KING & SPALDING

# Client Alert

Healthcare Practice Group

August 30, 2017

## California's Surprising New "No Surprise" Health Care Billing Law

As it "rolls out" over time, California's new "No Surprise" billing law will prohibit certain physicians and other clinicians from billing and collecting more than applicable deductibles and co-pays from their patients. Contrary to what many law firms' bulletins and articles say about the new law, it does not apply to all providers or to emergency services, and is not really a "balance billing" law. The law is addressed to individual health professionals ("IHPs")[i] who are *not* contracted with their patients' health plans or insurers but who practice at hospitals and other facilities that *are* contracted, i.e., "in-network."

Despite its nickname, the law includes many surprises: it is the first law to impose pricing terms on private health care providers, dictating that IHPs who are not contracted with their patients' health care service plans and insurers must accept discounted rates as payment in full. These rates will be either based on contracts that the payers negotiated at least two years ago with unknown and unrelated third parties or, in the unlikely event it is higher, 125% of Medicare fee-for-service rates. In essence, the law permits health plans and insurers to pay discounted rates to IHPs without a bargained-for exchange of benefits.

Thus, payers now have no incentive to contract with IHPs. According to Dietmar A. Grellmann of the California Hospital Association ("CHA"), this is contrary to the long-expressed legislative policy of encouraging negotiated contracting between private providers and payers.

The good news for non-contracted hospitals and other providers that are not IHPs, Mr. Grellmann also noted, is that the new law explicitly contradicts recent court and arbitration decisions that the reasonable value of non-contracted providers' services may be based on contract. The law re-confirms and emphasizes that contract and statutorily set rates are not equivalent to the "reasonable value" of medical services.

This article provides an overview of the more surprising parts of the new law and describes the impetus for it, the reimbursement limitations, problems it creates and expands, why it is not really a "balance billing law," IHPs' pending court challenge to its enforceability, its burdens on public tax dollars, and the silver lining it creates for some providers.

For more information, contact:

**Marcia L. Augsburger**
+1 916 321 4803
maugsburger@kslaw.com

**King & Spalding**
***Sacramento***
621 Capitol Mall
Suite 1500
Sacramento, CA 95814
Tel: +1 916 321 4800
Fax: +1 916 321 4900

**www.kslaw.com**

**Overview of the New Law**

The law began "rolling out" on July 1, 2017. That is, it only applies to services covered by health care service plans[ii] and insurance policies[iii] as and when they are issued, amended, or renewed on or after July 1, 2017. Thus, the law will apply to more and more health plans and insurers over time.

Specifically, the new law addresses "surprise billing" by (1) requiring that health plans and insurance policies limit enrollees' and insureds' liability for covered services they receive from non-contracted IHPs to the same cost-sharing amount that the patient would pay if the IHP were contracted,[iv] i.e., the "in-network cost-sharing amount"; and (2) providing that non-contracted IHPs may not bill or collect from these patients any more than this cost-sharing amount.[v]

But the legislature went far beyond addressing the concern about consumer surprise: it limited health plans' and insurers' liabilities for non-contracted IHP services to "the greater of the average contracted rate (what the plan or insurer pays contracted providers in the geographic region for the same or similar services) or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered."[vi] The "average contracted rate" is determined by rates in unrelated contracts in effect during the calendar year 2015.[vii]

Accordingly, as further described below, health plans and insurers will now receive the same discounts on IHP charges that they received from unrelated providers under 2015 contracts –and without being required to extend any of the benefits to the IHPs that they extended to the contracting parties. That is, the new law essentially rewards the payers who created the problem in the first place when they refused to pay IHPs' standard rates and/or to negotiate fair and reasonable contract terms, permitting them now to *force* IHPs to accept discounted rates as payment in full even though these rates were negotiated with other providers in very different situations and were provided in exchange for contract terms that benefitted the providers.

