AMENDED IN ASSEMBLY MAY 6, 2014

AMENDED IN ASSEMBLY APRIL 22, 2014

AMENDED IN ASSEMBLY MARCH 28, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 2533

Introduced by Assembly Member Ammiano

February 21, 2014

An act to add Section 1367.031 to the Health and Safety Code, ~~and to amend Section 10133.5 of,~~ and to add Section 10133.51 to~~,~~ the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2533, as amended, Ammiano. Health care coverage: noncontracting providers.

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. Existing law requires the Department of Managed Care and the Insurance Commissioner to adopt regulations to ensure that ~~enrollee's~~ *enrollees* and insureds have access to needed health care services in a timely manner, as specified. Existing law authorizes the Department of Managed Care to assess administrative penalties for noncompliance with the requirements, which are paid into the Managed Care Administrative Fines and Penalties Fund.

~~This bill would require the Department of Insurance, in developing the regulations, to develop indicators of timeliness of access to care~~

~~considering specified indicators of timeliness of access to care, including waiting time for appointments with physicians. The bill would require contracts between health insurers that contract with providers for alternative rates and health care providers to assure compliance with the developed standards. The bill would authorize the Insurance Commissioner to investigate and take enforcement action against health insurers regarding noncompliance with the requirements of these provisions, including assessing administrative penalties that would be paid to the Health Insurance Administrative Fines and Penalties Account in the Insurance Fund, which the bill would establish.~~

~~This bill would require a health care service plan or health insurer to arrange for the provision of a medically necessary service by a licensed noncontracting provider if the plan or insurer is unable to meet timely access standards established by the Department of Managed Care or the Insurance Commissioner. The bill would require the noncontracting provider to seek reimbursement for the covered service solely from the health care service plan or health insurer, except for allowable copayments, coinsurance, and deductibles. The bill would authorize the Director of Managed Care and the Insurance Commissioner to assess administrative penalties of a minimum of $1,000 per violation against a health care service plan or health insurer that fails to comply with these requirements. The bill would require that the penalties assessed against health care service plans be deposited into the Managed Care Administrative Fines and Penalties Fund. The bill would require penalties assessed against health insurers to be deposited into the Health Insurance Administrative Fines and Penalties Account, to be used, upon appropriation by the Legislature, to support the Department of Insurance.~~

This bill would require a health care service plan or health insurer that contracts for alternative rates of payment to arrange for, or assist in arranging for, an enrollee or insured who is unable to obtain a medically necessary covered service to receive the care or service from a noncontracting provider in an accessible and timely manner. The bill would prohibit the health care service plan or health insurer from imposing copayments, coinsurance, or deductibles on an enrollee or insured that exceed what the enrollee or insured would pay for services from a contracting provider. The bill would require a health care service plan or health insurer to report annually to the respective department on the occurrences of denial of care and complaints received by the plan or insurer regarding accessible and timely access to care. The bill would require each department to review those complaints and any

complaints received by the department regarding accessibility or timeliness of care and annually prepare and post on its Internet Web site a report of the information received.

This bill would authorize the Insurance Commissioner to investigate and take enforcement action against insurers regarding noncompliance with these provisions and would authorize the commissioner to assess administrative penalties for violations, as specified. The bill would require the commissioner, on or before January 1, 2016, to promulgate related regulations and review the regulations every 3 years to determine if the regulations should be updated.

Because a willful violation of these requirements with respect to health care service plans 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:

SECTION 1. Section 1367.031 is added to the Health and Safety Code, immediately following Section 1367.03, to read:

1367.031. (a) If an enrollee is unable to obtain a medically necessary covered service in an accessible and timely manner, as required under Section 1367.03, from a contracted provider, the health care service plan shall arrange for, or assist the enrollee in arranging for, the enrollee to receive the care or service in an accessible and timely manner from a noncontracting provider, and shall not impose copayments, coinsurance, or deductibles on the enrollee that exceed what the enrollee would pay for services from a contracting provider.

