

AMENDED IN SENATE FEBRUARY 18, 2014  
AMENDED IN ASSEMBLY JANUARY 16, 2014  
AMENDED IN ASSEMBLY JANUARY 6, 2014  
CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

**ASSEMBLY BILL**

**No. 369**

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**Introduced by Assembly Member Pan**

February 14, 2013

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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 or a health insurer to provide for the completion of covered services by a terminated provider for enrollees or insureds who were receiving services from the provider for a specified condition at the time of the contract or 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.

This 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under an individual health care service plan contract or an individual health insurance policy whose prior coverage was withdrawn from the market between December 1, 2013, and March 31, 2014, inclusive, as specified.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:  $\frac{2}{3}$ . 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).

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

3 (1) An acute condition. An acute condition is a medical  
4 condition that involves a sudden onset of symptoms due to an  
5 illness, injury, or other medical problem that requires prompt  
6 medical attention and that has a limited duration. Completion of  
7 covered services shall be provided for the duration of the acute  
8 condition.

9 (2) A serious chronic condition. A serious chronic condition is  
10 a medical condition due to a disease, illness, or other medical  
11 problem or medical disorder that is serious in nature and that  
12 persists without full cure or worsens over an extended period of  
13 time or requires ongoing treatment to maintain remission or prevent  
14 deterioration. Completion of covered services shall be provided  
15 for a period of time necessary to complete a course of treatment  
16 and to arrange for a safe transfer to another provider, as determined  
17 by the health care service plan in consultation with the enrollee  
18 and the terminated provider or nonparticipating provider and  
19 consistent with good professional practice. Completion of covered  
20 services under this paragraph shall not exceed 12 months from the  
21 contract termination date or 12 months from the effective date of  
22 coverage for a newly covered enrollee.

23 (3) A pregnancy. A pregnancy is the three trimesters of  
24 pregnancy and the immediate postpartum period. Completion of  
25 covered services shall be provided for the duration of the  
26 pregnancy.

27 (4) A terminal illness. A terminal illness is an incurable or  
28 irreversible condition that has a high probability of causing death  
29 within one year or less. Completion of covered services shall be  
30 provided for the duration of a terminal illness, which may exceed  
31 12 months from the contract termination date or 12 months from  
32 the effective date of coverage for a new enrollee.

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

38 (6) Performance of a surgery or other procedure that is  
39 authorized by the plan as part of a documented course of treatment  
40 and has been recommended and documented by the provider to

1 occur within 180 days of the contract's termination date or within  
2 180 days of the effective date of coverage for a newly covered  
3 enrollee.

4 (d) (1) The plan may require the terminated provider whose  
5 services are continued beyond the contract termination date  
6 pursuant to this section to agree in writing to be subject to the same  
7 contractual terms and conditions that were imposed upon the  
8 provider prior to termination, including, but not limited to,  
9 credentialing, hospital privileging, utilization review, peer review,  
10 and quality assurance requirements. If the terminated provider  
11 does not agree to comply or does not comply with these contractual  
12 terms and conditions, the plan is not required to continue the  
13 provider's services beyond the contract termination date.

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

24 (e) (1) The plan may require a nonparticipating provider whose  
25 services are continued pursuant to this section for a newly covered  
26 enrollee to agree in writing to be subject to the same contractual  
27 terms and conditions that are imposed upon currently contracting  
28 providers providing similar services who are not capitated and  
29 who are practicing in the same or a similar geographic area as the  
30 nonparticipating provider, including, but not limited to,  
31 credentialing, hospital privileging, utilization review, peer review,  
32 and quality assurance requirements. If the nonparticipating provider  
33 does not agree to comply or does not comply with these contractual  
34 terms and conditions, the plan is not required to continue the  
35 provider's services.

36 (2) Unless otherwise agreed upon by the nonparticipating  
37 provider and the plan or by the nonparticipating provider and the  
38 provider group, the services rendered pursuant to this section shall  
39 be compensated at rates and methods of payment similar to those  
40 used by the plan or the provider group for currently contracting

1 providers providing similar services who are not capitated and  
2 who are practicing in the same or a similar geographic area as the  
3 nonparticipating provider. Neither the plan nor the provider group  
4 is required to continue the services of a nonparticipating provider  
5 if the provider does not accept the payment rates provided for in  
6 this paragraph.