The legislature's justification for imposing limits on IHP recoveries from payers was that they were necessary to address the shortfalls between what IHPs billed and health plans and insurers paid. But limiting non-contracted IHP reimbursement was not "necessary" to address the shortfalls – the legislature could have simply required health plans and insurers to pay more. For example, the legislature could have required insurers to pay IHPs' standard charges unless they agreed otherwise. Alternatively, the legislature could have avoided the complexity of determining and imposing average contract rates and the unfairness of doing so without an exchange of benefits, by specifying that health plans and insurers must pay IHPs a more reasonable and common amount, e.g., 300% of Medicare. Or, the legislature could have created a reasonable value statute applicable to IHPs, like 28 Cal. Code of Reg. § 1300.71(a)(3)(B), which describes factors to be considered in determining reasonable value.

In fact, many physicians have said they would be willing to accept low rates in exchange for payers' agreements to pay those rates promptly without denials based on some retrospective medical necessity denial issued by a company staff member who was not present with the patient and was not the treating physician or based on unfounded accusations, unnecessary requests for medical records, incorrect assertions that claims were duplicative. These are the common experiences that, along with other red-tape, make it difficult for physicians to realize expected reimbursement under their contracts or stand firm on their rates in negotiations.

Instead of working toward a solution to the real underlying problems, the legislature chose to benefit health care service plans and insurance companies at IHPs' expense. Certainly the extent of this benefit to payers depends in part on whether two year old rates in contracts with strangers to IHPs or 125% of Medicare are higher than what health plans and insurers were paying to non-contracted IHPs. However, this does not appear to be the case. According to the Association of American Physicians & Surgeons, Inc., which recently filed a lawsuit challenging the constitutionality of

the new law, the law will limit the amount that non-contracted physicians can earn in their occupation, give rate-setting authority to private insurance companies, empower private insurance companies to deprive out-of-network physicians of the market value for their services, and arbitrarily deny them just compensation.

Industry professionals are concerned that the new law also portends further legislative attempts to set pricing for services rendered by other providers like hospitals. For now, however, the law expresses that the legislature will not make such attempts any time soon, and in fact, as noted, it provides new legal support for non-IHP providers like hospitals when they seek to recover the reasonable value of their services, as discussed further below. Typically, such providers argue that contract rates *do not* establish reasonable and customary values and payers argue the opposite. The new law resolves this in favor of providers, explicitly stating that its price-setting at the greater of average contract rates or 125% of Medicare is *not* to be considered reasonable and customary pricing as to non-IHP providers.

**Why IHPs Were Billing Patients**

Patients may have been surprised by the bills they were receiving, but health plans and insurers were not. The bills were a direct result of certain laws, industry practices, and realities that few consumers understand.

> *Health Plans and Insurance Companies Unilaterally Paid Less Than IHPs' Standard Charges, Often Based on Contracts Negotiated with Other Practitioners Who Received Important Benefits Under the Contracts in Exchange for Discounts.*

IHPs submitted bills to health plans and insurers for their full standard rates because they had no contract enticing or requiring them to do otherwise. In non-contracted situations, payers were legally required to pay IHPs the reasonable and customary amounts for the services. *See, e.g.*, 28 Cal. Code of Reg. § 1300.71(a)(3)(B). Because no contract offered benefits to IHPs in exchange for discounted rates, the reasonable and customary amounts for the services were generally higher than contract rates. Indeed, health care providers have shown in many legal actions against payers that contract rates are discounted only in exchange for non-rate related value to the providers, for example, a health plan's agreement to direct patients to the contracted providers for services, to pay bills within 15 days, or to pay 15% interest on late payments.

However, payers have also prevailed where judges and arbitrators failed to recognize the value of contract benefits to providers or ruled that even so, the reasonable and customary value of the services was equivalent to the contract rates. Therefore, payers continued refusing to pay IHPs' standard rates, arguing they were not reasonable and customary.

> *Why IHPs Didn't Just Solve The Problem By Contracting With Payers.*

Solo practitioners, IHPs, and small medical groups have long lacked sufficient bargaining power to negotiate favorable rates and contract terms with payers. These providers had little to offer health plans and insurers to incentivize them to pay more. Therefore, the payers demanded steep discounts without offering many benefits in exchange. In many cases, if not the vast majority, accepting the terms offered would mean business failure for physicians; the discounted rates would not allow small providers to make a living or cover their overhead. In fact, physicians are already earning less through Medicare and other payments on an inflation adjusted basis than they earned 10 and 20 years ago.

