RESOLUTION 05-08-2016

DIGEST

Health and Safety: Rules of Disclosure and Prohibition on Surprise Charges
Adds Health and Safety Code section 1367.28 to establish "The End of Surprise Billing Act," which specifies the required disclosures of billing information to insureds.

TEXT OF RESOLUTION

RESOLVED that the Conference of California Bar Associations recommend that legislation be sponsored to add Health and Safety Code section 1367.28 to read as follows:

1 §1367.28
2 (a) This Act may be cited or referred to as the End of Surprise Billing Act.
3 (b) For purposes of this Act:
4 (1) "Emergency" means a medical condition manifesting itself by acute symptoms of
5 sufficient severity (including severe pain) such that if not immediately diagnosed and treated
6 could reasonably be expected to result in placing the patient's health in serious jeopardy, serious
7 impairment to bodily functions, or serious dysfunction of any bodily organ or part, or any
8 imminent threat to life, limb or organ system requiring immediate medical attention, and where
9 the individual is not medically stable or where at the time it is not reasonably prudent or safe to
10 transfer the individual for the care immediately required to an outside similarly qualified health
11 care provider.
12 (2) "Health care provider" means any person licensed or certified pursuant to Division 2
13 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to
14 the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter
15 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any
16 clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with
17 Section 1200) of the Health and Safety Code. "Health care providers" includes the legal
18 representative of a health care provider.
19 (3) "Health benefits coverage" or "health benefits plan" includes any insurance, plan,
20 programs or source of collateral benefits offered the individual in the group or individual market,
21 or a government-sponsored health plan or program. "Health benefits plan provider" means the
22 insurer, government or private provider or administrator of as the health benefits coverage or
23 plan.
24 (4) "Individual" means a patient or prospective patient seeking or receiving health,
25 medical or related items and services, who is covered by a health benefit coverage plan, program
26 or insurance, or similar form of collateral benefits.
27 (5) "Representative of the individual" is either a legal representative, conservator,
28 custodian, or guardian of the "individual," or a person designated with power of attorney or
29 authority regarding health care, medical or related care for the individual.
30 (6) This Act applies with respect to an individual who has health benefit coverage, or
31 who seeks to be furnished items or services or is to be furnished items or services by a health
32 care provider.
33 (c) (1) On the date on which an individual, or representative of the individual, first
34 makes an appointment for the year to be furnished items or services, if applicable, the health care

35 provider shall endeavor in good faith to promptly determine and advise the individual, as soon as
36 practicable in advance of the appointment if feasible, whether the health care provider is or is not
37 an in-network or participating health care provider under the individual's health benefits plan. If
38 it is determined that the health care provider is not an in-network or participating health care
39 provider under the individual's health benefits coverage, the health care provider shall also
40 inform the individual that there may be diminished or no coverage under the individual's health
41 benefits plan for services or items furnished by that out-of-network health care provider. In such
42 a case, the individual shall be advised to confer with the individual's health benefits coverage
43 provider regarding any financial and coverage implications in receiving services or items from
44 an out-of-network provider in contrast with the option of using a network provider.
45 (2) On the date on which the individual is to be first furnished with items or services, in
46 advance of providing such items or services, and incurring the cost thereof, the health care
47 provider shall provide the individual, or representative of the individual, a written notice, as
48 specified through rule-making by the Director of the Department of Managed Care, in
49 consultation with the Insurance Commissioner, that:
50 (i) Contains the information required under paragraph (e);
51 (ii) Is signed by the individual, and/or if applicable, the representative of the individual;
52 (iii) A copy of which is provided to the individual, or representative of the individual;
53 and
54 (iv) Is retained as part of the individual's chart with the health care provider, for a period
55 of at least seven (7) years after the date of signing.
56 (d) In the case such health care provider is not within the health care provider network or
57 otherwise a participating provider of services or supplier with respect to the health benefits
58 coverage, program or plan of the individual, absent an emergency situation as described in
59 paragraph (h), the health care provider shall obtain from the individual, or representative of the
60 individual, the consent as described in paragraph (f).
61 (e) The notice described in paragraph (c)(2) shall include, with respect to an individual
62 with health benefits coverage described in paragraph (b)(6), who inquires or seeks to be
63 furnished items or services, or is to be furnished with items or services by a health care provider,
64 a notification of each of the following:
65 (1) Whether the health care provider is or is not within the health care provider network
66 or an otherwise participating provider of services or supplier with respect to health benefits
67 coverage of such individual.
68 (2) If the health care provider is a participating provider under the individual's health
69 benefits plan, the estimated amount the health care provider will charge the individual for such
70 items and services, in excess of any cost-sharing obligation the individual would otherwise have
71 under such health benefits coverage.
72 (3) If the health care provider is not within network or otherwise a participating provider
73 or supplier of the individual's health benefits coverage or plan:
74 (i) A statement notifying the individual 1) that the health care provider is not an in-
75 network or participating provider or supplier under the individual's health benefits coverage or
76 plan, and in receiving items or services from this provider as an out-of-network or non-
77 participating provider, there may be diminished or no coverage under the individual's health
78 benefits plan for services or items furnished by that out-of-network health care provider; 2) that
79 the individual has the option of receiving the full financial, cost-controlled, cost-sharing and
80 related benefits and protections under the individual's health benefits plan by instead having

