california legislature—2013–14 regular session

ASSEMBLY BILL No. 1558

Introduced by Assembly Member Roger Hernández

January 28, 2014

An act to add Title 22.5 (commencing with Section 100800) to the Government Code, to amend Sections 1375.7 and 1395.6 of the Health and Safety Code, and to amend Sections 10178.3 and 10178.4 of the Insurance Code, relating to health care coverage.

legislative counsel's digest

AB 1558, as introduced, Roger Hernández. California Health Data Organization.

Existing law establishes the Office of Statewide Health Planning and Development (OSHPD) to perform various functions and duties with respect to health facilities, health professions development, and health policy and planning, including, but not limited to, consulting with the Insurance Commissioner, the Director of the Department of Managed Health Care, and others to adopt a California uniform billing form format for professional health care services and a California uniform billing form format for institutional provider services. Existing law requires organizations that operate or own a health facility to file specified reports with OSHPD containing various financial and patient data.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to provide an explanation of benefits or explanation of review

that identifies the name of the network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered.

This bill would request the University of California to establish the California Health Data Organization and would require health care service plans and health insurers to provide the explanations of benefits or explanations of review to that organization to the extent permitted by federal law. The bill would require the organization to organize the data provided in those documents and to design and maintain an Internet Web site that allows consumers to compare the prices paid by carriers for procedures, as specified. The bill would request the University of California to seek funding from the federal government and other private sources to cover the costs associated with these provisions and would authorize the organization to charge a fee to each person or entity requesting access to data in the database it creates.

Because a willful violation of the bill's requirement for a health care service plan to provide an explanation of benefits or explanation of review to the organization 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. Title 22.5 (commencing with Section 100800)
2 is added to the Government Code, to read:
3
4 TITLE 22.5. CALIFORNIA HEALTH DATA
5 ORGANIZATION
6
7 100800. For purposes of this title, the following definitions
8 shall apply:
9 (a) "Organization" means the California Health Data
10 Organization established pursuant to Section 100801.

1 (b) "Carrier claims database" or "database" means a database
2 that receives and stores data from carriers reported to the
3 organization pursuant to Section 1395.6 of the Health and Safety
4 Code and Section 10178.3 of the Insurance Code.
5 (c) "Carrier" means either a private health insurer holding a
6 valid outstanding certificate of authority from the Insurance
7 Commissioner or a health care service plan licensed by the
8 Department of Managed Health Care.
9 (d) "Health care service plan" has the same meaning as that
10 term is defined in subdivision (f) of Section 1345 of the Health
11 and Safety Code.
12 (e) "Health insurer" means an insurer admitted to transact health
13 insurance business in this state. For purposes of this subdivision,
14 "health insurance" has the meaning used in Section 106 of the
15 Insurance Code.
16 (f) "Individually identifiable information" means information
17 that includes or contains any element of personal identifying
18 information sufficient to allow identification of the individual,
19 including the person's name, address, electronic mail address,
20 telephone number, or social security number, or other information
21 that, alone or in combination with other publicly available
22 information, reveals the individual's identity.
23 100801. (a) The Legislature hereby requests the University of
24 California to establish the California Health Data Organization.
25 (b) The organization shall be staffed by persons with
26 demonstrated experience in all of the following:
27 (1) Performing statewide individual-level data collection.
28 (2) Managing and analyzing complex patient-level data.
29 (3) Complying with HIPAA requirements.
30 (4) Communicating information to the public via a user-friendly
31 web interface.
32 (c) The Legislature hereby requests the University of California
33 to seek funding from the federal government and other private
34 sources to cover costs associated with the planning,
35 implementation, and administration of this title.
36 100803. The organization shall do all of the following:
37 (a) Establish a carrier claims database using the data collected
38 and organized as described in this title.

