

AMENDED IN ASSEMBLY JANUARY 16, 2014

AMENDED IN ASSEMBLY JANUARY 6, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 369

Introduced by Assembly Member Pan

February 14, 2013

An act to amend Section 1373.96 of the Health and Safety Code, and to amend Section 10133.56 of the Insurance Code, relating to health care coverage, *and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

AB 369, as amended, Pan. Continuity of care.

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 a health care service plan, ~~with some exceptions, or a health insurer~~ to provide for the completion of covered services by a terminated provider ~~or a nonparticipating provider~~ for enrollees *or insureds* who were receiving services from the provider for ~~one of the a specified conditions condition~~ at the time of the contract *or policy* termination ~~or at the time a newly covered enrollee's coverage became effective~~. Existing law requires a health insurer, with some exceptions, to provide for the completion of covered services by a terminated provider for insureds who were receiving services from the provider for one of the specified conditions at the time of the policy termination. *Existing law also*

requires a health care service plan to provide for the completion of covered services by a nonparticipating provider to a newly covered enrollee who, at the time his or her coverage became effective, was receiving services from that provider for a specified condition. Existing law specifies that this provision does not apply to a newly covered enrollee under an individual subscriber agreement.

~~Under the federal Patient Protection and Affordable Care Act (PPACA), each state is required, by January 1, 2014, to establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers. Existing state law establishes the California Health Benefit Exchange (Exchange) within state government, specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and small employers by January 1, 2014.~~

~~This bill would require a health insurer to arrange for the completion of covered services by a nonparticipating provider at the request of a newly covered insured under a group insurance policy. The bill would require a health care service plan and a health insurer to arrange for the completion of covered services by a nonparticipating provider for a newly covered enrollee and a newly covered insured under an individual health care service plan contract or *an individual health* insurance policy whose prior coverage was ~~terminated~~ *withdrawn from the market* between ~~January~~ *December* 1, 2013, and March 31, 2014, inclusive, *as specified*.~~

~~Because a willful violation of these provisions by a health care service plan would, in part, 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.~~

~~*This bill would declare that it is to take effect immediately as an urgency statute.*~~

~~Vote: ~~majority~~^{2/3}. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.~~

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

1 SECTION 1. Section 1373.96 of the Health and Safety Code
2 is amended to read:

3 1373.96. (a) A health care service plan shall at the request of
4 an enrollee, provide the completion of covered services as set forth
5 in this section by a terminated provider or by a nonparticipating
6 provider.

7 (b) (1) The completion of covered services shall be provided
8 by a terminated provider to an enrollee who at the time of the
9 contract's termination, was receiving services from that provider
10 for one of the conditions described in subdivision (c).

11 (2) The completion of covered services shall be provided by a
12 nonparticipating provider to a newly covered enrollee who, at the
13 time his or her coverage became effective, was receiving services
14 from that provider for one of the conditions described in
15 subdivision (c).

16 (c) The health care service plan shall provide for the completion
17 of covered services for the following conditions:

18 (1) An acute condition. An acute condition is a medical
19 condition that involves a sudden onset of symptoms due to an
20 illness, injury, or other medical problem that requires prompt
21 medical attention and that has a limited duration. Completion of
22 covered services shall be provided for the duration of the acute
23 condition.

24 (2) A serious chronic condition. A serious chronic condition is
25 a medical condition due to a disease, illness, or other medical
26 problem or medical disorder that is serious in nature and that
27 persists without full cure or worsens over an extended period of
28 time or requires ongoing treatment to maintain remission or prevent
29 deterioration. Completion of covered services shall be provided
30 for a period of time necessary to complete a course of treatment
31 and to arrange for a safe transfer to another provider, as determined
32 by the health care service plan in consultation with the enrollee
33 and the terminated provider or nonparticipating provider and
34 consistent with good professional practice. Completion of covered
35 services under this paragraph shall not exceed 12 months from the
36 contract termination date or 12 months from the effective date of
37 coverage for a newly covered enrollee.

1 (3) A pregnancy. A pregnancy is the three trimesters of
2 pregnancy and the immediate postpartum period. Completion of
3 covered services shall be provided for the duration of the
4 pregnancy.