Hospitals and hospital systems can afford to contract because they have more bargaining power than small providers. For example, health plans are motivated to include certain hospitals in their networks to ensure their enrollees will have access to needed care in their geographical area, respond to enrollees' demands for access to care at particular hospitals, and avoid paying undiscounted rates for emergency and other care. Further, because hospital care can be much more expensive and potentially more critical than physician visits, having access to hospitals on an in-network basis is much

more important to payers and enrollees than having individual physicians be in-network. Thus, compared to hospitals, physicians have little to say when health plans and insurers demand steep discounts.

Hospitals cannot help IHPs with contracting and they cannot control IHPs' billing decisions. California law prohibits hospitals from employing or otherwise controlling physicians,[viii] and specifically prohibits hospitals from requiring physicians to contract with payers.[ix] Moreover, for various other state and federal regulatory reasons, hospitals may not bill for IHP services – IHPs must bill separately.

However, the new law could cause IHPs to take action the legislature would want even less than surprise billing: being forced to accept the legislatures' pricing terms because they are not contracted may prod them to join larger medical groups where they will have more bargaining power. The extent to which this will happen remains to be seen, but the effect it would have on health care costs is easily predictable.

> *No One Should Have Been Surprised That Consumers Received Bills For IHP Charges That Their Health Plans and Insurers Did Not Pay.*

Anyone familiar with the health care system should have known IHPs would stand by their undiscounted charges when payers refused to meaningfully negotiate contract terms and when payers took the position that their coverage agreements with their enrollees or members did not require them to pay IHPs' charges. Those who understand balance billing law should not have been surprised that IHPs would bill patients for the amounts payers said they did not owe. For example, Health and Safety Code §1340 provides, in pertinent part, that patients "shall not be liable to the provider for any sums **owed by the plan**." Once a plan took the position it did not owe the remaining billed charges, providers were free to bill their patients for the balance owed.

But IHP patients likely had no information about all of this. Thus, enrollees felt duped by hospitals and by their health plans and insurers.

Instead of educating consumers or addressing the underlying problems, such as by prohibiting payers from underpaying and incentivizing them to negotiate reasonable contract terms, the legislature set pricing to avoid "Surprise Billing." This only compounded the problems and created others, including taxpayer expense, as addressed below.

**The Reimbursement Limitations**

As mentioned above, reimbursement is limited, as to patients whose health plans or insurance policies were or are issued, amended, or renewed on or after July 1, 2017, to "the greater of the average contracted rate (what the plan or insurer pays contracted providers in the geographic region for the same or similar services) or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered."[x] This calculation is to be based on two or more year old contracts: those in effect during the calendar year 2015. For each calendar year after 2017, health plans and insurers must increase these rates based on the Consumer Price Index for Medical Care Services, as published by the United States Bureau of Labor Statistics.

Providing yet another benefit to health plans and insurers, devising methodologies to determine the average contracted rate for services subject to the new law is left to these payers.[xi] They were required to provide these methodologies to the DMHC and the Commissioner by July 1, 2017, along with data listing the average contracted rates for services most frequently subject to the new law in each geographic region in which the services are rendered for the calendar year 2015 and the policies and procedures used to determine the average contracted rates. The only constraint on the payers

is that the methodologies must ensure that the highest and lowest contracted rates for the calendar year 2015 are included in determining the average contracted rate.

Health plans and insurers will continue to pay IHPs based on these "average" contracted rates until January 1, 2019. At that time, the DMHC and Commissioner must specify a methodology that plans and insurers will use to determine the "average contracted rate," as further described below.

