncontracting individual health professional for services subject to Section 1371.9.

~~(2) A noncontracting individual health professional may appeal a claim to the independent dispute resolution process established pursuant to this section after the noncontracting individual health professional has completed the plan's internal dispute resolution mechanism, as defined in subdivision (h) of Section 1367, or if 30 days have elapsed since the noncontracting individual health professional initiated the plan's internal dispute resolution mechanism.~~

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

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

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

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

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

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

~~(3) The plan shall provide all documents submitted to the department for the independent dispute resolution process to the individual health professional appealing the claim. The statistically credible information on the average payments described in~~

~~subdivision (b) of Section 1371.31 shall be exempt from public disclosure.~~

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

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

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

~~(d) If the disputed claim is appealed pursuant to paragraph (1) of subdivision (c), the department shall determine whether the payment provided to the noncontracting individual health professional is the plan's average contracted rate as defined in paragraph (1) of subdivision (c) of Section 1371.31. If the department determines that the payment is lower than the plan's average contracted rate, the plan shall correct the statistically credible information required by Section 1371.31 and provide payment to the noncontracting individual health professional, consistent with subdivision (j).~~

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

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

~~(2) The nature of the services provided.~~

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

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

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

~~(6) Any unusual circumstances in the case.~~

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

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

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

~~(3) A dispute concerning a late payment.~~

~~(4) A dispute concerning an interest payment.~~

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

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

~~(7) A dispute regarding a claim that does not involve covered benefits.~~

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

~~(g) (1) A noncontracting individual health professional may initiate an appeal to the department's independent dispute resolution process by following the procedures specified by the department. A noncontracting individual health professional or group of noncontracting individual health professionals may aggregate disputed claim amounts. An aggregated claim shall involve the same or similar services and the same health care service plan.~~

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

~~(h)~~

(c) The department may contract with one or more independent organizations that specialize in dispute resolution to conduct the proceedings. The independent organization handling a dispute shall be independent of either party to the dispute. The department ~~may~~ *shall* establish~~, additional requirements, including~~ conflict-of-interest standards, consistent with the purposes of this section, that an organization shall meet in order to qualify for participation in the independent dispute resolution program. The department may contract with the same independent organization or organizations as the Department of Insurance.

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

~~(j)~~

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

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

~~(*l*) In determining what constitutes an "unfair payment pattern" as defined in Section 1371.37, the department shall take into consideration determinations of the independent dispute resolution process in order to determine whether a plan has engaged in an unfair payment pattern.~~

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

~~(n)~~

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

~~(o)~~

(f) If a health care service plan delegates payment functions to a contracted entity, including, but not limited to, a medical group

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

(g) This section shall not apply to emergency services and care, as defined in Section 1317.1.

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

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

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

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

~~(b)~~

1371.31. (a) (1) The health care service plan shall maintain statistically credible information, updated at least annually, regarding rates paid to currently contracting individual health professionals *or a group of professionals* who provide similar services, are not capitated, and are practicing in the same or a similar geographic area as the noncontracting individual health professional.

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

(2) If, based on the health care service plan's model or payment arrangements, a health care service plan does not pay a statistically significant number or dollar amount of claims for covered services in order to maintain the statistically credible information required by paragraph (1), the health care service plan shall demonstrate to the department that it has access to a statistically credible database reflecting reasonable rates paid to providers for services provided in the same or similar geographic area.

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

~~(c)~~

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

(2) ~~For~~ *If* nonemergency services *are* provided by ~~the~~ *a* noncontracting individual health professional to an enrollee *who has voluntarily chosen to use his or her out-of-network benefit for services* covered by a preferred provider organization or a point of service plan, unless otherwise agreed to by the plan and the noncontracting individual health professional, the amount paid shall be the amount set forth in the enrollee's evidence of coverage.

~~(d) (1) A health care service plan's failure to pay a noncontracting individual health professional pursuant to this section shall constitute an "unfair payment pattern" within the meaning of Section 1371.37.~~

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

(3) A noncontracting individual health professional who disputes the claim reimbursement shall utilize the independent dispute resolution process described in Section 1371.30.

(c) If a health care service plan delegates by written contract 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) A payment made by the health care service plan to the noncontracting health care professional for nonemergency services as required by Section 1371.9 and this section, in addition to the applicable cost sharing owed by the enrollee, shall constitute payment in full for nonemergency services rendered.

(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) of, Chapter 8 (commencing with Section 14200) of, 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.

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

1371.9. (a) (1) A health care service plan contract issued, amended, or renewed on or after January 1, 2016, shall provide that if an enrollee obtains care 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 the noncontracting individual health professional no more than the same cost sharing that the enrollee would have paid for the same covered benefits received from a contracting individual health professional. This amount shall be referred to as the "in-network cost sharing."