5 (4) A terminal illness. A terminal illness is an incurable or
6 irreversible condition that has a high probability of causing death
7 within one year or less. Completion of covered services shall be
8 provided for the duration of a terminal illness, which may exceed
9 12 months from the contract termination date or 12 months from
10 the effective date of coverage for a new enrollee.

11 (5) The care of a newborn child between birth and age 36
12 months. Completion of covered services under this paragraph shall
13 not exceed 12 months from the contract termination date or 12
14 months from the effective date of coverage for a newly covered
15 enrollee.

16 (6) Performance of a surgery or other procedure that is
17 authorized by the plan as part of a documented course of treatment
18 and has been recommended and documented by the provider to
19 occur within 180 days of the contract's termination date or within
20 180 days of the effective date of coverage for a newly covered
21 enrollee.

22 (d) (1) The plan may require the terminated provider whose
23 services are continued beyond the contract termination date
24 pursuant to this section to agree in writing to be subject to the same
25 contractual terms and conditions that were imposed upon the
26 provider prior to termination, including, but not limited to,
27 credentialing, hospital privileging, utilization review, peer review,
28 and quality assurance requirements. If the terminated provider
29 does not agree to comply or does not comply with these contractual
30 terms and conditions, the plan is not required to continue the
31 provider's services beyond the contract termination date.

32 (2) Unless otherwise agreed by the terminated provider and the
33 plan or by the individual provider and the provider group, the
34 services rendered pursuant to this section shall be compensated at
35 rates and methods of payment similar to those used by the plan or
36 the provider group for currently contracting providers providing
37 similar services who are not capitated and who are practicing in
38 the same or a similar geographic area as the terminated provider.
39 Neither the plan nor the provider group is required to continue the

1 services of a terminated provider if the provider does not accept
2 the payment rates provided for in this paragraph.

3 (e) (1) The plan may require a nonparticipating provider whose
4 services are continued pursuant to this section for a newly covered
5 enrollee to agree in writing to be subject to the same contractual
6 terms and conditions that are imposed upon currently contracting
7 providers providing similar services who are not capitated and
8 who are practicing in the same or a similar geographic area as the
9 nonparticipating provider, including, but not limited to,
10 credentialing, hospital privileging, utilization review, peer review,
11 and quality assurance requirements. If the nonparticipating provider
12 does not agree to comply or does not comply with these contractual
13 terms and conditions, the plan is not required to continue the
14 provider's services.

15 (2) Unless otherwise agreed upon by the nonparticipating
16 provider and the plan or by the nonparticipating provider and the
17 provider group, the services rendered pursuant to this section shall
18 be compensated at rates and methods of payment similar to those
19 used by the plan or the provider group for currently contracting
20 providers providing similar services who are not capitated and
21 who are practicing in the same or a similar geographic area as the
22 nonparticipating provider. Neither the plan nor the provider group
23 is required to continue the services of a nonparticipating provider
24 if the provider does not accept the payment rates provided for in
25 this paragraph.

26 (f) The amount of, and the requirement for payment of,
27 copayments, deductibles, or other cost sharing components during
28 the period of completion of covered services with a terminated
29 provider or a nonparticipating provider are the same as would be
30 paid by the enrollee if receiving care from a provider currently
31 contracting with or employed by the plan.

32 (g) If a plan delegates the responsibility of complying with this
33 section to a provider group, the plan shall ensure that the
34 requirements of this section are met.

35 (h) This section shall not require a plan to provide for
36 completion of covered services by a provider whose contract with
37 the plan or provider group has been terminated or not renewed for
38 reasons relating to a medical disciplinary cause or reason, as
39 defined in paragraph (6) of subdivision (a) of Section 805 of the
40 Business and Profession Code, or fraud or other criminal activity.

1 (i) This section shall not require a plan to cover services or
2 provide benefits that are not otherwise covered under the terms
3 and conditions of the plan contract. Except as provided in
4 subdivision-~~(k)~~ (l), this section shall not apply to a newly covered
5 enrollee covered under an individual subscriber agreement who is
6 undergoing a course of treatment on the effective date of his or
7 her coverage for a condition described in subdivision (c).

