Assembly Bill No. 290

CHAPTER 862

An act to add Sections 1210, 1367.016, and 1385.09 to the Health and Safety Code, and to add Sections 10176.11 and 10181.8 to the Insurance Code, relating to health care coverage.

[Approved by Governor October 13, 2019. Filed with Secretary of State October 13, 2019.]

LEGISLATIVE COUNSEL'S DIGEST

AB 290, Wood. Health care service plans and health insurance: third-party payments.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. These provisions govern, among other things, procedures by health care service plans and insurers with respect to premium payments.

This bill would require a health care service plan or an insurer that provides a policy of health insurance to accept payments from specified third-party entities, including an Indian tribe or a local, state, or federal government program. The bill would also require a financially interested entity, as defined, other than those entities, that is making a third-party premium payment to provide that assistance in a specified manner and to perform other related duties, including disclosing to the plan or the insurer the name of the enrollee or insured, as applicable, for each plan or policy on whose behalf a third-party premium payment will be made. The bill would require each plan or insurer to provide to the appropriate department information regarding premium payments by financially interested entities and reimbursement for services to providers, and would set forth standards governing the reimbursement of financially interested providers, including, but not limited to, chronic dialysis clinics, that meet certain criteria. Commencing January 1, 2022, the bill would require reimbursement to contracted providers to be the higher of the Medicare reimbursement rate or the rate determined pursuant to an independent dispute resolution process, as established by the bill, if either party seeks a rate determination pursuant to that process, and would require reimbursement for noncontracted providers to be governed by the terms and conditions of the health care service plan contract or health insurance policy, or the rate determined pursuant to the dispute resolution process, as prescribed. The reimbursement rates and dispute resolution process established by the bill would not apply to reimbursement for an enrollee or insured on behalf of whom a financially

interested provider was already making premium payments to a health care service plan or insurer on or before October 1, 2019, except under specified circumstances. The bill would not alter existing obligations and requirements applicable to a health care service plan or health insurer relating to offering, marketing, selling, and issuing a health benefit plan, and cancellation or nonrenewal, as specified. The bill would specify that its requirements do not supersede or modify any privacy and information security requirements and protections in federal and state law regarding protected health information or personally identifiable information. The bill would declare that an enrollee's or insured's loss of coverage due to a financially interested entity's failure to pay premiums on a timely basis would be deemed a triggering event to allow for special enrollment, requiring a health care service plan or health insurer to allow an individual to enroll in or change individual health benefit plans, as specified.

Existing law establishes requirements for the licensure and regulation of clinics by the State Department of Public Health, which include certain types of specialty clinics, such as chronic dialysis clinics, as defined. A violation of these provisions is a crime.

This bill would prohibit a chronic dialysis clinic from steering, directing, or advising a patient regarding any specific coverage program option or health care service plan contract. The bill would require a chronic dialysis clinic to post a notice requiring questions about Medicare coverage for patients with end stage renal disease to be directed to the Health Insurance Counseling and Advocacy Program, as specified.

This bill would make certain of its provisions operative, for specified financially interested entities, on July 1, 2020, or upon a finding by the United States Department of Health and Human Services Office of Inspector General that compliance by the financially interested entities with those provisions does not violate federal law, as specified.

By expanding the requirements applicable to chronic dialysis clinics, and because a willful violation of certain of the bill's requirements by a health care service plan would be a crime, this 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.

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

SECTION 1. The Legislature finds and declares as follows:

(a) There has been a rapid increase in the practice of certain health care providers and provider-funded groups paying health insurance premiums in California's individual and group health insurance markets on behalf of

consumers with very high-cost conditions such as end stage renal disease and addiction to alcohol or drugs.

(b) These third-party payment arrangements have proliferated in recent years as a result of health care providers that have demonstrated a willingness to exploit the Affordable Care Act's guaranteed issue rules for their own financial benefit.

(c) Encouraging patients to enroll in commercial insurance coverage for the financial benefit of the provider may result in an unjust enrichment of the financially interested provider at the expense of consumers purchasing health insurance. This practice can also expose patients to direct harm.