(b) In addition to any reporting requirements in subdivision (f) of Section 1367.03, a health care service plan shall report annually to the department on any and all occurrences of denial of care and on complaints received by the health care service plan regarding accessible and timely access to care. The department shall review these complaints and any complaints received by the

department regarding accessibility or timeliness of care and annually prepare and post on the department's Internet Web site a report on the information received.

SEC. 2. Section 10133.51 is added to the Insurance Code, to read:

10133.51. (a) This section shall apply to insurers that contract for alternative rates of payment pursuant to Section 10133.

(b) If an insured is unable to obtain a medically necessary covered service in an accessible and timely manner, as required under Section 10133.5, from a contracted provider, the health insurer shall arrange for, or assist the insured in arranging for, the insured to receive the care or service in an accessible and timely manner from a noncontracting provider, and shall not impose copayments, coinsurance, or deductibles on the insured that exceed what an insured would pay for services from a contracting provider.

(c) In addition to the reporting requirements in Section 10133.5, health insurers shall report annually to the department on any and all occurrences of denial of care and on complaints received by the insurer regarding accessible and timely access to care. The department shall review these complaints and any complaints received by the department regarding accessibility or timeliness of care and annually prepare and post on the department's Internet Web site a report on the information received.

(d) The commissioner shall, on or before January 1, 2016, promulgate regulations pursuant to this section and Section 10133.5 to ensure that insureds have the opportunity to access medically necessary health care services in an accessible and timely manner. Every three years, the commissioner shall review the latest version of the regulations adopted pursuant to this section and determine if the regulations should be updated to further the intent of this section.

(e) The commissioner may investigate and take enforcement action against insurers regarding noncompliance with the requirements of this section and Section 10133.5. The commissioner may, by order, assess administrative penalties for violations of this section and Section 10133.5, subject to appropriate notice of, and the opportunity for, a hearing in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The insurer

may provide to the commissioner, and the commissioner may consider, information regarding the insurer's overall compliance with the requirements of this section. The administrative penalties available to the commissioner pursuant to this section are not exclusive and may be sought and employed in any combination with civil, criminal, and other administrative remedies as determined by the commissioner.

SEC. 3. 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.

~~SECTION 1. Section 1367.031 is added to the Health and Safety Code, immediately following Section 1367.03, to read:~~

~~1367.031. (a) If a health care service plan is unable to meet timely access standards established pursuant to Section 1367.03, and is thereby unable to ensure timely access by an enrollee to a medically necessary covered service provided by a contracted provider, the health care service plan shall arrange for the provision of the service by a licensed noncontracting provider in the area of practice appropriate to treat the enrollee's condition.~~

~~(1) A health care service plan shall not impose copayments, coinsurance, or deductibles for a noncontracting provider that exceed those of contracting providers.~~

~~(2) A noncontracting provider providing a service to an enrollee pursuant to subdivision (a) shall seek reimbursement for a covered service solely from an enrollee's health care service plan, and shall not seek payment from the enrollee for the covered service, except for allowable copayments, coinsurance, and deductibles.~~

~~(3) A health care service plan referring an enrollee to a noncontracting provider shall ensure that the location of the facilities of the noncontracting provider is within reasonable proximity of the business or personal residence of the enrollee, and that the hours of operation and provision for after-hours care is reasonable so as not to result in barriers to accessibility.~~

~~(4) The health care service plan shall consider referral to a specific noncontracting provider preferred by the enrollee. If the health care service plan does not refer the enrollee to the enrollee's preferred noncontracting provider, the health care service plan shall provide the enrollee with a written explanation outlining the reasons why the enrollee's preferred noncontracting provider was not selected to provide the covered service.~~

~~(5) If an enrollee prefers to wait for a contracted provider to provide the covered service, the health care service plan shall accommodate the enrollee's preference.~~