8 (j) *Subdivision (b) does not apply to a newly covered enrollee*
9 *who is offered an out-of-network option or to a newly covered*
10 *enrollee who had the option to continue with his or her previous*
11 *health plan or provider and instead voluntarily chose to change*
12 *health plans.*

13 ~~(j)~~
14 (k) The provisions contained in this section are in addition to
15 any other responsibilities of a health care service plan to provide
16 continuity of care pursuant to this chapter. Nothing in this section
17 shall preclude a plan from providing continuity of care beyond the
18 requirements of this section.

19 ~~(k)~~
20 (l) (1) A health care service plan shall, at the request of a newly
21 covered enrollee under an individual health care service plan
22 contract, arrange for the completion of covered services by a
23 nonparticipating provider for one of the conditions described in
24 subdivision (c) if the newly covered enrollee meets both of the
25 following:

26 (A) The newly covered enrollee's prior coverage was terminated
27 *under paragraph (5) or (6) of subdivision (a) of Section 1365*
28 *between January December 1, 2013, and March 31, 2014, inclusive.*

29 (B) At the time his or her coverage became effective, the newly
30 covered enrollee was receiving services from that provider for one
31 of the conditions described in subdivision (c).

32 (2) *The completion of covered services required to be provided*
33 *under this subdivision apply to services rendered to the newly*
34 *covered enrollee on and after the effective date of his or her new*
35 *coverage.*

36 ~~(2)~~
37 (3) A violation of this subdivision does not constitute a crime
38 under Section 1390.

39 ~~(t)~~

1 (m) The following definitions apply for the purposes of this
2 section:

3 (1) “Individual provider” means a person who is a licentiate, as
4 defined in Section 805 of the Business and Professions Code, or
5 a person licensed under Chapter 2 (commencing with Section
6 1000) of Division 2 of the Business and Professions Code.

7 (2) “Nonparticipating provider” means a provider who is not
8 contracted with a health care service plan. ~~A nonparticipating
9 provider does not include a terminated provider.~~

10 (3) “Provider” shall have the same meaning as set forth in
11 subdivision (i) of Section 1345.

12 (4) “Provider group” means a medical group, independent
13 practice association, or any other similar organization.

14 ~~(5) “Terminated provider” means a provider whose contract to
15 provide services to enrollees is terminated or not renewed by the
16 plan or one of the plan’s contracting provider groups.~~

17 SEC. 2. Section 10133.56 of the Insurance Code is amended
18 to read:

19 10133.56. (a) (1) A health insurer that enters into a contract
20 with a professional or institutional provider to provide services at
21 alternative rates of payment pursuant to Section 10133 shall, at
22 the request of an insured, arrange for the completion of covered
23 services by a terminated provider, if the insured is undergoing a
24 course of treatment for any of the following conditions:

25 (1)

26 (A) An acute condition. An acute condition is a medical
27 condition that involves a sudden onset of symptoms due to an
28 illness, injury, or other medical problem that requires prompt
29 medical attention and that has a limited duration. Completion of
30 covered services shall be provided for the duration of the acute
31 condition.

32 (2)

33 (B) A serious chronic condition. A serious chronic condition is
34 a medical condition due to a disease, illness, or other medical
35 problem or medical disorder that is serious in nature and that
36 persists without full cure or worsens over an extended period of
37 time or requires ongoing treatment to maintain remission or prevent
38 deterioration. Completion of covered services shall be provided
39 for a period of time necessary to complete a course of treatment
40 and to arrange for a safe transfer to another provider, as determined

1 by the health insurer in consultation with the insured and the
2 terminated provider and consistent with good professional practice.
3 Completion of covered services under this paragraph shall not
4 exceed 12 months from the contract termination date.

5 ~~(3)~~

6 (C) A pregnancy. A pregnancy is the three trimesters of
7 pregnancy and the immediate postpartum period. Completion of
8 covered services shall be provided for the duration of the
9 pregnancy.

10 ~~(4)~~

11 (D) A terminal illness. A terminal illness is an incurable or
12 irreversible condition that has a high probability of causing death
13 within one year or less. Completion of covered services shall be
14 provided for the duration of a terminal illness, which may exceed
15 12 months from the contract termination date.