81 items or services provided by an in-network, participating health care provider; and 3) the
82 individual is advised to contact and consult with the individual's health benefits plan provider
83 regarding a) any financial and coverage implications in receiving services or items from an out-
84 of-network provider or non-participating provider in contrast to the option of using an in-
85 network provider or participating provider, as well as b) how to obtain care from a participating
86 provider under the individual's health benefits plan.
87 (ii) The estimated amount the health care provider will charge the individual for such
88 items and services, along with notification that the individual should check with the individual's
89 health benefits plan to determine what if any of that amount, for which the individual will be
90 responsible, will or will not be covered under the individual's health benefits plan.
91 (4) Whether any of the providers of services or suppliers to furnish items or services at
92 the hospital or critical access hospital, or associated with the health care provider, or to whom the
93 health care provider may refer or seek consultation or items or services in connection with the
94 individual's assessment or care, are not within the health care provider network or otherwise a
95 participating provider of services or supplier of the individual's health benefits coverage or plan.
96 If any such other providers of services or suppliers are out-of-network or otherwise a non-
97 participating provider or supplier, the individual should be further advised of the individual's
98 option to received services and supplies from an in-network or participating provider, and the
99 individual should confer with the individual's health benefits plan provider to determine the
100 coverage implications and options and the resources available to the individual through the
101 individual's health benefits plan.
102 (f) For purposes of paragraph (d), the consent described in this paragraph with respect to
103 an individual with health benefits coverage described in paragraph (b)(6) who is to be furnished
104 items or services by the health care provider that is not within the health care provider network
105 or otherwise a participating provider of services or supplier with respect to health benefits
106 coverage of such individual, is a document specified by the Director of the Department of
107 Managed Care, in consultation with the Insurance Commissioner, through rule-making, that is
108 signed by the individual, or the individual's representative prior to the individual being furnished
109 such items or services by such health care provider, that:
110 (1) Acknowledges that the individual has been 1) provided a written estimate of the
111 charge that the individual will be personally assessed and responsible to pay for the items or
112 services anticipated to be furnished to the individual by the health care provider that is not within
113 such network or otherwise such a participating provider of services or supplies; 2) informed that
114 payment by the individual of such charges may not accrue toward any limitations that the health
115 benefits coverage places on the annual out-of-pocket expenses to be paid by the individual, or
116 upon the in-network deductible to be paid by the individual, which may not be the case were the
117 items or services furnished by an in-network or participating health care provider; and 3) the
118 individual's option to obtain items or services from an in-network or participating provider
119 associated with the individual's health benefits coverage, in order for the individual to assure
120 maximum benefits under the individual's health benefit coverage, at generally a lower cost than
121 will be the case if receiving services and items by this non-network, non-participating health care
122 provider.
123 (2) Documents the consent of the individual to
124 (i) Be furnished with such items or services by such non-network, non-participating
125 health care provider; and