1 (b) Collect data from carriers reported pursuant to Section
2 1395.6 of the Health and Safety Code and Section 10178.3 of the
3 Insurance Code.
4 (c) Organize data reported by carriers pursuant to Section 1395.6
5 of the Health and Safety Code and Section 10178.3 of the Insurance
6 Code into the following categories:
7 (1) Charges and total amounts paid by carriers and patients,
8 including, but not limited to, charge amount, paid amount, prepaid
9 amount, copayment, coinsurance, deductible, and allowed amount.
10 (2) Type of health care service, including, but not limited to,
11 ambulatory care procedures and services and inpatient physician
12 services reported by Common Procedural Terminology (CPT)
13 codes, and inpatient hospital services reported by
14 Diagnosis-Related Group (DRG) codes.
15 (3) Information relating to risk adjustment, including other
16 diagnoses, length of stay, and discharge.
17 (d) Ensure that patient privacy is protected in compliance with
18 state and federal laws. Patient privacy shall be protected using
19 encryption and storage of the information on secure servers.
20 100805. (a) The organization may do all of the following:
21 (1) Receive and accept gifts, grants, or donations of moneys
22 from any agency of the United States, any agency of the state, any
23 municipality, county, or other political subdivision of the state.
24 (2) Receive and accept gifts, grants, or donations from
25 individuals, associations, private foundations, or corporations, in
26 compliance with the conflict-of-interest provisions to be adopted
27 by the board at a public meeting.
28 (3) Charge a reasonable fee to each person or entity requesting
29 access to data stored in the database, not to exceed the actual costs
30 of providing that access.
31 (4) Explore alternative sources of funding, to the extent
32 permitted by law, to ensure the sustainabilty of the organization.
33 (b) The organization shall not accept gifts or grants from an
34 entity that may have a vested interest in the decisions of the
35 organization.
36 100809. (a) The organization shall disseminate the information
37 collected pursuant to this title to the public in a meaningful and
38 comprehensive manner.
39 (b) For purposes of this section, the organization shall do all of
40 the following:

1 (1) Design and maintain an interactive searchable Internet Web
2 site that is accessible to the public and in which both of the
3 following requirements are satisfied:
4 (A) Information on payments for services is easily searchable
5 by the average consumer.
6 (B) The format used allows for the comparison of prices paid
7 by carriers per procedure.
8 (2) Investigate how to combine price information with quality
9 information, either within the database or by linkage to other
10 searchable databases.
11 (3) Investigate the most efficient way of presenting information
12 to the public, including, but not limited to, reporting on price
13 information for the average severity of the condition or for different
14 tiers of severity.
15 (4) Coordinate efforts with the health care coverage market and
16 provide information to the public using the geographic areas used
17 by carriers in order to do both of the following:
18 (A) Make price transparency readily available to all purchasers
19 of health care coverage.
20 (B) Help guide consumers in their choice between different
21 health plans available through the California Health Benefit
22 Exchange established by Section 100500.
23 (c) Information disclosed pursuant to this section shall not
24 contain any individually identifiable information.
25 (d) To allow for the development of the Internet Web site
26 described in this section without delay, the organization may
27 contract with a qualified, nongovernmental, independent third
28 party for the delivery of a commercially available claims dataset
29 with the appropriate level of detail in term of payments, geocoding,
30 and provider information. This information shall be replaced with
31 information directly collected by the organization once the first
32 set of data directly collected from carriers has been cleaned and
33 analyzed.
34 100811. The organization shall use the data collected pursuant
35 to this title and produce annual reports on the cost of specific
36 ambulatory care procedures and services and inpatient physician
37 services aggregated within geographic market areas in this state,
38 as determined by the organization, so as not to identify individual
39 physicians.