16 ~~(5)~~

17 (E) The care of a newborn child between birth and age 36
18 months. Completion of covered services under this paragraph shall
19 not exceed 12 months from the contract termination date.

20 ~~(6)~~

21 (F) Performance of a surgery or other procedure that has been
22 recommended and documented by the provider to occur within
23 180 days of the contract's termination date.

24 ~~(b)~~

25 (2) The insurer may require the terminated provider whose
26 services are continued beyond the contract termination date
27 pursuant to this ~~section~~ *subdivision*, to agree in writing to be subject
28 to the same contractual terms and conditions that were imposed
29 upon the provider prior to termination, including, but not limited
30 to, credentialing, hospital privileging, utilization review, peer
31 review, and quality assurance requirements. If the terminated
32 provider does not agree to comply or does not comply with these
33 contractual terms and conditions, the insurer is not required to
34 continue the provider's services beyond the contract termination
35 date.

36 ~~(e)~~

37 (3) Unless otherwise agreed upon between the terminated
38 provider and the insurer or between the terminated provider and
39 the provider group, the agreement shall be construed to require a
40 rate and method of payment to the terminated provider, for the

1 services rendered pursuant to this ~~section~~ *subdivision*, that are the
2 same as the rate and method of payment for the same services
3 while under contract with the insurer and at the time of termination.
4 The provider shall accept the reimbursement as payment in full
5 and shall not bill the insured for any amount in excess of the
6 reimbursement rate, with the exception of copayments and
7 deductibles pursuant to ~~subdivision (e)~~ (c).

8 ~~(d)~~

9 (b) Notice as to the process by which an insured may request
10 completion of covered services pursuant to this section shall be
11 provided in any insurer evidence of coverage and disclosure form
12 issued after March 31, 2004. An insurer shall provide a written
13 copy of this information to its contracting providers and provider
14 groups. An insurer shall also provide a copy to its insureds upon
15 request.

16 ~~(e)~~

17 (c) The payment of copayments, deductibles, or other
18 cost-sharing components by the insured during the period of
19 completion of covered services with a terminated provider *pursuant*
20 *to subdivision (a) or a nonparticipating provider pursuant to*
21 *subdivision (i)* shall be the same copayments, deductibles, or other
22 cost-sharing components that would be paid by the insured when
23 receiving care from a provider currently contracting with the
24 insurer.

25 ~~(f)~~

26 (d) If an insurer delegates the responsibility of complying with
27 this section to its contracting entities, the insurer shall ensure that
28 the requirements of this section are met.

29 ~~(g)~~

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

32 (1) "Provider" means a person who is a licentiate as defined in
33 Section 805 of the Business and Professions Code or a person
34 licensed under Chapter 2 (commencing with Section 1000) of
35 Division 2 of the Business and Professions Code.

36 (2) "Provider group" includes a medical group, independent
37 practice association, or any other similar organization.

38 (3) "Nonparticipating provider" means a provider who does not
39 have a contract with an insurer to provide services to insureds. ~~A~~
40 ~~nonparticipating provider does not include a terminated provider.~~

1 (4) “Terminated provider” means a provider whose contract to
 2 provide services to insureds is terminated or not renewed by the
 3 insurer or one of the insurer’s contracting provider groups. A
 4 *terminated provider is not a provider who voluntarily leaves the*
 5 *insurer or contracting provider group.*

6 ~~(h)~~

7 (f) This section shall not require an insurer or provider group
 8 to provide for the completion of covered services by a provider
 9 whose contract with the insurer or provider group has been
 10 terminated or not renewed for reasons relating to medical
 11 disciplinary cause or reason, as defined in paragraph (6) of
 12 subdivision (a) of Section 805 of the Business and Professions
 13 Code, or fraud or other criminal activity.

14 ~~(i)~~

15 (g) This section shall not require an insurer to cover services or
 16 provide benefits that are not otherwise covered under the terms
 17 and conditions of the insurer contract.

18 ~~(j)~~

19 (h) The provisions contained in this section are in addition to
 20 any other responsibilities of insurers to provide continuity of care
 21 pursuant to this chapter. Nothing in this section shall preclude an
 22 insurer from providing continuity of care beyond the requirements
 23 of this section.