(d) According to the federal Centers for Medicare and Medicaid Services, patients caught up in these schemes may face higher out-of-pocket costs and mid-year disruptions in coverage, and may have a more difficult time obtaining critical care such as kidney transplants.

(e) Consumers also pay higher health insurance premiums due to the distortion of the insurance risk pool caused when providers steer patients into particular health insurance plans with the promise of having the patients' premiums paid. Nationally, this problem has added billions of dollars of costs to the individual and group health insurance markets.

(f) Certain residential substance use disorder treatment facilities have induced patients to enroll in health insurance with assurances that the treatment center will pay the patients' health insurance premiums. In some cases, patients were not even informed that health insurance was being purchased on their behalf. According to news reports, at the end of their treatment benefit, patients are sometimes stranded far from home and enter a cycle of homelessness.

(g) Large dialysis organizations control 77 percent of California's dialysis clinics, and this market concentration has risen dramatically in recent years. Nationally, the two largest dialysis companies account for 92 percent of all dialysis industry revenue. These companies systematically exert their market dominance to command commercial reimbursement rates that are many times the cost associated with providing care.

(h) Large dialysis companies contribute more than 80 percent of the revenue to a nonprofit that pays health insurance premiums for patients on dialysis for kidney failure. In turn, this nonprofit generates hundreds of millions of dollars for large dialysis organizations by artificially increasing the number of their patients who have commercial insurance coverage.

(i) It is the intent of the Legislature in enacting this act to protect the sustainability of risk pools within the individual and group health insurance markets, shield patients from potential harm caused by being steered into coverage options that may not be in their best interest and to correct a market failure that has allowed large dialysis organizations to use their oligopoly power to inflate commercial reimbursement rates and unjustly drive up the cost of care.

(j) It is the intent of the Legislature that the delayed implementation and conditional nature of certain provisions of this act will allow the American Kidney Fund to request an updated advisory opinion from the United States

Department of Health and Human Services Office of Inspector General for the purposes of protecting patients in California.

SEC. 2. Section 1210 is added to the Health and Safety Code, to read:

1210. (a) A chronic dialysis clinic shall not steer, direct, or advise a patient regarding any specific coverage program option or health care service plan contract.

(b) A chronic dialysis clinic shall post a notice in a prominent location visible to all patients displayed in large font type that questions about Medicare coverage for patients with end stage renal disease should be directed to the Health Insurance Counseling and Advocacy Program or HICAP at 1-800-434-0222.

SEC. 3. Section 1367.016 is added to the Health and Safety Code, to read:

1367.016. (a) A health care service plan shall accept premium payments from the following third-party entities without the need to comply with subdivision (c):

(1) A Ryan White HIV/AIDS Program under Title XXVI of the federal Public Health Service Act.

(2) An Indian tribe, tribal organization, or urban Indian organization.

(3) A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf.

(4) A member of the individual's family, defined for purposes of this section to include the individual's spouse, domestic partner, child, parent, grandparent, and siblings, unless the true source of funds used to make the premium payment originates with a financially interested entity.

(b) A financially interested entity that is not specified in subdivision (a) and is making third-party premium payments shall comply with all of the following requirements:

(1) It shall provide assistance for the full plan year and notify the enrollee prior to an open enrollment period, if applicable, if financial assistance will be discontinued. Notification shall include information regarding alternative coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans, if applicable. Assistance may be discontinued at the request of an enrollee who obtains other health coverage, or if the enrollee dies during the plan year.

(2) It shall agree not to condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device.

(3) It shall inform an applicant of financial assistance, and shall inform a recipient annually, of all available health coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans, if applicable.

(4) It shall agree not to steer, direct, or advise the patient into or away from a specific coverage program option or health care service plan contract.

(5) It shall agree that financial assistance shall not be conditioned on the use of a specific facility, health care provider, or coverage type.

(6) It shall agree that financial assistance shall be based on financial need in accordance with criteria that are uniformly applied and publicly available.