SEC. 2. Section 1375.7 of the Health and Safety Code is amended to read:
1375.7. (a) This section shall be known and may be cited as the Health Care Providers' Bill of Rights.
(b) No contract issued, amended, or renewed on or after January 1, 2003, between a plan and a health care provider for the provision of health care services to a plan enrollee or subscriber shall contain any of the following terms:
(1) (A) Authority for the plan to change a material term of the contract, unless the change has first been negotiated and agreed to by the provider and the plan or the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. If a change is made by amending a manual, policy, or procedure document referenced in the contract, the plan shall provide 45 business days' notice to the provider, and the provider has the right to negotiate and agree to the change. If the plan and the provider cannot agree to the change to a manual, policy, or procedure document, the provider has the right to terminate the contract prior to the implementation of the change. In any event, the plan shall provide at least 45 business days' notice of its intent to change a material term, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter timeframe for compliance. However, if the parties mutually agree, the 45-business day notice requirement may be waived. Nothing in this subparagraph limits the ability of the parties to mutually agree to the proposed change at any time after the provider has received notice of the proposed change.
(B) If a contract between a provider and a plan provides benefits to enrollees or subscribers through a preferred provider arrangement, the contract may contain provisions permitting a material change to the contract by the plan if the plan provides at least 45 business days' notice to the provider of the change and the provider has the right to terminate the contract prior to the implementation of the change.
(C) If a contract between a noninstitutional provider and a plan provides benefits to enrollees or subscribers covered under the Medi-Cal or Healthy Families Program and compensates the provider on a fee-for-service basis, the contract may contain

1 provisions permitting a material change to the contract by the plan,
2 if the following requirements are met:
3 (i) The plan gives the provider a minimum of 90 business days'
4 notice of its intent to change a material term of the contract.
5 (ii) The plan clearly gives the provider the right to exercise his
6 or her intent to negotiate and agree to the change within 30 business
7 days of the provider's receipt of the notice described in clause (i).
8 (iii) The plan clearly gives the provider the right to terminate
9 the contract within 90 business days from the date of the provider's
10 receipt of the notice described in clause (i) if the provider does not
11 exercise the right to negotiate the change or no agreement is
12 reached, as described in clause (ii).
13 (iv) The material change becomes effective 90 business days
14 from the date of the notice described in clause (i) if the provider
15 does not exercise his or her right to negotiate the change, as
16 described in clause (ii), or to terminate the contract, as described
17 in clause (iii).
18 (2) A provision that requires a health care provider to accept
19 additional patients beyond the contracted number or in the absence
20 of a number if, in the reasonable professional judgment of the
21 provider, accepting additional patients would endanger patients'
22 access to, or continuity of, care.
23 (3) A requirement to comply with quality improvement or
24 utilization management programs or procedures of a plan, unless
25 the requirement is fully disclosed to the health care provider at
26 least 15 business days prior to the provider executing the contract.
27 However, the plan may make a change to the quality improvement
28 or utilization management programs or procedures at any time if
29 the change is necessary to comply with state or federal law or
30 regulations or any accreditation requirements of a private sector
31 accreditation organization. A change to the quality improvement
32 or utilization management programs or procedures shall be made
33 pursuant to paragraph (1).
34 (4) A provision that waives or conflicts with any provision of
35 this chapter. A provision in the contract that allows the plan to
36 provide professional liability or other coverage or to assume the
37 cost of defending the provider in an action relating to professional
38 liability or other action is not in conflict with, or in violation of,
39 this chapter.

