

AMENDED IN ASSEMBLY JUNE 26, 2012

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, *as defined*, 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 *150% of* 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, *as specified*, 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:

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

1 1371.4. (a) A health care service plan that covers hospital,
2 medical, or surgical expenses, or its contracting medical providers,
3 shall provide 24-hour access for enrollees and providers, including,
4 but not limited to, noncontracting hospitals, to obtain timely
5 authorization for medically necessary care, for circumstances where
6 the enrollee has received emergency services and care is stabilized,
7 but the treating provider believes that the enrollee may not be
8 discharged safely. A physician and surgeon shall be available for
9 consultation and for resolving disputed requests for authorizations.
10 A health care service plan that does not require prior authorization
11 as a prerequisite for payment for necessary medical care following
12 stabilization of an emergency medical condition or active labor
13 need not satisfy the requirements of this subdivision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 (4) An enrollee who is billed by a hospital in violation of Section
24 1262.8 may report receipt of the bill to the health care service plan
25 and the department. The department shall forward that report to
26 the State Department of Public Health.

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

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

33
34 Article 3. Hospital Emergency Pricing
35

36 127465. (a) For purposes of this article, the following
37 definitions shall apply:

38 (1) "Health care service plan" has the same meaning as that
39 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: $\$2,000 \times (\text{PPI} - 129.9) / 129.9$. 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) “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.

(8) “Out-of-network emergency utilization rate” means the percentage of all major emergency department encounters at a hospital during the course of the two most recent calendar years 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 two most recently completed calendar years, 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 two calendar years of local, privately insured patients, provided that if the most recent calendar year ended within the previous 90 days, then data for the two calendar years preceding the most recently completed calendar year shall be used.

(7)
(9) “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)
(10) (A) “Privately insured patient” means a patient for whom the primary payer is a health insurer, a health care service plan, or an employer plan sponsor, and is not Medicare, Medi-Cal, the Healthy Families Program, the Federal Temporary High Risk Pool, the Major Risk Medical Insurance Program, or any other government program of health benefits, ~~excluding public employee benefit plans~~ or managed care product provided pursuant to any government program of health benefits.

(B) “Privately insured patient” does not include any patient receiving prestabilization emergency services and care as treatment for an injury that is compensable for purposes of workers’ compensation.

~~(9) “Out-of-network” refers to care provided to a patient by a hospital that has not contracted with the patient’s health care~~

1 service plan or health insurer for reimbursement at a negotiated
2 rate with respect to the care provided.

3 ~~(10) “Out-of-network emergency utilization rate” means the~~
4 ~~percentage of all major emergency department encounters at a~~
5 ~~hospital during the course of a calendar year that are out-of-network~~
6 ~~for local, privately insured patients. This rate shall be calculated~~
7 ~~by dividing a hospital’s total number of major emergency~~
8 ~~department encounters during the most recently completed calendar~~
9 ~~year that involved local, privately insured patients for whom the~~
10 ~~emergency services and care provided were out-of-network, by~~
11 ~~the hospital’s total number of major emergency department~~
12 ~~encounters in the same calendar year of local, privately insured~~
13 ~~patients; provided that if the calendar year ended within the~~
14 ~~previous 90 days, data for the calendar year preceding the most~~
15 ~~recently completed calendar year shall be used.~~

16 *(b) For purposes of this article, the following shall not be*
17 *considered to be a government program of health benefits:*

18 *(1) A health care service plan, qualified health plan, or health*
19 *insurance policy or product offered through the California Health*
20 *Benefit Exchange established pursuant to Section 100500 of the*
21 *Government Code.*

22 *(2) An employer-sponsored health benefit plan or contract*
23 *providing health benefits or coverage for state, local, or other*
24 *government employees, retirees, or their family members,*
25 *including, but not limited to, a health benefit plan or contract*
26 *entered into with the Board of Administration of the Public*
27 *Employees’ Retirement System pursuant to the Public Employees’*
28 *Medical and Hospital Care Act (Part 5 (commencing with Section*
29 *22750) of Division 5 of Title 2 of the Government Code).*

30 ~~(b)~~

31 *(c) The definitions of Section 1317.1, with the exception of the*
32 *definition of “hospital,” shall control the construction of this article,*
33 *unless the context otherwise requires.*

34 127466. (a) (1) A hospital with an out-of-network emergency
35 utilization rate of 50 percent or greater shall adjust its total billed
36 charges for emergency services and care provided to a patient prior
37 to stabilization in accordance with paragraph (2). The hospital’s
38 total billed charges subject to adjustment under this subdivision
39 shall not include charges billed by an emergency physician, as that
40 term is defined in Section 127450. This subdivision shall not apply

1 to any hospital that has an out-of-network emergency utilization
2 rate that is less than 50 percent.

3 (2) The adjustment made pursuant to this subdivision shall be
4 such that the hospital's total expected payment shall not exceed
5 *150 percent of* the amount of payment the hospital reasonably
6 could expect to receive from Medicare for providing the
7 prestabilization emergency services and care if the services and
8 care were subject to payment by Medicare. ~~If there is no established~~
9 ~~payment amount by Medicare for the emergency services and care~~
10 ~~provided, or if the established Medicare payment amount is less~~
11 ~~than the actual cost to the hospital of the prestabilization emergency~~
12 ~~services and care provided, the adjustment made pursuant to this~~
13 ~~subdivision shall be such that the hospital's total expected payment~~
14 ~~shall not exceed a good faith and reasonable estimate of the actual~~
15 ~~cost of providing the necessary prestabilization emergency services~~
16 ~~and care.~~

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

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

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

33 (6) The adjustment required by this subdivision shall not apply
34 if existing law, including Article 1 (commencing with Section
35 127400), requires a hospital to limit expected payment for
36 prestabilization emergency services and care provided to a patient
37 to an amount that is less than the hospital's total billed charges, as
38 adjusted in accordance with paragraph (2). Nothing in this article
39 shall prevent a hospital from adjusting its total billed charges to
40 limit expected payments for prestabilization emergency services

1 and care to amounts that are less than the total billed charges as
2 adjusted in accordance with paragraph (2).

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

18 127467. Nothing in this article shall be construed to require a
19 hospital to modify its uniform schedule of charges or published
20 rates, nor shall this article preclude the recognition of a hospital's
21 established charge schedule or published rates for purposes of
22 applying any payment limit, interim payment amount, or other
23 payment calculation based upon a hospital's rates or charges under
24 the Medi-Cal program, the Medicare program, workers'
25 compensation, or other federal, state, or local public program of
26 health benefits.

27 127468. A hospital subject to Section 127466 shall provide
28 reimbursement for any amount actually paid in excess of the
29 amount due under this article, including interest. Interest owed by
30 the hospital shall accrue at the rate set forth in Section 685.010 of
31 the Code of Civil Procedure, beginning on the date payment is
32 received by the hospital. However, a hospital is not required to
33 provide a reimbursement if the amount due is less than five dollars
34 (\$5).

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

1 the Government Code, or changes the definition of a crime within
2 the meaning of Section 6 of Article XIII B of the California
3 Constitution.

O