(c) A financially interested entity shall not make a third-party premium payment unless the entity complies with both of the following requirements:

(1) Annually provides a statement to the health care service plan that it meets the requirements set forth in subdivision (b), as applicable.

(2) Discloses to the health care service plan, prior to making the initial payment, the name of the enrollee for each health care service plan contract on whose behalf a third-party premium payment described in this section will be made.

(d) (1) Reimbursement for enrollees for whom a nonprofit financially interested entity described in paragraph (2) of subdivision (h) that was already making premium payments to a health care service plan on the enrollee's behalf prior to October 1, 2019, is not subject to subdivisions (e) and (f) and the financially interested entity is not required to comply with the disclosure requirements described in subdivision (c) for those enrollees.

(2) Notwithstanding paragraph (1), a financially interested entity shall comply with the disclosure requirements of subdivision (c) for an enrollee on whose behalf the financially interested entity was making premium payments to a health care service plan on the enrollee's behalf prior to October 1, 2019, if the enrollee changes health care service plans on or after March 1, 2020.

(3) The amount of reimbursement for services paid to a financially interested provider shall be governed by the terms of the enrollee's health care service plan contract, except for an enrollee who has changed health care service plans pursuant to paragraph (2), in which case, commencing January 1, 2022, the reimbursement amount shall be determined in accordance with subdivisions (e) and (f).

(e) Commencing January 1, 2022, if a financially interested entity makes a third-party premium payment to a health care service plan on behalf of an enrollee, reimbursement to a provider who is also a financially interested entity for covered services provided shall be determined by the following:

(1) For a contracted financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the enrollee shall be the higher of the Medicare reimbursement or the rate determined pursuant to the process described in this subdivision, if a rate determination pursuant to that process is sought by either the provider or the health care service plan. Financially interested providers shall neither bill the enrollee nor seek reimbursement from the enrollee for services provided, except for cost sharing pursuant to the terms and conditions of the enrollee's health care service plan contract. If an enrollee's contract imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health care service plan pursuant to this paragraph.

(2) For a noncontracting financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for

covered services that shall be paid to the financially interested provider on behalf of the enrollee shall be governed by the terms and conditions of the enrollee's health care service plan contract or the rate determined pursuant to the process described in this subdivision, whichever is lower, if a rate determination pursuant to that process is sought by either the provider or the health care service plan. Financially interested providers shall neither bill the enrollee nor seek reimbursement from the enrollee for services provided, except for cost sharing pursuant to the terms and conditions of the enrollee's health care service plan contract. If an enrollee's contract imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health care service plan pursuant to this paragraph. A claim submitted to a health care service plan by a noncontracting financially interested provider may be considered an incomplete claim and contested by the health care service plan pursuant to Section 1371 or 1371.35 if the financially interested provider has not provided the information as required in subdivision (c).

(f) (1) By October 1, 2021, the department shall establish an independent dispute resolution process for the purpose of determining if the amount required to be reimbursed by subdivision (e) is appropriate.

(2) If either the provider or health care service plan submits a claim to the department's independent dispute resolution process, the other party shall participate in the independent dispute resolution process.

(3) In making its determination, the independent organization shall consider information submitted by either party regarding the actual cost to provide services, patient eligibility for Medicare or Medi-Cal, and the rate that would be paid by Medicare or Medi-Cal for patients eligible for those programs.

(4) The health care service plan shall implement the determination obtained through the independent dispute resolution process. The independent organization's determination of the amount required to be reimbursed shall apply for the duration of the plan year for that enrollee. If dissatisfied, either party may pursue any right, remedy, or penalty established under any other applicable law.

(5) In establishing the independent dispute resolution process, the department shall permit the bundling of claims submitted to the same plan or the same delegated entity for the same or similar services. The department shall permit claims on behalf of multiple enrollees from the same provider to the same health care service plan to be combined into a single independent dispute resolution process.

(6) The department shall establish uniform written procedures for the submission, receipt, processing, and resolution of claim payment disputes pursuant to this section and any other guidelines for implementing this section.

(7) The department shall establish reasonable and necessary fees not to exceed the reasonable costs of administering this subdivision.