1 (5) A requirement to permit access to patient information in
2 violation of federal or state laws concerning the confidentiality of
3 patient information.
4 (c) With respect to a health care service plan contract covering
5 dental services or a specialized health care service plan contract
6 covering dental services, all of the following shall apply:
7 (1) If a material change is made to the health care service plan's
8 rules, guidelines, policies, or procedures concerning dental provider
9 contracting or coverage of or payment for dental services, the plan
10 shall provide at least 45 business days' written notice to the dentists
11 contracting with the health care service plan to provide services
12 under the plan's individual or group plan contracts, including
13 specialized health care service plan contracts, unless a change in
14 state or federal law or regulations or any accreditation requirements
15 of a private sector accreditation organization requires a shorter
16 timeframe for compliance. For purposes of this paragraph, written
17 notice shall include notice by electronic mail or facsimile
18 transmission. This paragraph shall apply in addition to the other
19 applicable requirements imposed under this section, except that it
20 shall not apply where notice of the proposed change is required to
21 be provided pursuant to subparagraph (C) of paragraph (1) of
22 subdivision (b).
23 (2) For purposes of paragraph (1), a material change made to a
24 health care service plan's rules, guidelines, policies, or procedures
25 concerning dental provider contracting or coverage of or payment
26 for dental services is a change to the system by which the plan
27 adjudicates and pays claims for treatment that would reasonably
28 be expected to cause delays or disruptions in processing claims or
29 making eligibility determinations, or a change to the general
30 coverage or general policies of the plan that affect rates and fees
31 paid to providers.
32 (3) A plan that automatically renews a contract with a dental
33 provider shall annually make available to the provider, within 60
34 days following a request by the provider, either online, via email,
35 or in paper form, a copy of its current contract and a summary of
36 the changes described in paragraph (1) of subdivision (b) that have
37 been made since the contract was issued or last renewed.
38 (4) This subdivision shall not apply to a health care service plan
39 that exclusively contracts with no more than two medical groups

1 in the state to provide or arrange for the provision of professional
2 medical services to the enrollees of the plan.
3 (d) (1) When a contracting agent sells, leases, or transfers a
4 health provider's contract to a payor, the rights and obligations of
5 the provider shall be governed by the underlying contract between
6 the health care provider and the contracting agent.
7 (2) For purposes of this subdivision, the following terms shall
8 have the following meanings:
9 (A) "Contracting agent" has the meaning set forth in paragraph
10 (2) of subdivision ~~(d)~~ *(e)* of Section 1395.6.
11 (B) "Payor" has the meaning set forth in paragraph (3) of
12 subdivision ~~(d)~~ *(e)* of Section 1395.6.
13 (e) Any contract provision that violates subdivision (b), (c), or
14 (d) shall be void, unlawful, and unenforceable.
15 (f) The department shall compile the information submitted by
16 plans pursuant to subdivision (h) of Section 1367 into a report and
17 submit the report to the Governor and the Legislature by March
18 15 of each calendar year.
19 (g) Nothing in this section shall be construed or applied as
20 setting the rate of payment to be included in contracts between
21 plans and health care providers.
22 (h) For purposes of this section the following definitions apply:
23 (1) "Health care provider" means any professional person,
24 medical group, independent practice association, organization,
25 health care facility, or other person or institution licensed or
26 authorized by the state to deliver or furnish health services.
27 (2) "Material" means a provision in a contract to which a
28 reasonable person would attach importance in determining the
29 action to be taken upon the provision.
30 SEC. 3. Section 1395.6 of the Health and Safety Code is
31 amended to read:
32 1395.6. (a) In order to prevent the improper selling, leasing,
33 or transferring of a health care provider's contract, it is the intent
34 of the Legislature that every arrangement that results in a payor
35 paying a health care provider a reduced rate for health care services
36 based on the health care provider's participation in a network or
37 panel shall be disclosed to the provider in advance and that the
38 payor shall actively encourage beneficiaries to use the network,
39 unless the health care provider agrees to provide discounts without
40 that active encouragement.

(b) Beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor, as defined in subparagraph (A) of paragraph (3) of subdivision ~~(d)~~ *(e)*, or another contracting agent shall, upon entering or renewing a provider contract, do all of the following:

(1) Disclose to the provider whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents, and specify whether those payors or contracting agents include workers' compensation insurers or automobile insurers.

(2) Disclose what specific practices, if any, payors utilize to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate. For purposes of this paragraph, a payor is deemed to have actively encouraged its beneficiaries to use the list of contracted providers if one of the following occurs:

(A) The payor's contract with subscribers or insureds offers beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information to its beneficiaries, who are parties to the contract, or, in the case of workers' compensation insurance, the employer, advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to beneficiaries in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or Internet web site addresses supplied directly to every beneficiary. However, internet web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of a beneficiary.

(3) Disclose whether payors to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the payors' beneficiaries to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.