**Why Contract Rates Are an Inadequate and Improper Tool for Getting to "Reasonable and Customary Value"**

Under the new law, IHPs must accept payment "in an amount that is the greater of the average contracted rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered." Most hospital physicians' contract rates are closer to 180-200% of Medicare depending on the IHP's specialty and other factors. Thus, in most situations, IHPs will be required to accept the average of contract rates that health plans and insurers negotiated with unrelated parties in 2014 and/or 2015. These contracts may not even set rates for services similar to those rendered by the IHPs, and/or may not account for quality, availability in the community, the providers' training and length of time in practice, special skills or other circumstances.

The IHPs will never know what was considered in negotiating the rates they must now accept. The identities of the parties to these contracts will also most certainly be unknown to IHPs; contracts between plans or insurers and providers are considered highly confidential and proprietary and contain strong confidentiality provisions.

Imposing pricing on IHPs who are entitled to the reasonable value of their services seems contrary to Title 28 Cal. Code of Reg. § 1300.71(a)(3)(B), which provides:

> For contracted providers without a written contract and non-contracted providers, …the payment of the reasonable and customary value for the health care services rendered [is] based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case[.]

The rates dictated by the new law are not based on statistically credible information that is updated at least annually and based on the above factors; they are based on health plans' and insurers' calculations of average contract rates in what the payers decide is the "general geographic region" as where services were provided – a term open to broad interpretation and application.

Thus, instead of paying IHPs the reasonable value of their services, as required by Title 28 Cal. Code of Reg. § 1300.71(a)(3)(B) or their billed charges or undiscounted rates, health plans and insurers may pay the IHPs as if they had entered into a contract under which the IHP provided discounts in exchange for benefits like volume guaranties or prompt payment. That is, because contract rates are generally much less than standard provider rates, paying less than standard rates is not only permissible – IHPs are statutorily required to accept them in a non-contracted situation. Health plans and insurance companies, therefore, now have even less incentive to contract with IHPs, and IHPs have even less bargaining power than ever.

**The New Law Also Limits IHPs' Abilities to Bill and Collect Out-Of-Network Patient Cost Shares**

The new law imposes another surprising requirement on non-contracted IHPs. It provides that where enrollees' plans or policies *include coverage* for out-of-network benefits, the non-contracting IHP may only bill or collect the patient's out-of-network cost share if (1) the IHP, not a facility representative, obtained (2) written consent from the patient (3) 24 hours before services are rendered and not while the patient was being admitted or prepared for a procedure; (4) in a document separate from other consents (5) accompanied by a written estimate of the patient's total out-of-pocket cost of care based on the professional's billed charges for the service to be provided.[xii]

This requirement is surprisingly burdensome and appears calculated to either prevent non-contracted IHPs from collecting patient cost-shares or to contract with payers for even less than their average contracted rates or 12% of Medicare. Many physicians will consider it unethical to be dealing with financial matters directly with a patient and will simply refuse to do so. Many IHPs will not see patients so far in advance. Patients with scheduled services are rarely if ever admitted 24 hours before services are rendered. Likewise, patients with urgent or critical medical needs are rarely admitted so far in advance and are commonly incapacitated. In these situations, any written consent the IHP may be able to obtain probably will be unenforceable based on lack of capacity or duress. Thus, the consent provisions effectively preclude non-contracted IHPs from collecting anything from patients in most situations.

**The Next Roll-Out Phase: State Agencies Will Regulate Pricing of IHP Services**

Health plans and insurers will not be permitted to set prices forever; the law transfers that right to the DMHC and the Commissioner effective January 1, 2019. Between now and then, these government entities will collect information to help them specify a methodology that plans and insurers must use to determine the "average contracted rate." Cal. Health & Safety Code § 1371.31 and Cal. Ins. Code § 10112.82. This will include the plan's and/or insurer's highest and lowest contracted rates (which will remain confidential and not be subject to the California Public Records Act), the policies and procedures the plans and insurers use to determine the average contracted rates, and information they expect to come from the dispute resolution processes described below.

Presumably, the government bodies will also consider cost and loss information from IHPs, and California law on determining reasonable value, described below. However, the new law does not require this.