(8) The department may contract with one or more independent organizations to conduct the proceedings. The independent organization handling a dispute shall be independent of either party to the dispute.

(9) The department shall use conflict-of-interest standards consistent with the standards pursuant to subdivisions (c) and (d) of Section 1374.32.

(10) The department may contract with the same independent organization or organizations as the Department of Insurance.

(11) The independent organization retained to conduct proceedings shall be deemed to be consultants for purposes of Section 43.98 of the Civil Code.

(12) Contracts entered into pursuant to the authority in this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(13) This subdivision does not alter a health care service plan's obligations under Section 1371.

(14) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-plan letters or similar instructions, without taking regulatory action, until regulations are adopted.

(g) For the purposes of this section, third-party premium payments only include health care service plan premium payments made directly by a provider or other third party, made indirectly through payments to the individual for the purpose of making health care service plan premium payments, or provided to one or more intermediaries with the intention that the funds be used to make health care service plan premium payments for the individuals.

(h) The following definitions apply for purposes of this section:

(1) "Enrollee" means an individual whose health care service plan premiums are paid by a financially interested entity.

(2) "Financially interested" includes any of the following entities:

(A) A provider of health care services that receives a direct or indirect financial benefit from a third-party premium payment.

(B) An entity that receives the majority of its funding from one or more financially interested providers of health care services, parent companies of providers of health care services, subsidiaries of health care service providers, or related entities.

(C) A chronic dialysis clinic that is operated, owned, or controlled by a parent entity or related entity that meets the definition of a large dialysis clinic organization (LDO) under the federal Centers for Medicare and Medicaid Services Comprehensive ESRD Care Model as of January 1, 2019. A chronic dialysis clinic that does not meet the definition of an LDO or has no more than 10 percent of California's market share of licensed chronic dialysis clinics shall not be considered financially interested for purposes of this section.

(3) "Health care service plan contract" means an individual or group health care service plan contract that provides medical, hospital, and surgical benefits, except a specialized health care service plan contract. The term does not include coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, long-term care insurance, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation law or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(4) "Provider" means a professional person, organization, health facility, or other person or institution that delivers or furnishes health care services.

(i) The following shall occur if a health care service plan subsequently discovers that a financially interested entity fails to provide disclosure pursuant to subdivision (c):

(1) The health care service plan shall be entitled to recover 120 percent of the difference between a payment made to a provider and the payment to which the provider would have been entitled pursuant to subdivision (e), including interest on that difference.

(2) The health care service plan shall notify the department of the amount by which the provider was overpaid and shall remit to the department any amount exceeding the difference between the payment made to the provider and the payment to which the provider would have been entitled pursuant to subdivision (e), including interest on that difference that was recovered pursuant to paragraph (1).

(j) Commencing January 1, 2022, each health care service plan licensed by the department and subject to this section shall provide to the department information regarding premium payments by financially interested entities and reimbursement for services to providers under subdivision (e). The information shall be provided at least annually at the discretion of the department and shall include, to the best of the health care service plan's knowledge, the number of enrollees whose premiums were paid by financially interested entities, disclosures provided to the plan pursuant to subdivision (c), the identities of any providers whose reimbursement rate was governed by subdivision (e), the identities of any providers who failed to provide disclosure as described in subdivision (c), and, at the discretion of the department, additional information necessary for the implementation of this section.

(k) This section does not limit the authority of the Attorney General to take action to enforce this section.

(*l*) This section does not affect a contracted payment rate for a provider who is not financially interested.

(m) This section does not alter any of a health care service plan's obligations and requirements under this chapter, including, but not limited to, the following:

(1) The obligation of a health care service plan to fairly and affirmatively offer, market, sell, and issue a health benefit plan to any individual,

consistent with Article 11.8 (commencing with Section 1399.845), or small employer, consistent with Article 3.1 (commencing with Section 1357).

(2) The obligations of a health care service plan with respect to cancellation or nonrenewal as provided in this chapter, including, but not limited to, Section 1365.

(3) A health care service plan may not deny coverage to an enrollee whose premiums are paid by a third party.