(4) Disclose, upon the initial signing of a contract, and within 30 calendar days of receipt of a written request from a provider or provider panel, a payor summary of all payors currently eligible to claim a provider's contracted rate due to the provider's and payor's respective written agreement with any contracting agent.

(5) Allow providers, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care as described in paragraph (2). Each provider's election under this paragraph shall be binding on the contracting agent with which the provider has the contract and any contracting agent that buys, leases, or otherwise obtains the list of contracted providers. A provider shall not be excluded from any list of contracted providers that is sold, leased, transferred, or conveyed to payors that actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care, based upon the provider's refusal to be included on any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care.

(6) Nothing in this subdivision shall be construed to impose requirements or regulations upon payors, as defined in subparagraph (A) of paragraph (3) of subdivision ~~(d)~~ *(e)*.

(c) Beginning July 1, 2000, a payor, as defined in subparagraph (B) of paragraph (3) of subdivision ~~(d)~~ *(e)*, shall do all of the following:

(1) Provide an explanation of benefits or explanation of review that identifies the name of the network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered.

1 (2) Demonstrate that it is entitled to pay a contracted rate within
2 30 business days of receipt of a written request from a provider
3 who has received a claim payment from the payor. The failure of
4 a payor to make the demonstration within 30 business days shall
5 render the payor responsible for the amount that the payor would
6 have been required to pay pursuant to the applicable health care
7 service plan contract, including a specialized health care service
8 plan contract, covering the beneficiary, which amount shall be due
9 and payable within 10 business days of receipt of written notice
10 from the provider, and shall bar the payor from taking any future
11 discounts from that provider without the provider's express written
12 consent until the payor can demonstrate to the provider that it is
13 entitled to pay a contracted rate as provided in this paragraph. A
14 payor shall be deemed to have demonstrated that it is entitled to
15 pay a contracted rate if it complies with either of the following:
16 (A) Discloses the name of the network that has a written
17 agreement with the provider whereby the provider agrees to accept
18 discounted rates, and describes the specific practices the payor
19 utilizes to comply with paragraph (2) of subdivision (b).
20 (B) Identifies the provider's written agreement with a contracting
21 agent whereby the provider agrees to be included on lists of
22 contracted providers sold, leased, transferred, or conveyed to payors
23 that do not actively encourage beneficiaries to use the list of
24 contracted providers pursuant to paragraph (5) of subdivision (b).
25 *(d) To the extent permitted by federal law, beginning on the*
26 *date that the Health Care Data Organization is established by the*
27 *University of California pursuant to Title 22.5 (commencing with*
28 *Section 100800) of the Government Code, a payor, as defined in*
29 *subparagraph (B) of paragraph (3), of subdivision (e) shall provide*
30 *a copy of the explanation of benefits or explanation of review*
31 *provided pursuant to paragraph (1) of subdivision (c) to the Health*
32 *Care Data Organization.*
33 ~~(d)~~
34 *(e)* For the purposes of this section, the following terms have
35 the following meanings:
36 (1) "Beneficiary" means:
37 (A) For workers' compensation insurance, an employee seeking
38 health care services for a work-related injury.
39 (B) For automobile insurance, those persons covered under the
40 medical payments portion of the insurance contract.

(C) For group or individual health services covered through a health care service plan contract, including a specialized health care service plan contract, or a policy of disability insurance that covers hospital, medical, or surgical benefits, a subscriber, an enrollee, a policyholder, or an insured.

(2) "Contracting agent" means a health care service plan, including a specialized health care service plan, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying, a provider or provider panel to payors to provide health care services to beneficiaries.

(3) (A) For the purposes of subdivision (b), "payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries.

(B) For the purposes of ~~subdivision~~ *subdivisions* (c) *and (d)*, "payor" means only a health care service plan, including a specialized health care service plan that has purchased, leased, or otherwise obtained the use of a provider or provider panel to provide health care services to beneficiaries pursuant to a contract that authorizes payment at discounted rates.

(4) "Payor summary" means a written summary that includes the payor's name and the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan.

