AMENDED IN ASSEMBLY JUNE 11, 2012

AMENDED IN SENATE MAY 9, 2012

AMENDED IN SENATE MARCH 26, 2012

SENATE BILL No. 1285

Introduced by Senator Hernandez

February 23, 2012

An act to amend Section 1371.4 of, and to add Article 3 (commencing with Section 127465) to Chapter 2.5 of Part 2 of Division 107 of, the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 1285, as amended, Hernandez. Hospital billing: emergency services and care.

Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health and requires a licensed facility that maintains and operates an emergency department to provide emergency services and care to any person requesting the services or care for any condition in which the person is in danger of loss of life or serious injury or illness, as specified. Existing law requires hospitals to maintain a written policy regarding discount payments for financially qualified patients as well as a written charity care policy. Existing law requires a hospital to limit the expected payment for services it provides to certain low-income patients to the highest amount the hospital would expect to receive for providing services from a government-sponsored program of health benefits in which the hospital participates. 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 and makes a

willful violation of the act a crime. Existing law requires health care service plans, or their contracting medical providers, to reimburse providers for emergency services and care provided to their enrollees until the care results in stabilization of the enrollee.

This bill would require a hospital with an out-of-network emergency utilization rate of 50% or more to adjust its total billed charges for emergency services and care provided to a patient prior to stabilization to an amount no greater than the amount the hospital could expect to receive from Medicare for the services and care or, if there is no established payment amount by Medicare or if that amount is not sufficient to cover the actual cost to the hospital, an amount no greater than a good faith and reasonable estimate of the actual cost of providing the necessary services and care, as specified. The bill would specify that this provision does not apply to charges billed by emergency physicians, as defined, or to charges provided as treatment for an injury that is compensable for purposes of workers' compensation. The bill would also specify that its provisions do not apply if any other law requires the hospital to limit expected payment for the emergency services and care to a lesser amount, if a contract governs the total billed charges for the emergency services and care, or if a government program of health benefits is the primary payer for the emergency services and care. The bill would require health care service plans or their contracting medical providers to reimburse hospitals in accordance with these provisions. Because a willful violation of that reimbursement requirement by a health care service plan or its contracting medical providers would be a crime, the bill would impose a state-mandated local program.

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

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

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. Section 1371.4 of the Health and Safety Code is amended to read:

1371.4. (a) A health care service plan that covers hospital, medical, or surgical expenses, or its contracting medical providers, shall provide 24-hour access for enrollees and providers, including, but not limited to, noncontracting hospitals, to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.

(b) A health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan, or its contracting medical providers, reasonably determines that the emergency services and care were never performed; provided that a health care service plan, or its contracting medical providers, may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital

under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

(e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.

(f) Subdivisions (b), (c), (d), (h), and (i) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician.

(g) A health care service plan, or its contracting medical providers, that is obligated to reimburse providers for emergency services and care provided to its enrollees prior to stabilization pursuant to subdivision (b) shall reimburse hospitals in accordance with Section 127466.

(h) The Department of Managed Health Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when an enrollee requires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization.

(i) The Department of Managed Health Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider requires necessary medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan.

(j) The definitions set forth in Section 1317.1 shall control the construction of this section.

(k) (1) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall, within 30 minutes of the time the hospital makes the initial telephone call requesting information,

either authorize poststabilization care or inform the hospital that it will arrange for the prompt transfer of the enrollee to another hospital.

(2) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall reimburse the hospital for poststabilization care rendered to the enrollee if any of the following occur:

(A) The health care service plan authorizes the hospital to provide poststabilization care.

(B) The health care service plan does not respond to the hospital's initial contact or does not make a decision regarding whether to authorize poststabilization care or to promptly transfer the enrollee within the timeframe set forth in paragraph (1).

(C) There is an unreasonable delay in the transfer of the enrollee, and the noncontracting physician and surgeon determines that the enrollee requires poststabilization care.

(3) A health care service plan shall not require a hospital representative or a noncontracting physician and surgeon to make more than one telephone call pursuant to Section 1262.8 to the number provided in advance by the health care service plan. The representative of the hospital that makes the telephone call may be, but is not required to be, a physician and surgeon.

(4) An enrollee who is billed by a hospital in violation of Section 1262.8 may report receipt of the bill to the health care service plan and the department. The department shall forward that report to the State Department of Public Health.

(5) For purposes of this section, "poststabilization care" means medically necessary care provided after an emergency medical condition has been stabilized.

SEC. 2. Article 3 (commencing with Section 127465) is added to Chapter 2.5 of Part 2 of Division 107 of the Health and Safety Code, to read:

Article 3. Hospital Emergency Pricing

127465. (a) For purposes of this article, the following definitions shall apply:

(1) "Health care service plan" has the same meaning as that term is defined in Section 1345.

(2) "Health insurer" means an insurer that issues policies of health insurance, as defined in Section 106 of the Insurance Code.

(3) "Hospital" means a hospital licensed under subdivision (a) or (f) of Section 1250, with an emergency department licensed by the State Department of Public Health~~.~~*, with the following exceptions:*

(A) "Hospital" does not include designated public hospitals described in subdivision (d) of Section 14166.1 of the Welfare and Institutions Code.

(B) "Hospital" does not include a hospital owned or operated by an entity that is a city, a county, a city and county, the State of California, the University of California, a local health or hospital authority, any other political subdivision of the state, any combination of political subdivisions of the state organized pursuant to a joint powers agreement, or a new hospital that is described in Section 14165.50 of the Welfare and Institutions Code.

(4) A "local" patient is a patient whose residence is in the same county as the hospital at which the patient receives services and care, or whose residence is in a county adjacent to the county where the hospital at which the patient receives services and care is located.