(n) This section does not supersede or modify any privacy and information security requirements and protections in federal and state law regarding protected health information or personally identifiable information, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg).

(o) Notwithstanding clause (iii) of subparagraph (A) of paragraph (1) of subdivision (d) of Section 1399.849, an enrollee's loss of coverage due to a financially interested entity's failure to pay premiums on a timely basis shall be deemed a triggering event for special enrollment pursuant to subparagraph (A) of paragraph (1) of subdivision (d) of Section 1399.849.

SEC. 4. Section 1385.09 is added to the Health and Safety Code, to read:

1385.09. A health care service plan contract subject to Section 1385.03 or 1385.04 shall file a separate schedule documenting the cost savings associated with Section 1367.016 and the impact on rates.

SEC. 5. Section 10176.11 is added to the Insurance Code, to read:

10176.11. (a) An insurer that provides a policy of health insurance shall accept premium payments from the following third-party entities without the need to comply with subdivision (c):

(1) A Ryan White HIV/AIDS Program under Title XXVI of the federal Public Health Service Act.

(2) An Indian tribe, tribal organization, or urban Indian organization.

(3) A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf.

(4) A member of the individual's family, defined for purposes of this section to include the individual's spouse, domestic partner, child, parent, grandparent, and siblings, unless the true source of funds used to make the premium payment originates with a financially interested entity.

(b) A financially interested entity that is not specified in subdivision (a) and is making third-party premium payments shall comply with all of the following requirements:

(1) It shall provide assistance for the full policy year and notify the insured prior to an open enrollment period, if applicable, if financial assistance will be discontinued. Notification shall include information regarding alternative coverage options, including, but not limited to, Medicare, Medicaid, individual market policies, and employer policies, if applicable. Assistance may be discontinued at the request of an insured who obtains other health insurance coverage, or if the insured dies during the policy year.

(2) It shall agree not to condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device.

(3) It shall inform an applicant of financial assistance, and shall inform an insured annually, of all available health coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans, if applicable.

(4) It shall agree not to steer, direct, or advise the insured into or away from a specific coverage program option or health coverage.

(5) It shall agree that financial assistance shall not be conditioned on the use of a specific facility, health care provider, or coverage type.

(6) It shall agree that financial assistance shall be based on financial need in accordance with criteria that are uniformly applied and publicly available.

(c) A financially interested entity shall not make a third-party premium payment unless the entity complies with both of the following requirements:

(1) Annually provides a statement to the health insurer that it meets the requirements set forth in subdivision (b), as applicable.

(2) Discloses to the health insurer, prior to making the initial payment, the name of the insured for each policy on whose behalf a third-party premium payment described in this section will be made.

(d) (1) Reimbursement for insureds for whom a nonprofit financially interested entity described in paragraph (2) of subdivision (h) that was already making premium payments to a health insurer on the insured's behalf prior to October 1, 2019, is not subject to subdivisions (e) and (f) and the financially interested entity is not required to comply with the disclosure requirements described in subdivision (c) for those insureds.

(2) Notwithstanding paragraph (1), a financially interested entity shall comply with the disclosure requirements of subdivision (c) for an insured on whose behalf the financially interested entity was making premium payments to a health insurer on the insured's behalf prior to October 1, 2019, if the insured changes health insurers on or after March 1, 2020.

(3) The amount of reimbursement for services paid to a financially interested provider shall be governed by the terms of the insured's health insurance policy contract, except for an insured who has changed health insurers pursuant to paragraph (2), in which case, commencing January 1, 2022, the reimbursement amount shall be determined in accordance with subdivisions (e) and (f).

(e) Commencing January 1, 2022, if a financially interested entity makes a third-party premium payment to a health insurer on behalf of an insured, reimbursement to a financially interested provider for covered services shall be determined by the following:

(1) For a contracted financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the insured shall be governed by the higher of the Medicare reimbursement or the rate determined pursuant to the process described in this subdivision, if a rate determination pursuant to that process is sought by either the provider or the health insurer. Financially interested providers shall neither bill the insured nor seek reimbursement from the insured for

services provided, except for cost sharing pursuant to the terms and conditions of the insured's health insurance policy. If an insured's policy imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health insurer pursuant to this paragraph.