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

(3) Except as provided in subdivision (d), if the noncontracting individual health professional collects more than the in-network cost sharing from the enrollee, the noncontracting individual health professional shall refund any overpayment to the enrollee within 30 working days of receiving notice from the plan of the in-network cost sharing amount owed by the enrollee pursuant to paragraph (2). If the noncontracting individual health professional does not refund any overpayment within 30 working days after being informed of the enrollee's in-network cost sharing, interest shall accrue at the rate of 15 percent per annum beginning with the first

calendar day after the 30-working day period. A noncontracting individual health professional shall automatically include in his or her refund of the overpayment all interest that has accrued pursuant to this section without requiring the enrollee to submit a request for the interest amount.

(4) If the noncontracting individual health professional has advanced to collections any amount owed by the enrollee, the plan shall not reimburse the noncontracting individual health professional for services provided to the enrollee by the noncontracting individual health professional at a contracting health facility. In submitting a claim to the plan, the noncontracting individual health professional at a contracting health facility shall affirm in writing that he or she has not advanced to collections any payment owed by the enrollee. A noncontracting individual health professional shall not attempt to collect more than the in-network cost sharing from the enrollee after receiving payment from the plan. Once the noncontracting individual health professional receives payment from the plan, the noncontracting individual health professional may advance to collections any in-network cost sharing owed by the enrollee if the enrollee fails to pay the in-network cost sharing after the plan has informed the noncontracting individual health professional of the amount owed by the enrollee pursuant to paragraph (2).

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

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

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

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

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

(A) Licensed hospital.
(B) Skilled nursing facility.
(C) Ambulatory surgery.
(D) Laboratory.
(E) Radiology or imaging.
(F) Facilities providing mental health or substance abuse treatment.
(G) Any other provider as the department may by regulation define as a health facility for purposes of this section.
(3) "Individual health professional" means a physician or surgeon or other professional who is licensed by this state to deliver or furnish health care services.
(d) An enrollee may voluntarily consent to the use of a noncontracting individual health professional. For purposes of this section, consent shall be voluntary if at least 24 hours in advance of the receipt of services, the enrollee is provided a written estimate of the cost of care by the noncontracting individual health professional and the enrollee consents in writing to both the use of a noncontracting individual health professional and payment of the estimated additional cost for the services to be provided by the noncontracting individual health professional. The consent shall inform the enrollee that the cost of the services of the noncontracting individual health professional will not accrue to the limit on annual out-of-pocket expenses or the enrollee's deductible, if any.
(e) This section shall not be construed to require a plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.
(f) 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 v. Northridge Emergency Medical Group et al., (2009) 45 Cal.4th 497, that an emergency room physician is prohibited from billing an enrollee of a health care service plan directly for sums that the health care service plan has failed to pay for the enrollee's emergency room treatment.
(g) 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.

(h) This section ~~does~~ *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) of, Chapter 8 (commencing with Section 14200) ~~and~~ of, *and* Chapter 8.75 (commencing with Section 14591) ~~of~~ Part 3 of Division 9 of the Welfare and Institutions Code.

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

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

10112.8. (a) (1) A health insurance policy issued, amended, or renewed on or after January 1, 2016, shall provide that if an insured obtains care from a contracting health facility at which, or as a result of which, the insured receives services provided by a noncontracting individual health professional, the insured shall pay the noncontracting individual health professional no more than the same cost sharing that the insured would have paid for the same covered benefits received from a contracting individual health professional. This amount shall be referred to as the "in-network cost sharing."

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

(3) Except as provided in subdivision (d), if the noncontracting individual health professional collects more than the in-network cost sharing from the insured, the noncontracting individual health professional shall refund any overpayment to the insured within 30 working days of receiving notice from the health insurer of the in-network cost sharing amount owed by the insured pursuant to paragraph (2). If the noncontracting individual health professional does not refund any overpayment within 30 working days after being informed of the insured's in-network cost sharing, interest

shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30-working day period. A noncontracting individual health professional shall automatically include in his or her refund of the overpayment all interest that has accrued pursuant to this section without requiring the insured to submit a request for the interest amount.

(4) If the noncontracting individual health professional has advanced to collections any amount owed by the insured, the health insurer shall not reimburse the noncontracting individual health professional for services provided to the insured by the noncontracting individual health professional at a contracting health facility. In submitting a claim to the health insurer, the noncontracting individual health professional at a contracting health facility shall affirm in writing that he or she has not advanced to collections any payment owed by the insured. A noncontracting individual health professional shall not attempt to collect more than the in-network cost sharing from the insured after receiving payment from the health insurer. Once the noncontracting individual health professional receives payment from the health insurer, the noncontracting individual health professional may advance to collections any in-network cost sharing owed by the insured if the insured fails to pay the in-network cost sharing after the health insurer has informed the noncontracting individual health professional of the amount owed by the insured pursuant to paragraph (2).

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

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

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

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

(1) "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.

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

(A) Licensed hospital.

(B) Skilled nursing facility.