24 ~~(k) (1) A health insurer shall, at the request of a newly covered~~
 25 ~~insured under a group insurance policy, arrange for the completion~~
 26 ~~of covered services by a nonparticipating provider for one of the~~
 27 ~~conditions described in subdivision (a).~~

28 ~~(2)~~

29 (i) (1) A health insurer shall, at the request of a newly covered
 30 insured under an individual insurance policy, arrange for the
 31 completion of covered services by a nonparticipating provider for
 32 one of the conditions described in subdivision (a) if the newly
 33 covered insured meets both of the following:

34 (A) The newly covered insured’s prior coverage was terminated
 35 *under subdivision (d) or (e) of Section 10273.6 between January*
 36 *December 1, 2013, and March 31, 2014, inclusive.*

37 (B) At the time his or her coverage became effective, the newly
 38 covered insured was receiving services from that provider for one
 39 of the conditions described in subdivision (a).

1 (2) *The completion of covered services required to be provided*
2 *under this subdivision shall apply to services rendered to the newly*
3 *covered insured on and after the effective date of his or her new*
4 *coverage.*

5 (3) (A) The insurer may require a nonparticipating provider
6 whose services are continued pursuant to this ~~section~~ *subdivision*
7 for a newly covered insured to agree in writing to be subject to the
8 same contractual terms and conditions that are imposed upon
9 currently participating providers providing similar services who
10 are practicing in the same or a similar geographic area as the
11 nonparticipating provider, including, but not limited to,
12 credentialing, hospital privileging, utilization review, peer review,
13 and quality assurance requirements. If the nonparticipating provider
14 does not agree to comply or does not comply with these contractual
15 terms and conditions, the insurer is not required to continue the
16 provider's services.

17 (B) Unless otherwise agreed upon by the nonparticipating
18 provider and the insurer ~~or by the nonparticipating provider and~~
19 ~~the provider group~~, the services rendered pursuant to this ~~section~~
20 *subdivision* shall be compensated at rates and methods of payment
21 similar to those used by the insurer ~~or the provider group~~ for
22 currently participating providers providing similar services who
23 are practicing in the same or a similar geographic area as the
24 nonparticipating provider. Neither the insurer nor the provider
25 group is required to continue the services of a nonparticipating
26 provider if the provider does not accept the payment rates provided
27 for in this paragraph. ~~The provider shall accept the reimbursement~~
28 ~~as payment in full and shall not bill the insured for any amount in~~
29 ~~excess of the reimbursement rate, with the exception of copayments~~
30 ~~and deductibles pursuant to subdivision (e).~~

31 *SEC. 3. It is the intent of the Legislature that a nonparticipating*
32 *provider whose services are continued pursuant to Section*
33 *10133.56 of the Insurance Code accept the reimbursement provided*
34 *under that section as payment in full and not bill the insured for*
35 *any amount in excess of the reimbursement rate, with the exception*
36 *of copayments and deductibles pursuant to subdivision (c) of*
37 *Section 10133.56.*

38 ~~SEC. 3.~~

39 *SEC. 4. No reimbursement is required by this act pursuant to*
40 *Section 6 of Article XIII B of the California Constitution because*

1 the only costs that may be incurred by a local agency or school
2 district will be incurred because this act creates a new crime or
3 infraction, eliminates a crime or infraction, or changes the penalty
4 for a crime or infraction, within the meaning of Section 17556 of
5 the Government Code, or changes the definition of a crime within
6 the meaning of Section 6 of Article XIII B of the California
7 Constitution.

8 *SEC. 5. This act is an urgency statute necessary for the*
9 *immediate preservation of the public peace, health, or safety within*
10 *the meaning of Article IV of the Constitution and shall go into*
11 *immediate effect. The facts constituting the necessity are:*

12 *Many health care service plans and health insurers terminated*
13 *health plans between December 1, 2013, and March 31, 2014, in*
14 *anticipation of compliance with the federal Patient Protection and*
15 *Affordable Care Act. In order to allow an individual enrolled in*
16 *such a plan who was receiving covered treatment under the plan*
17 *from a provider for a certain condition to continue to receive*
18 *services from that provider for the condition, it is necessary that*
19 *this act take effect immediately.*