Indeed, the new law does not even require the DMHC and Insurance Commissioner to consider the factors set out in Title 28 Cal. Code of Reg. § 1300.71(a)(3)(B), including the provider's training, qualifications, and length of time in practice, the nature of the services provided, and other factors listed above. This could lead to patients being denied care by specialists and other non-contracted IHPs who cannot afford to provide services at non-specialist rates. This illustrates the risk of unintended consequences the new law poses.

> *Dispute Resolution Process: A Research Tank for the DMHC and Insurance Commissioner to Reset Prices January 1, 2019?*

Health and Safety Code § 1371.30 and Insurance Code section 10112.81 dictate that the DMHC and the Commissioner develop dispute resolution processes to resolve claims disputes between health plans and IHPs and between insurers and IHPs.[xiii] When available, the new processes may make challenging health plans' and insurers' denials and underpayments less expensive and time consuming for IHPs than litigation, thereby encouraging more IHPs to take action when their claims are denied or underpaid. However, given the rate setting in the new law, it is more likely that IHPs will not use the process. IHPs may feel they cannot win, given that the 2015 contract rates seem to create a presumption or legislative expression of support for payers, and fighting for more money may cost more in attorneys' fees and practice interruption expenses than the IHPs could recover.

The new law does not address this very important factor when it comes to IHP decisions to arbitrate: What party must pay for the process? Requiring the losing party to pay may discourage frivolous arbitrations or unreasonable positions, but the specter of bearing the costs may discourage valid and important claims – especially if a party could be required to pay the other parties' costs or attorneys' fees. Arbitration is often as prohibitively expensive for physicians as going to court. Lawyers have to spend the same amount of time analyzing and preparing the case, and arbitrators generally charge $800 or more per hour, at least in private arbitrations.

Thus, if IHPs were reluctant to pursue payers before the new law because the costs were greater than the potential benefits, they will likely be more reluctant now when the cards seem stacked against them. How the DMHC and Insurance Commissioner will gather sufficient information through this process to determine what payers' pricing methodologies should be remains to be seen.

**Physicians' Challenges to the Constitutionality of the New Law**

To IHPs, this law first permits profit-motivated health plans and insurers, who the physicians view as unfair competitors, to unilaterally determine physicians' income and viability, and then permits the government to regulate pricing in the extremely complex health care industry. Not surprisingly, in October, 2016, the Association of American Physicians & Surgeons, Inc. ("Association"), filed a lawsuit in the United States District Court for the Eastern District of California challenging the constitutionality of this new law. Specifically, the Association alleges that the new law limits the amount that non-contracted physicians may make in violation of the due process clause of the U.S. and California constitutions by delegating rate-setting authority to private insurance companies and by requiring physicians to arbitrate rather than to have their "day in court." The Association also alleges violation of Takings Clause of the U.S. and state constitutions because it empowers private insurance companies to deprive out-of-network physicians of the market value for their services and arbitrarily denies them just compensation. Further, the Association alleges that the law violates the Equal Protection Clauses of the constitutions in that it imposes a disparate impact on minority patients for whom availability of medical care will sharply decline as out-of-network physicians are coerced to withdraw services from predominately minority communities.

The Association did not obtain injunctive relief to stop implementation of the law. Rather it appears to be on the defensive; a motion by the government to dismiss the case was scheduled for August 10, 2017. However, as of this writing, the motion has been taken off calendar.

**A Potential Silver Lining for Non-Contracted Hospitals and Emergency Service Providers**

As noted above, in a non-contracted situation, especially where emergency services are provided out-of-network, health plans and insurers often argue that what they pay other providers under written contracts constitutes the reasonable value of the services. Providers counter that contracted rates are fundamentally different than the rates that should apply in a non-contracted situation because, for example, contracts provide discounts because other terms provide value, such as volume guaranties, the promise of encouraging patients to seek scheduled services from the providers, or an agreement to pay promptly. The first part of the new law raises concern for non-IHP non-contracted providers, e.g., hospitals, that courts or arbitrators may require them to accept average contract rates or 125% of Medicare as the reasonable value of their services.