126 (ii) In the case that the health care provider furnishes such items or services, the
127 individual will be charged and will personally be responsible for paying an amount approximate
128 to the estimated charge described in subparagraph (e)(3)(ii) with respect to such items and
129 services.
130 (3) Such document shall be retained as part of the individual's chart with the health care
131 provider, for a period of at least seven (7) years after the date of signing.
132 (g) In the case of an individual with health benefits coverage described in paragraph
133 (b)(6) who is furnished items or services by a health care provider that is not within the health
134 care provider network or otherwise a participating provider of services or supplier with respect to
135 the health benefits coverage of such individual, if the health care provider does not comply with
136 the requirements of paragraphs (c)(2) and (e), in a situation other than that described in
137 paragraph (h), the health care provider may not charge the individual more than the amount that
138 the individual would have been required to pay in cost-sharing if such items or services had been
139 furnished by an in-network or otherwise participating provider of the individual's health benefits
140 coverage or plan, and based on what the individual's health benefits plan provider would
141 determine as the reasonable or contract rate for the furnished service or item. The out-of-network
142 health care provider shall have the burden of proving what that amount would be under the
143 individual's health benefits coverage. In those cases where the amount cannot be determined
144 with reasonably accurate certainty, the amount charged the individual by such out-of-network
145 health care provider is voidable at the option of the individual.
146 (h) (1) In the case of an individual with health benefits coverage described in paragraph
147 (b)(6) who is furnished items or services on an emergency basis by a health care provider that is
148 not within the health care provider network or otherwise a participating provider of services or
149 supplier with respect to the health benefits coverage of such individual, where it is not safe or
150 feasible under the presenting circumstances for notice or consent under paragraphs (c) and (d) to
151 be given and obtained, or for such services to be furnished by an in-network or participating
152 provider upon transfer, nothing in this Act shall preclude a health care provider from seeking and
153 obtaining compensation under any terms of the individual's health benefits coverage, and absent
154 an applicable provision for benefits thereunder, charging the individual what would be the
155 amount compensable to an in-network or participating health care provider for such items or
156 services under the individual's health benefits coverage.
157 (2) Nothing in this Act is intended to abrogate the provisions regarding emergency care
158 set forth at Sections 1317 and 1317.1 of the Health and Safety Code.
159 (i) Nothing in this Act is intended to alter the provisions of the Knox-Keene Health Care
160 Service Plan, as provided Chapter 2.2, of Division 2, of the Health and Safety Code,
161 commencing at Section 1340; Part 2 of Division 2 of the Insurance Code, commencing at Section
162 10110; Chapter 7, commencing at Section 14000, and Chapter 8, commencing at Section 14200,
163 of Part 3, Division 9, of the Welfare and Institutions Code; and Subchapters XVIII and XIX of
164 Chapter 7 of Title 42 of the United States Code, and related federal and state regulations
165 concerning the Medicare and Medicaid (MediCal) programs.
166 (j) Nothing in this Act is intended to limit the authority of the Director of the Department
167 of Managed Care, the Insurance Commissioner, or the Medical Board of California of the
168 Department of Consumer Affairs.
169 (k) Nothing in this Act is intended to affect the rights otherwise accorded health care
170 providers under the provisions of Chapter 4 of Title 14 of the Civil Code, commencing at Section
171 3045.1.

(Proposed new language underlined; language to be deleted stricken)

PROPONENT: Los Angeles County Bar Association

STATEMENT OF REASONS

The Problem: If a patient insured by a health plan obtains services from an out-of-network healthcare professional, the patient's individual responsibility for the fees incurred will be substantially more than if provided by an in-network provider. Under some plans, there may be no coverage at all. With many health plans, it is often confusing and difficult to determine which provider is or isn't in-network. Researching insurance directories of providers is rarely simple or practicable. Most patients reasonably rely on office personnel to tell them. The insured patient who unwittingly proceeds with treatment with an out-of-network provider is rarely prepared for the frequently huge medical bill received following care—for which there will be personal liability. An unsophisticated insured patient with a tightly-restricted health plan is particularly at risk for making a critical mistake regarding complexities of coverage. Insured patients, innocently believing their medical care is covered because they have insurance, should not be surprised by receiving a huge medical bill after care because the treatment was out-of-network. Hospital or medical services not covered or controlled by insurance can be shockingly astronomical, and catastrophic. Uninsured medical bills have put many individuals into major debt, and has been a major source for many bankruptcies.