7 (f) The amount of, and the requirement for payment of,  
8 copayments, deductibles, or other cost sharing components during  
9 the period of completion of covered services with a terminated  
10 provider or a nonparticipating provider are the same as would be  
11 paid by the enrollee if receiving care from a provider currently  
12 contracting with or employed by the plan.

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

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

22 (i) This section shall not require a plan to cover services or  
23 provide benefits that are not otherwise covered under the terms  
24 and conditions of the plan contract. Except as provided in  
25 subdivision (l), this section shall not apply to a newly covered  
26 enrollee covered under an individual subscriber agreement who is  
27 undergoing a course of treatment on the effective date of his or  
28 her coverage for a condition described in subdivision (c).

29 (j) ~~Subdivision (b) does~~ *Except as provided in subdivision (l),*  
30 *this section shall* not apply to a newly covered enrollee who is  
31 offered an out-of-network option or to a newly covered enrollee  
32 who had the option to continue with his or her previous health plan  
33 or provider and instead voluntarily chose to change health plans.

34 (k) The provisions contained in this section are in addition to  
35 any other responsibilities of a health care service plan to provide  
36 continuity of care pursuant to this chapter. Nothing in this section  
37 shall preclude a plan from providing continuity of care beyond the  
38 requirements of this section.

39 (l) (1) A health care service plan shall, at the request of a newly  
40 covered enrollee under an individual health care service plan

1 contract, arrange for the completion of covered services *as set*  
 2 *forth in this section* by a nonparticipating provider for one of the  
 3 conditions described in subdivision (c) if the newly covered  
 4 enrollee meets both of the following:

5 (A) The newly covered enrollee’s prior coverage was terminated  
 6 under paragraph (5) or (6) of subdivision (a) of Section 1365 *or*  
 7 *subdivision (d) or (e) of Section 10273.6 of the Insurance Code*  
 8 between December 1, 2013, and March 31, 2014, inclusive.

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

12 (2) The completion of covered services required to be provided  
 13 under this subdivision apply to services rendered to the newly  
 14 covered enrollee on and after the effective date of his or her new  
 15 coverage.

16 (3) A violation of this subdivision does not constitute a crime  
 17 under Section 1390.

18 (m) The following definitions apply for the purposes of this  
 19 section:

20 (1) “Individual provider” means a person who is a licentiate, as  
 21 defined in Section 805 of the Business and Professions Code, or  
 22 a person licensed under Chapter 2 (commencing with Section  
 23 1000) of Division 2 of the Business and Professions Code.

24 (2) “Nonparticipating provider” means a provider who is not  
 25 contracted with ~~a~~ *the enrollee’s health care service plan to provide*  
 26 *services under the enrollee’s plan contract.*

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

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

31 SEC. 2. Section 10133.56 of the Insurance Code is amended  
 32 to read:

33 10133.56. (a) (1) A health insurer that enters into a contract  
 34 with a professional or institutional provider to provide services at  
 35 alternative rates of payment pursuant to Section 10133 shall, at  
 36 the request of an insured, arrange for the completion of covered  
 37 services by a terminated provider, if the insured is undergoing a  
 38 course of treatment for any of the following conditions:

39 (A) An acute condition. An acute condition is a medical  
 40 condition that involves a sudden onset of symptoms due to an

1 illness, injury, or other medical problem that requires prompt  
2 medical attention and that has a limited duration. Completion of  
3 covered services shall be provided for the duration of the acute  
4 condition.