~~(b) Pursuant to subdivision (f) of Section 1367.03, a health care service plan shall report annually to the department on any and all occurrences of denial of care and on compliance with the requirements of this section. The department shall make this information public on the department's Internet Web site.~~

~~(c) (1) Pursuant to subdivision (g) of Section 1367.03, the department may assess an administrative penalty of a minimum of one thousand dollars ($1,000) per violation against any health care service plan that fails to comply with this section.~~

~~(2) The administrative penalties available to the department pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies as determined by the director for purposes of enforcing this chapter.~~

~~SEC. 2. Section 10133.5 of the Insurance Code is amended to read:~~

~~10133.5. (a) The commissioner shall, on or before January 1, 2016, promulgate regulations applicable to health insurers that contract with providers for alternative rates pursuant to Section 10133 to ensure that insureds have the opportunity to access needed health care services in a timely manner.~~

~~(b) These regulations shall be designed to assure accessibility of provider services in a timely manner to individuals comprising the insured or contracted group, pursuant to benefits covered under the policy or contract. In developing these regulations, the department shall develop indicators of timeliness of access to care and, in so doing, shall consider the following as indicators of timeliness of access to care:~~

~~(1) Waiting times for appointments with physicians, including primary care and specialty physicians.~~

~~(2) Timeliness of care in an episode of illness, including the timeliness of referrals and obtaining other services, if needed.~~

~~(3) Waiting time to speak to a physician, registered nurse, or other qualified health professional acting within his or her scope of practice who is trained to screen or triage an enrollee who may need care.~~

~~(4) Adequacy of number and locations of institutional facilities, including hospitals, and professional providers, and consultants in relationship to the size and location of the insured group and that the services offered are available at reasonable times. The department shall consider the nature of physician practices, including individual and group practices, and the nature of the provider network. The department shall also consider various circumstances affecting the delivery of care, including urgent care, care provided on the same day, and requests for specific providers.~~

~~(5) Adequacy of number of professional providers, and license classifications of the providers, in relationship to the projected demands for services covered under the group policy or plan. The department shall consider the nature of the specialty in determining the adequacy of professional providers. The department shall consider the availability of primary care physicians, specialty physicians, hospital care, and other health care.~~

~~(6) The policy or contract is not inconsistent with standards of good health care and clinically appropriate care.~~

~~(7) All contracts including contracts with providers, and other persons furnishing services, or facilities shall be fair and reasonable.~~

~~(c) In developing these standards for timeliness of access, the department shall consider all of the following:~~

~~(1) Clinical appropriateness.~~

~~(2) The nature of the specialty.~~

~~(3) The urgency of care.~~

~~(d) The department may adopt standards other than the time elapsed between an enrollee seeking health care and obtaining care. If the department adopts an alternative standard, it shall demonstrate why that standard is more appropriate. In developing standards pursuant to this subdivision, the department shall consider the nature of the provider network.~~

~~(e) In developing standards under subdivision (a), the department shall also consider requirements under federal law; requirements~~

~~under other state programs and law, including utilization review; and standards adopted by other states, national accrediting organizations and professional associations. The department shall further consider the accessability to provider services in rural areas, specifically those areas in which health facilities are more than 30 miles apart.~~

~~(f) In designing the regulations the commissioner shall consider the regulations in Title 28, of the California Code of Regulations, commencing with Section 1300.67.2, that are applicable to Knox-Keene plans, and all other relevant guidelines in an effort to accomplish maximum accessibility. The department shall consult with the Department of Managed Health Care concerning regulations developed by that department pursuant to Section 1367.03 of the Health and Safety Code and shall seek public input from a wide range of interested parties.~~

~~(g) (1) Contracts between health insurers that contract with providers for alternative rates and health care providers shall assure compliance with the standards developed under this section. These contracts shall require reporting by health care providers to health insurers that contract with providers for alternative rates and by health insurers that contract with providers for alternative rates to the department to ensure compliance with the standards.~~