(5) "Provider" means any of the following:

(A) Any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) Any person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) Any person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200).

(E) Any entity exempt from licensure pursuant to Section 1206.

~~(e)~~

(f) This section shall become operative on July 1, 2000.

SEC. 4. Section 10178.3 of the Insurance Code is amended to read:

10178.3. (a) In order to prevent the improper selling, leasing, or transferring of a health care provider's contract, it is the intent of the Legislature that every arrangement that results in a payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel shall be disclosed to the provider in advance and that the payor shall actively encourage beneficiaries to use the network, unless the health care provider agrees to provide discounts without that active encouragement.

(b) Beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor, as defined in subparagraph (A) of paragraph (3) of subdivision ~~(d)~~ *(e)*, or another contracting agent shall, upon entering or renewing a provider contract, do all of the following:

(1) Disclose whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents, and specify whether those payors or contracting agents include workers' compensation insurers or automobile insurers.

(2) Disclose what specific practices, if any, payors utilize to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate. For purposes of this paragraph, a payor is deemed to have actively encouraged its beneficiaries to use the list of contracted providers if one of the following occurs:

(A) The payor's contract with subscribers or insureds offers beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information to its beneficiaries, who are parties to the contract, or, in the case of workers' compensation insurance, the employer, advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and

1 telephone numbers of contracted providers to beneficiaries in
2 advance of their selection of a health care provider, which
3 approaches may include, but are not limited to, the use of provider
4 directories, or the use of toll-free telephone numbers or Internet
5 Web site addresses supplied directly to every beneficiary. However,
6 Internet Web site addresses alone shall not be deemed to satisfy
7 the requirements of this subparagraph. Nothing in this subparagraph
8 shall prevent contracting agents or payors from providing only
9 listings of providers located within a reasonable geographic range
10 of a beneficiary.
11 (3) Disclose whether payors to which the list of contracted
12 providers may be sold, leased, transferred, or conveyed may be
13 permitted to pay a provider's contracted rate without actively
14 encouraging the payors' beneficiaries to use the list of contracted
15 providers when obtaining medical care. Nothing in this subdivision
16 shall be construed to require a payor to actively encourage the
17 payor's beneficiaries to use the list of contracted providers when
18 obtaining medical care in the case of an emergency.
19 (4) Disclose, upon the initial signing of a contract, and within
20 30 calendar days of receipt of a written request from a provider or
21 provider panel, a payor summary of all payors currently eligible
22 to claim a provider's contracted rate due to the provider's and
23 payor's respective written agreements with any contracting agent.
24 (5) Allow providers, upon the initial signing, renewal, or
25 amendment of a provider contract, to decline to be included in any
26 list of contracted providers that is sold, leased, transferred, or
27 conveyed to payors that do not actively encourage the payors'
28 beneficiaries to use the list of contracted providers when obtaining
29 medical care as described in paragraph (2). Each provider's election
30 under this paragraph shall be binding on the contracting agent with
31 which the provider has a contract and any other contracting agent
32 that buys, leases, or otherwise obtains the list of contracted
33 providers. A provider shall not be excluded from any list of
34 contracted providers that is sold, leased, transferred, or conveyed
35 to payors that actively encourage the payors' beneficiaries to use
36 the list of contracted providers when obtaining medical care, based
37 upon the provider's refusal to be included on any list of contracted
38 providers that is sold, leased, transferred, or conveyed to payors
39 that do not actively encourage the payors' beneficiaries to use the
40 list of contracted providers when obtaining medical care.