(2) For a noncontracting financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the insured shall be governed by the terms and conditions of the insured's health insurance policy or the rate determined pursuant to the process described in this subdivision, whichever is lower, if a rate determination pursuant to that process is sought by either the provider or the health insurer. Financially interested providers shall not bill the insured nor seek reimbursement from the insured for services provided, except for cost sharing pursuant to the terms and conditions of the insured's health insurance policy. If the insured's policy imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health insurer pursuant to this paragraph. A claim submitted to a health insurer by a noncontracting financially interested provider may be considered an incomplete claim and contested by the health insurer pursuant to Section 10123.13 or 10123.147 if the financially interested provider has not provided the information as required in subdivision (c).

(f) (1) By October 1, 2021, the department shall establish an independent dispute resolution process for the purpose of determining if the amount required to be reimbursed by subdivision (e) is appropriate.

(2) If either the provider or health insurer submits a claim to the department's independent dispute resolution process, the other party shall participate in the independent dispute resolution process.

(3) In making its determination, the independent organization shall consider information submitted by either party regarding the actual cost to provide services, patient eligibility for Medicare or Medi-Cal, and the rate that would be paid by Medicare or Medi-Cal for patients eligible for those programs.

(4) The health insurer shall implement the determination obtained through the independent dispute resolution process. The independent organization's determination of the amount required to be reimbursed shall apply for the duration of the policy year for that insured. If dissatisfied, either party may pursue any right, remedy, or penalty established under any other applicable law.

(5) In establishing the independent dispute resolution process, the department shall permit the bundling of claims submitted to the same insurer or the same delegated entity for the same or similar services. The department shall permit claims on behalf of multiple insureds from the same provider to the same health insurer to be combined into a single independent dispute resolution process.

(6) The department shall establish uniform written procedures for the submission, receipt, processing, and resolution of claim payment disputes pursuant to this section and any other guidelines for implementing this section.

(7) The department shall establish reasonable and necessary fees not to exceed the reasonable costs of administering this subdivision.

(8) The department may contract with one or more independent organizations to conduct the proceedings. The independent organization handling a dispute shall be independent of either party to the dispute.

(9) The department shall use conflict-of-interest standards consistent with the standards pursuant to subdivisions (c) and (d) of Section 10169.2.

(10) The department may contract with the same independent organization or organizations as the Department of Managed Health Care.

(11) The independent organization retained to conduct proceedings shall be deemed to be consultants for purposes of Section 43.98 of the Civil Code.

(12) Contracts entered into pursuant to the authority in this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(13) This subdivision does not alter a health insurer's obligations under Section 10123.13.

(14) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by issuing guidance, without taking regulatory action, until regulations are adopted.

(g) For the purposes of this section, third-party premium payments only include health insurance premium payments made directly by a provider or other third party, made indirectly through payments to the individual for the purpose of making health insurance premium payments, or provided to one or more intermediaries with the intention that the funds be used to make health insurance premium payments for the individuals.

(h) The following definitions apply for purposes of this section:

(1) "Financially interested" includes any of the following entities:

(A) A provider of health care services that receives a direct or indirect financial benefit from a third-party premium payment.

(B) An entity that receives the majority of its funding from one or more financially interested providers of health care services, parent companies of providers of health care services, subsidiaries of health care service providers, or related entities.

(C) A chronic dialysis clinic that is operated, owned, or controlled by a parent entity or related entity that meets the definition of a large dialysis clinic organization (LDO) under the federal Centers for Medicare and Medicaid Services Comprehensive ESRD Care Model as of January 1, 2019. A chronic dialysis clinic that does not meet the definition of an LDO or has no more than 10 percent of California's market share of licensed chronic

dialysis clinics shall not be considered financially interested for purposes of this section.

(2) "Health insurance" means an individual or group health insurance policy as defined in subdivision (b) of Section 106. The term does not include coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, or specialized health insurance coverage as described in subdivision (c) of Section 106.