~~(2) Health insurers that contract for alternative rates of payment with providers shall report annually on the number of occurrences of denial of care and on complaints received by the insurer regarding timely access to care. The department shall review these complaints and any complaints received by the department regarding timeliness of care and shall make public this information on the department's Internet Web site.~~

~~(h) Every three years, the commissioner shall review the latest version of the regulations adopted pursuant to subdivision (a) and shall determine if the regulations should be updated to further the intent of this section.~~

~~(i) (1) The commissioner may investigate and take enforcement action against plans regarding noncompliance with the requirements of this section. When substantial harm to an insured has occurred as a result of plan noncompliance, the commissioner may, by order, assess administrative penalties subject to appropriate notice of, and the opportunity for, a hearing in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division~~

~~3 of Title 2 of the Government Code. The health insurer may provide to the commissioner, and the commissioner may consider, information regarding the health insurer's overall compliance with the requirements of this section.~~

~~(2) The administrative penalties available to the commissioner pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies as determined by the commissioner for purposes of enforcing this chapter.~~

~~(3) The administrative penalties shall be paid to the Health Insurance Administrative Fines and Penalties Account in the Insurance Fund.~~

~~(j) There is hereby created the Health Insurance Administrative Fines and Penalties Account in the Insurance Fund established pursuant to Section 12975.7. All moneys in the account shall be subject to annual appropriation each fiscal year for the support of the Department of Insurance.~~

~~SEC. 3. Section 10133.51 is added to the Insurance Code, immediately following Section 10133.5, to read:~~

~~10133.51. (a) If a health insurer that contracts with providers for alternative rates pursuant to Section 10133 is unable to meet timely access standards established pursuant to Section 10133.5, and is thereby unable to ensure timely access by an insured to a medically necessary covered service provided by a contracted provider, the health insurer shall arrange for the provision of the service by a licensed noncontracting provider in the area of practice appropriate to treat the insured's condition.~~

~~(1) A health insurer shall not impose copayments, coinsurance, or deductibles for a noncontracting provider that exceed those of contracting providers in the event that an insured receives services from a noncontracting provider because a health insurer was unable to ensure timely access to a medically necessary, covered service by a contracted provider.~~

~~(2) A noncontracting provider providing a service to an insured pursuant to subdivision (a) shall seek reimbursement for the covered service solely from the insured's health insurer, and shall not seek payment from the insured for the covered service, except for allowable copayments, coinsurance, and deductibles.~~

~~(3) A health insurer referring an insured to a noncontracting provider shall ensure that the location of the facilities of the~~

~~noncontracting provider is within reasonable proximity of the business or personal residence of the insured, and that the hours of operation and provision for after-hours care is reasonable so as not to result in barriers to accessibility.~~

~~(4) The health insurer shall consider referral to a specific noncontracting provider preferred by the insured. If the health insurer does not refer the insured to the insured's preferred noncontracting provider, the health insurer shall provide the insured with a written explanation outlining the reasons why the insured's preferred noncontracting provider was not selected to provide the covered service.~~

~~(5) If an insured prefers to wait for a contracted provider to provide the covered service, the health insurer shall accommodate the insured's preference.~~

~~(b) (1) The commissioner may investigate and take enforcement action against health insurers regarding noncompliance with the requirements of this section.~~

~~(2) The commissioner may, by order, assess an administrative penalty of a minimum of one thousand dollars ($1,000) per violation against a health insurer that fails to comply with this section, subject to appropriate notice and the opportunity for a hearing in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The health insurer may provide to the commissioner, and the commissioner may consider, information regarding the health insurer's overall compliance with the requirements of this section. The administrative penalties shall not be deemed an exclusive remedy available to the commissioner.~~

~~SEC. 4. 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 are the result of a program for which legislative authority was requested by that local agency or school district, within the meaning of Section 17556 of the Government Code and Section 6 of Article XIII B of the California Constitution.~~

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