(5) A "major emergency department encounter" means a patient encounter in a hospital emergency department for which the hospital's total billed charges for all inpatient and outpatient services and care provided, excluding charges billed by an emergency physician, as that term is defined in Section 127450, are greater than the major emergency department encounter threshold, as defined in paragraph (6).

(6) Commencing January 1, 2013, the "major emergency department encounter threshold" shall be two thousand dollars ($2,000). Commencing April 1, 2013, for an emergency encounter that began on or after April 1 of a given calendar year and through March 31 of the following calendar year, the "major emergency department encounter threshold" shall be an amount equal to: $2,000 x (PPI - 129.9)/129.9. For purposes of this paragraph, "PPI" shall be the Producer Price Index for general medical and surgical hospitals, commodity code 6221, not seasonally adjusted, as it appears in the PPI Detailed Report published by the United States Department of Labor, Bureau of Labor Statistics, as reported in

December of the calendar year that precedes the April 1 through March 31 period during which the emergency encounter began.

(7) "Primary payer" means the payer, other than the patient, who is or was legally required or responsible to make payment with respect to an item or service, or any portion thereof, before any other payer, other than the patient.

(8) "Privately insured patient" means a patient for whom the primary payer is a health insurer ~~or~~, a health care service plan, *or an employer plan sponsor,* and is not Medicare, Medi-Cal, or any other government program of health benefits, excluding public employee benefit plans.

(9) "Out-of-network" refers to care provided to a patient by a hospital that has not contracted with the patient's health care service plan or health insurer for reimbursement at a negotiated rate with respect to the care provided.

(10) "Out-of-network emergency utilization rate" means the percentage of all major emergency department encounters at a hospital during the course of a calendar year that are out-of-network for local, privately insured patients. This rate shall be calculated by dividing a hospital's total number of major emergency department encounters during the most recently completed calendar year that involved local, privately insured patients for whom the emergency services and care provided were out-of-network, by the hospital's total number of major emergency department encounters in the same calendar year of local, privately insured patients; provided that if the calendar year ended within the previous 90 days, data for the calendar year preceding the most recently completed calendar year shall be used.

(b) The definitions of Section 1317.1, with the exception of the definition of "hospital," shall control the construction of this article, unless the context otherwise requires.

127466. (a) (1) A hospital with an out-of-network emergency utilization rate of 50 percent or greater shall adjust its total billed charges for emergency services and care provided to a patient prior to stabilization in accordance with paragraph (2). The hospital's total billed charges subject to adjustment under this subdivision shall not include charges billed by an emergency physician, as that term is defined in Section 127450. This subdivision shall not apply to any hospital that has an out-of-network emergency utilization rate that is less than 50 percent.

(2) The adjustment made pursuant to this subdivision shall be such that the hospital's total expected payment shall not exceed the amount of payment the hospital reasonably could expect to receive from Medicare for providing the prestabilization emergency services and care if the services and care were subject to payment by Medicare. If there is no established payment amount by Medicare for the emergency services and care provided, or if the established Medicare payment amount is less than the actual cost to the hospital of the prestabilization emergency services and care provided, the adjustment made pursuant to this subdivision shall be such that the hospital's total expected payment shall not exceed a good faith and reasonable estimate of the actual cost of providing the necessary prestabilization emergency services and care.

(3) If a contract, including a contract with a health insurer, health care service plan, or other health care coverage provider, governs the adjustment of the total billed charges for the prestabilization emergency services and care provided to a patient by the hospital, the contract shall control and the provisions of this subdivision shall not apply.

(4) The adjustment required by this subdivision shall not apply to a hospital's charges for prestabilization emergency services and care provided to a patient as treatment for an injury that is compensable for purposes of workers' compensation.

(5) The adjustment required by this subdivision shall not apply to a hospital's charges for prestabilization emergency services and care provided to a patient for whom Medicare, Medi-Cal, or any other government program of health benefits, excluding public employee benefit plans, is the primary payer for those services and care.

(6) The adjustment required by this subdivision shall not apply if existing law, including Article 1 (commencing with Section 127400), requires a hospital to limit expected payment for prestabilization emergency services and care provided to a patient to an amount that is less than the hospital's total billed charges, as adjusted in accordance with paragraph (2). Nothing in this article shall prevent a hospital from adjusting its total billed charges to limit expected payments for prestabilization emergency services and care to amounts that are less than the total billed charges as adjusted in accordance with paragraph (2).

(b) If application of federal law, including Section 2719A of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19a), and its implementing regulations, requires that a health care service plan or health insurer provide payment for prestabilization emergency services and care in an amount greater than the hospital's total billed charges for those services and care as adjusted in accordance with subdivision (a), the hospital shall adjust its total billed charges such that the total expected payment for the prestabilization emergency services and care shall be the minimum amount that will comply with the applicable federal law. Nothing in this subdivision shall be construed as confirming any federal obligation of a health insurer or health care service plan to provide payments of any particular amount for out-of-network emergency services provided to its policyholders or enrollees prior to stabilization.

127467. Nothing in this article shall be construed to require a hospital to modify its uniform schedule of charges or published rates, nor shall this article preclude the recognition of a hospital's established charge schedule or published rates for purposes of applying any payment limit, interim payment amount, or other payment calculation based upon a hospital's rates or charges under the Medi-Cal program, the Medicare program, workers' compensation, or other federal, state, or local public program of health benefits.

127468. A hospital subject to Section 127466 shall provide reimbursement for any amount actually paid in excess of the amount due under this article, including interest. Interest owed by the hospital shall accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date payment is received by the hospital. However, a hospital is not required to provide a reimbursement if the amount due is less than five dollars ($5).

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

the meaning of Section 6 of Article XIII B of the California Constitution.

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