(C) Ambulatory surgery.

(D) Laboratory.

(E) Radiology or imaging.

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

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

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

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

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

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

(g) This section shall not apply to emergency services and care, as defined in Section 1317.1.

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

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

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

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

~~(4) The disputed claim is limited to covered services rendered by a noncontracting individual health professional, as defined by paragraph (3) of subdivision (c) of Section 10112.8, at a contracting health facility, as defined by paragraph (2) of subdivision (c) of Section 10112.8.~~

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

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

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

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

~~(3) The insurer shall provide all documents submitted to the commissioner for the independent dispute resolution process to the individual health professional appealing the claim. The~~

~~statistically credible information on the average payments described in subdivision (b) of Section 10112.82 shall be exempt from the disclosure required by this paragraph.~~

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

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

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

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

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

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

~~(2) The nature of the services provided.~~

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

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

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

~~(6) Any unusual circumstances in the case.~~

~~(f) An eligible claim does not include the following:~~

~~(1) A dispute concerning a claim that has not previously been submitted to the insurer's dispute resolution mechanism established pursuant to subdivision (b) of Section 10123.137, or a claim for which fewer than 30 days have elapsed since the individual health professional initiated the insurer's internal dispute resolution process.~~

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

~~(3) A dispute concerning a late payment.~~

~~(4) A dispute concerning an interest payment.~~

~~(5) A Medi-Cal claim dispute for which a fair hearing pursuant to Chapter 7 (commencing with Section 10950) of Part 2 of Division 9 of the Welfare and Institutions Code has commenced.~~

~~(6) A claim dispute that is not subject to the commissioner's jurisdiction.~~

~~(7) A claim dispute with a health insurer licensed or regulated by another entity or state.~~

~~(8) A dispute regarding a claim that does not involve covered benefits.~~

~~(9) A claim denied on the basis that the services were not medically necessary or were experimental or investigational in nature.~~

~~(g) (1) A noncontracting individual health professional may initiate an appeal to the independent dispute resolution process established pursuant to this section by following the procedures specified by the commissioner. A noncontracting individual health professional may aggregate disputed claim amounts. An aggregated claim shall involve the same or similar services and the same insurer.~~

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

~~(h)~~

(c) The commissioner may contract with one or more independent organizations that specialize in dispute resolution to conduct the proceedings. The independent organization handling a dispute shall be independent of either party to the dispute. The commissioner ~~may~~ *shall* establish ~~additional requirements, including~~ conflict-of-interest standards, consistent with the purposes of this section, that an organization shall meet in order to qualify for participation in the independent dispute resolution program. The commissioner may contract with the same

independent organization or organizations as the Department of Managed Health Care.

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

~~(j)~~

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

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

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

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

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

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

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

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

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

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

~~(b)~~

10112.82. (a) (1) ~~The~~ *A health* insurer shall maintain statistically credible information, updated at least annually, regarding rates paid to currently contracting individual health professionals *or a group of professionals* who provide similar ~~services, are not capitated,~~ *services* and are practicing in the same or a similar geographic area as the noncontracting individual health professional.

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

(2) If a health insurer does not pay a statistically significant number or dollar amount of claims for covered services in order to maintain the statistically credible information required by paragraph (1), the health insurer shall demonstrate to the department that it has access to a statistically credible database reflecting reasonable rates paid to providers for services provided in the same or a similar geographic area.

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

~~(c)~~

(b) (1) Unless otherwise provided in this section or otherwise agreed to by the noncontracting individual health professional and the insurer, the insurer shall base reimbursement of *noncontracted* claims *for services rendered according to Section 10112.81 on the average rates based* on the statistically credible information with regard to the amount paid to ~~providers~~ *contracted individual health professionals* who are providing similar ~~services, are not capitated,~~ *services* and practicing in the same or similar geographic area.

(2) ~~For~~ *If* nonemergency services *are* provided by ~~the~~ *a* noncontracting individual health professional to an insured *who has voluntarily chosen to use his or her out-of-network benefit for services* covered by a preferred provider organization or a point-of-service plan, unless otherwise agreed to by the insurer and the noncontracting individual health professional, the amount paid shall be the amount set forth in the insured's evidence of coverage.

~~(d) (1) An insurer's failure to pay a noncontracting individual health professional consistent with this section shall constitute an "unfair payment pattern" within the meaning of Section 1371.37 of the Health and Safety Code.~~

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

(3) A noncontracting individual health professional who disputes the claim reimbursement shall utilize the independent dispute resolution process described in Section 10112.81.

(c) A payment made by a health insurer to a noncontracting health care professional for nonemergency services as required by Section 10112.81 and this section, in addition to the applicable cost sharing owed by the insured, shall constitute payment in full for the nonemergency services rendered.

(d) This section shall not apply to a Medicare plan or a Medicare supplemental plan.

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

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, impose a

limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

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

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

O