However, the new law provides strength to the argument that these rates are *not* the reasonable and customary amounts for non-IHP providers: it states that notwithstanding any other law, the contracted rates paid by plans and/or insurers for services under the new law "shall not constitute the prevailing or customary charges, the usual fees to the general public, or other charges for other payers for an [IHP]." Cal. Health & Safety Code § 1371.319(d)(2); Cal. Ins. Code §

10112.82(d)(2). This is an important statement by the legislature that despite health plans' arguments to the contrary; what they pay under contracts with other providers does *not* establish the reasonable and customary pricing.

This is consistent with legislative expressions contained in what is known as California's Charity Care Law, Health and Safety Code §§ 127400 *et seq*. In brief, this law requires that hospitals limit expected payment for services they provide to patients at or below 350% of the federal poverty level to the greater of what the hospitals would expect to receive from Medicare, Medi-Cal, the Healthy Families Program, or another government-sponsored health program.[xiv] While this is not rate setting like the new "no surprise" law and does not create a contract for hospitals, it does limit their recovery in a non-contracted situation. Still, the legislature ensured that the reimbursement the Charity Care law required hospitals to accept would not be used to establish reasonable charges in other contexts.[xv].

**The Relationship of the New Law to "Balance Billing"**

The practice of "balance billing" was addressed in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 45 Cal. 4th 497, 507 (2009). In *Prospect*, the California Supreme Court ruled that when patients present for emergency treatment, non-contracted emergency room doctors who treat them may not directly bill the patients for the difference between their billed charges and payments they receive from health plans. Rather, "billing disputes over emergency medical care must be resolved solely between the emergency room doctors, who are entitled to a reasonable payment for their services, and the HMO, which is obligated to make that payment." This ruling was based on a variety of statutes, including Health and Safety Code §1340, which provides, in pertinent part, that patients "shall not be liable to the provider for any sums owed by the plan," that contracting providers may not collect or attempt to collect from patients any fees owed by the plan, and "[n]o contracting provider, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the plan."

Thus, balance billing precludes providers from collecting amounts owed by health plans in emergency, non-contracted situations. The new law also precludes IHPs from collecting any amounts from patients that exceed co-pays and deductibles, but also reduces the amounts owed by health plans so that the "balance" is less. The new law is unnecessary to ban IHPs from billing and collecting monies from enrollees. Further, neither *Prospect* nor Health and Safety Code §1340 create rate terms where there are no contracts between health plans or insurers and providers. The new law provides for rate setting initially by plans and insurers and later, beginning in 2019, by the DMHC and Commissioner. It is either not a "balance billing" statute or it is a "balance billing" statute "on steroids."

**Conclusion**

California's new "no-surprise billing" law limits not only what IHPs can bill patients but also the amounts non-contracted IHPs can collect from patients' health care service plans and insurance companies. That is, the law imposes pricing terms on private health care providers. This is a first. While it is the legislature's prerogative to allocate risk among medical service providers, HMOs, and insurers, absent a constitutional violation, the complexities and potential for unintended consequences of legislation affecting health care pricing makes the new law frightening. Allocating risk is quite different than legislative price-setting in a complex market like healthcare. Price-setting affects the availability and quality of treatment and the strength of our healthcare delivery system.

Further, despite lawmakers' expressed policy of encouraging contracting between private providers and payers, the new law discourages contracting. It permits health plans and insurers to pay discounted rates negotiated with third parties without having to provide any contract benefits to IHPs in exchange. Such a windfall for these payers was not necessary to address the problem of surprise *patient* billings. Moreover, the new law contradicts other California law, for example the law that obligates commercial health plans and insurers to pay non-contracted providers the reasonable value of their services and that defines "reasonable value" as based on multiple factors.

The one pleasant surprise is that the law explicitly confirms for out-of-network hospitals and other providers that the reasonable value of their services cannot be determined by looking to rates in contracts between payers and other parties.



[i] "Individual health professional" means a physician and surgeon or other professional who is licensed by this state to deliver or furnish health care services, except dentists. Cal. Health & Safety Code § 1371.9 (f)(3); Cal. Ins. Code § 10112.8(f)(3)."