The Solution: This resolution would require the healthcare professional—a fiduciary and someone in the best position to know whether it is an in-network provider under the patient's health insurance plan—to candidly disclose to the prospective insured patient, in advance of rendering services or incurring fees, if it is a non-participating provider, and if so, the estimated amount for which the individual will be personally responsible. Patients should be made aware of the significant financial import of treating out-of-network, and the option of getting maximum insurance benefits and control by treating with a network provider under the health benefit plan they have. As with the medical care, a patient is entitled to an informed consent on a matter of material economic consequences, and not otherwise be unwittingly taken advantage of. An out-of-network provider who furnishes medical care or items to an insured patient, without first making the required disclosures, and obtaining patient consent, will not be allowed to charge the patient in excess of what the patient would otherwise be responsible had the treatment been provided by a participating network provider. The recently enacted SB 137—requiring insurers to regularly post current provider directories online—is not an optimal solution. It does not solve the fundamental problem—the confusion, uncertainty and erroneous information, beliefs and influences at play in seeking covered care. It is important health insurers maintain current directories. Yet that does not resolve the practical problem, especially for many who simply lack the sophistication in making sound medical care decisions along with appreciating dauntingly complex coverage niceties, especially when concerned with an immediate medical problem or under the influence or convenience of an out-of-network provider…or the situation where a participating provider refers them to a non-network provider, consultant, lab or facility, which the patient may erroneously presume is in-network.

IMPACT STATEMENT
This resolution will not conflict with any other law, statute or rule.

CURRENT OR PRIOR RELATED LEGISLATION
H.R. 3770 (introduced Oct. 20, 2015), the End Surprise Billing Act of 2015, would amend title XVIII of the Social Security Act to prevent surprise billing practices in the Medicare system; S.B. 137 (2015, Sen. Hernandez) (Cal. Health & Safety Code § 1367.27, Cal. Ins. Code § 10133.15).

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RESPONSIBLE FLOOR DELEGATE: Joel Bruce Douglas

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RESOLUTIONS COMMITTEE RECOMMENDATION
APPROVE IN PRINCIPLE

History:
No similar resolutions found.

Reasons:
This resolution adds Health and Safety Code section 1367.28 to establish "The End of Surprise Billing Act," which specifies the required disclosures of billing information to insureds. This resolution should be approved in principle because it requires health providers to make important disclosures to insured individuals that may protect those individuals from unwittingly agreeing to health services that are out of network and at exorbitant costs.

As a result of the Affordable Care Act, tens of thousands more Californians than ever have access to health insurance. With this increase in insurance coverage has come an increase in people seeking health care. Unfortunately, not all health care is covered by an insured individual's plan, even when that individual is referred for service by an in-network provider. This resolution would provide insured individuals with notice, as defined, pertaining to the costs of the services sought, whether or not the services are being provided by a provider within the insured individual's plan, an opportunity to seek services at a lower cost from within the individual's plan, and additional protections in order to minimize the frequency of surprise bills and exorbitant fees that often result in crippling debt and bankruptcy. The resolution requires health care providers to provide the notice, and directs the director of the California Department of Managed Care and the California Insurance Commissioner to promulgate the actual notice documents that would be provided to the insureds as proof that they have been advised of their obligations and the limitations of the health care services, as described.

This resolution is similar to the federal bill H.R. No. 3770 (114th Cong., 1st Sess.), The "End Surprise Billing Act" of 2015, which seeks to amend Title XVIII of the Social Security Act to prevent surprise billing in the Medicare system.