(3) "Insured" means an individual whose health insurance premiums are paid by a financially interested entity.

(4) "Provider" means a professional person, organization, health facility, or other person or institution that delivers or furnishes health care services.

(i) The following shall occur if a health insurer subsequently discovers that a financially interested entity fails to provide disclosure pursuant to subdivision (c):

(1) The health insurer shall be entitled to recover 120 percent of the difference between payment made to a provider and the payment to which the provider would have been entitled pursuant to subdivision (e), including interest on that difference.

(2) The health insurer shall notify the department of the amount by which the provider was overpaid and shall remit to the department any amount exceeding the difference between the payment made to the provider and the payment to which the provider would have been entitled pursuant to subdivision (e), including interest on that difference that was recovered pursuant to paragraph (1).

(j) Commencing January 1, 2022, each health insurer licensed by the department and subject to this section shall provide to the department information regarding premium payments by financially interested entities and reimbursement for services to providers under subdivision (d). The information shall be provided at least annually at the discretion of the department and shall include, to the best of the health insurer's knowledge, the number of insureds whose premiums were paid by financially interested entities, disclosures provided to the insurer pursuant to subdivision (c), the identities of any providers whose reimbursement rate was governed by subdivision (e), the identities of any providers who failed to provide disclosure as described in subdivision (c), and, at the discretion of the department, additional information necessary for the implementation of this section.

(k) This section does not limit the authority of the Attorney General to take action to enforce this section.

(*l*) This section does not affect a contracted payment rate for a provider who is not financially interested.

(m) This section does not alter any of a health insurer's obligations and requirements under this part, including, but not limited to, the following:

(1) The obligation of a health insurer to fairly and affirmatively offer, market, sell, and issue a health benefit plan to any individual, consistent with Chapter 9.9 (commencing with Section 10965), or small employer, consistent with Chapter 8 (commencing with Section 10700).

(2) The obligations of a health insurer with respect to cancellation or nonrenewal as provided in this part, including, but not limited to, Sections 10273.4, 10273.6, and 10273.7.

(3) A health insurer may not deny coverage to an insured whose premiums are paid by a third party.

(n) This section does not supersede or modify any privacy and information security requirements and protections in federal and state law regarding protected health information or personally identifiable information, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg).

(o) Notwithstanding clause (iii) of subparagraph (A) of paragraph (1) of subdivision (d) of Section 10965.3, an insured's loss of coverage due to a financially interested entity's failure to pay premiums on a timely basis shall be deemed a triggering event for special enrollment pursuant to subparagraph (A) of paragraph (1) of subdivision (d) of Section 10965.3.

SEC. 6. Section 10181.8 is added to the Insurance Code, to read:

10181.8. A health insurance policy subject to Section 10181.3 or 10181.4 shall file a separate schedule documenting the cost savings associated with Section 10176.11 and the impact on rates.

SEC. 7. For financially interested entities covered by Advisory Opinion No. 97-1 issued by the United States Department of Health and Human Services Office of Inspector General, Sections 3 to 6, inclusive, of this act shall become operative on July 1, 2020, unless one or more parties to Advisory Opinion 97-1 requests an updated opinion from the United States Department of Health and Human Services Office of Inspector General and notifies the Department of Managed Health Care and the Department of Insurance of that request, in writing, including a copy of the request. If the notification and copy of the request are received by the departments prior to July 1, 2020, Sections 3 to 6, inclusive, of this act shall become operative with respect to those entities upon a finding by the United States Department of Health and Human Services Office of Inspector General, in accordance with Section 1128D(b) of the federal Social Security Act (42 U.S.C. Sec. 1320a-7d(b)) and Part 1008 (commencing with Section 1008.1) of Subchapter B of Chapter V of Title 42 of the Code of Federal Regulations, that compliance with those sections by a financially interested entity does not violate the federal laws addressed by Advisory Opinion 97-1 or a successor agreement. Each department shall post any notice received pursuant to this section and a copy of the request on its internet website.

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime

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

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