1 (6) Nothing in this subdivision shall be construed to impose
2 requirements or regulations upon payors, as defined in
3 subparagraph (A) of paragraph (3) of subdivision ~~(d)~~ *(e)*.
4 (c) Beginning July 1, 2000, a payor, as defined in subparagraph
5 (B) of paragraph (3) of subdivision ~~(d)~~ *(e)*, shall do all of the
6 following:
7 (1) Provide an explanation of benefits or explanation of review
8 that identifies the name of the network that has a written agreement
9 signed by the provider whereby the payor is entitled, directly or
10 indirectly, to pay a preferred rate for the services rendered.
11 (2) Demonstrate that it is entitled to pay a contracted rate within
12 30 business days of receipt of a written request from a provider
13 who has received a claim payment from the payor. The failure of
14 a payor to make the demonstration within 30 business days shall
15 render the payor responsible for the amount that the payor would
16 have been required to pay pursuant to the beneficiary's policy with
17 the payor, which amount shall be due and payable within 10
18 business days of receipt of written notice from the provider, and
19 shall bar the payor from taking any future discounts from that
20 provider without the provider's express written consent until the
21 payor can demonstrate to the provider that it is entitled to pay a
22 contracted rate as provided in this subdivision. A payor shall be
23 deemed to have demonstrated that it is entitled to pay a contracted
24 rate if it complies with either of the following:
25 (A) Discloses the name of the network that has a written
26 agreement with the provider whereby the provider agrees to accept
27 discounted rates, and describes the specific practices the payor
28 utilizes to comply with paragraph (2) of subdivision (b).
29 (B) Identifies the provider's written agreement with a contracting
30 agent whereby the provider agrees to be included on lists of
31 contracted providers sold, leased, transferred, or conveyed to payors
32 that do not actively encourage beneficiaries to use the list of
33 contracted providers pursuant to paragraph (5) of subdivision (b).
34 *(d) To the extent permitted by federal law, beginning on the*
35 *date that the Health Care Data Organization is established by the*
36 *University of California pursuant to Title 22.5 (commencing with*
37 *Section 100800) of the Government Code, a payor, as defined in*
38 *subparagraph (C) of paragraph (3) of subdivision (e) shall provide*
39 *a copy of the explanation of benefits or explanation of review*

provided pursuant to paragraph (1) of subdivision (c) to the Health Care Data Organization.

~~(d)~~

(e) For the purposes of this section, the following terms have the following meanings:

(1) "Beneficiary" means:

(A) For automobile insurance, those persons covered under the medical payments portion of the insurance contract.

(B) For group or individual health services covered through a health care service plan contract, including a specialized health care service plan contract, or a policy of disability insurance that covers hospital, medical, or surgical benefits, a subscriber, an enrollee, a policyholder, or an insured.

(C) For workers' compensation insurance, an employee seeking health care services for a work-related injury.

(2) "Contracting agent" means an insurer licensed under this code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, or workers' compensation insurance, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying a provider or provider panel to provide health care services to beneficiaries.

(3) (A) For the purposes of subdivision (b), "payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under this code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, or workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries.

(B) For the purposes of subdivision (c), "payor" means only an insurer licensed under this code to provide disability insurance that covers hospital, medical, or surgical benefits, or automobile insurance, if that insurer is responsible to pay for health care services provided to beneficiaries.

(C) For purposes of subdivision (d), "payor" means only an insurer licensed under this code to provide disability insurance that covers hospital, medical, or surgical benefits if that insurer is responsible to pay for health care services provided to beneficiaries.

(4) "Payor summary" means a written summary that includes the payor's name and the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan.

(5) "Provider" means any of the following:

(A) Any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) Any person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) Any person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(E) Any entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.

~~(e)~~

(f) This section shall become operative on July 1, 2000.

SEC. 5. Section 10178.4 of the Insurance Code is amended to read:

10178.4. (a) When a contracting agent sells, leases, or transfers a health provider's contract to a payor, the rights and obligations of the provider shall be governed by the underlying contract between the health care provider and the contracting agent.

(b) For purposes of this section, the following terms shall have the following meanings:

(1) "Contracting agent" has the meaning set forth in paragraph (2) of subdivision ~~(d)~~ *(e)* of Section 10178.3.

(2) "Payor" has the meaning set forth in paragraph (3) of subdivision ~~(d)~~ *(e)* of Section 10178.3.

SEC. 6. 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

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

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