[ii] These plans, i.e., health care coverage contracts, are issued by Health Care Service Plans, which are also known as Health Maintenance Organizations or "HMOs" ("HCSPs"). Health plans are governed by the California Health and Safety Code. Therefore, the new law that governs these health plans is codified in the Health & Safety Code, specifically at §§ 1371.9, 1371.30, and 1371.31. The California Department of Managed Healthcare ("DMHC") enforces the regulations applicable to health plans.

[iii] Insurance companies, including those that issue PPO and indemnity products, are governed by the California Insurance Code. Therefore, the new law that governs health insurers is codified in the Insurance Code, specifically at §§ 10112.8, 10112.81 and 10112.82. The California Insurance Commissioner ("Commissioner") enforces the Insurance Code.

[iv] Cal. Health & Safety Code §§ 1371.9, 1371.30, and 1371.31; Cal. Ins. Code §§ 10112.8, 10112.81 and 10112.82.

[v] Cal. Health & Safety Code § 1371.9.

[vi] The limitations on what non-contracted IHPs can recover apply to services rendered subject to Health & Safety Code § 1371.9 and Cal. Ins. Code § 10112.8, except where patients have out-of-network benefits and *voluntarily choose* to use them (in which case the plan or insurer pays the amount set forth in the patient's plan or policy unless otherwise agreed by the plan or insurer and the IHP).

[vii] Health plans and insurers must increase these rates each calendar year after July 1, 2017, based on the Consumer Price Index for Medical Care Services, as published by the United States Bureau of Labor Statistics.

[viii] California's ban against the corporate practice of medicine precludes this. *See* Cal. Bus. & Prof. Code § 2400; 16 Cal. Code Regs § 1340; California Research Bureau, The Corporate Practice of Medicine in a Changing Healthcare Environment, (April, 2016), http://www.library.ca.gov/crb/16/CRB_CPM_Final.pdf

[ix] Cal. Health & Saf. Code § 1322 prohibits hospitals that contract with an insurer, nonprofit hospital service plan, or health care service plan from determining or conditioning medical staff membership or clinical privileges on the physicians' participation or nonparticipation in a contract with that insurer, hospital service plan, or health care service plan.

[x] The limitations on what non-contracted IHPs can recover apply to services rendered subject to Health & Safety Code § 1371.9 and Cal. Ins. Code § 10112.8, except where patients have out-of-network benefits and voluntarily choose to use them (in which case the plan or insurer pays the amount set forth in the patient's plan or policy unless otherwise agreed by the plan or insurer and the IHP).

[xi] Health & Safety Code § 1371.8 and Cal. Ins. Code § 10112.8.

[xii] The consent form must also advise the patient that he or she may elect to seek care from a contracted provider or may contact his or her plan or insurer to arrange to receive the services from a contracted IHP for lower out-of-pocket costs, and that any costs incurred as a result of the patient's use of the out-of-network benefit will be in addition to in-network cost-sharing amounts and may not count toward the annual out-of-pocket maximum on in-network benefits or a deductible, if any, for in-network benefits. The law also requires the non-contracting IHP to refund any overpayments to the enrollee within 30 calendar days after receiving a payment that is in excess of the applicable cost share. Late refunds must automatically include interest at 15%. IHPs should review the statutes to ensure compliance with all requirements. For example, the statutes include such detailed specifics as the 12-point font required for communications from the non-contracting IHP to enrollees that the communication is not a bill and that the enrollee should not pay until the health care service plan informs the enrollee of any applicable cost share. Health & Saf. Code § 1371.9(a)(3); Cal. Ins. Code § 10112.8(a)(3).

[xiii] These processes must be developed by September 1, 2017. Where patients voluntarily choose to use their out-of-network benefit for services covered by a health plan or an insurer that includes coverage for out-of-network benefits and payment is in the amount set forth in the insured's policy, it is not subject to the independent dispute resolution processes.

[xiv] Health and Safety Code § 127405(d).

[xv] Health and Safety Code § 127443.