5 (B) A serious chronic condition. A serious chronic condition is  
6 a medical condition due to a disease, illness, or other medical  
7 problem or medical disorder that is serious in nature and that  
8 persists without full cure or worsens over an extended period of  
9 time or requires ongoing treatment to maintain remission or prevent  
10 deterioration. Completion of covered services shall be provided  
11 for a period of time necessary to complete a course of treatment  
12 and to arrange for a safe transfer to another provider, as determined  
13 by the health insurer in consultation with the insured and the  
14 terminated provider and consistent with good professional practice.  
15 Completion of covered services under this paragraph shall not  
16 exceed 12 months from the contract termination date *or 12 months*  
17 *from the effective date of coverage for a newly covered insured.*

18 (C) A pregnancy. A pregnancy is the three trimesters of  
19 pregnancy and the immediate postpartum period. Completion of  
20 covered services shall be provided for the duration of the  
21 pregnancy.

22 (D) A terminal illness. A terminal illness is an incurable or  
23 irreversible condition that has a high probability of causing death  
24 within one year or less. Completion of covered services shall be  
25 provided for the duration of a terminal illness, which may exceed  
26 12 months from the contract termination date *or 12 months from*  
27 *the effective date of coverage for a new insured.*

28 (E) The care of a newborn child between birth and age 36  
29 months. Completion of covered services under this paragraph shall  
30 not exceed 12 months from the contract termination date *or 12*  
31 *months from the effective date of coverage for a newly covered*  
32 *insured.*

33 (F) Performance of a surgery or other procedure that has been  
34 recommended and documented by the provider to occur within  
35 180 days of the contract's termination date *or within 180 days of*  
36 *the effective date of coverage for a newly covered insured.*

37 (2) The insurer may require the terminated provider whose  
38 services are continued beyond the contract termination date  
39 pursuant to this subdivision, to agree in writing to be subject to  
40 the same contractual terms and conditions that were imposed upon

1 the provider prior to termination, including, but not limited to,  
2 credentialing, hospital privileging, utilization review, peer review,  
3 and quality assurance requirements. If the terminated provider  
4 does not agree to comply or does not comply with these contractual  
5 terms and conditions, the insurer is not required to continue the  
6 provider's services beyond the contract termination date.

7 (3) Unless otherwise agreed upon between the terminated  
8 provider and the insurer or between the terminated provider and  
9 the provider group, the agreement shall be construed to require a  
10 rate and method of payment to the terminated provider, for the  
11 services rendered pursuant to this subdivision, that are the same  
12 as the rate and method of payment for the same services while  
13 under contract with the insurer and at the time of termination. The  
14 provider shall accept the reimbursement as payment in full and  
15 shall not bill the insured for any amount in excess of the  
16 reimbursement rate, with the exception of copayments and  
17 deductibles pursuant to subdivision (c).

18 (b) Notice as to the process by which an insured may request  
19 completion of covered services pursuant to this section shall be  
20 provided in any insurer evidence of coverage and disclosure form  
21 issued after March 31, 2004. An insurer shall provide a written  
22 copy of this information to its contracting providers and provider  
23 groups. An insurer shall also provide a copy to its insureds upon  
24 request.

25 (c) The payment of copayments, deductibles, or other  
26 cost-sharing components by the insured during the period of  
27 completion of covered services with a terminated provider pursuant  
28 to subdivision (a) or a nonparticipating provider pursuant to  
29 subdivision (i) shall be the same copayments, deductibles, or other  
30 cost-sharing components that would be paid by the insured when  
31 receiving care from a provider currently contracting with the  
32 insurer.

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

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

38 (1) "Provider" means a person who is a licentiate as defined in  
39 Section 805 of the Business and Professions Code or a person

1 licensed under Chapter 2 (commencing with Section 1000) of  
2 Division 2 of the Business and Professions Code.

3 (2) “Provider group” includes a medical group, independent  
4 practice association, or any other similar organization.

5 (3) “Nonparticipating provider” means a provider who ~~does not~~  
6 ~~have a contract with an insurer to provide services to insureds.~~ *is*  
7 *not contracted with the insured’s health insurer to provide services*  
8 *under the insured’s policy. A nonparticipating provider does not*  
9 *include a terminated provider.*

10 (4) “Terminated provider” means a provider whose contract to  
11 provide services to insureds is terminated or not renewed by the  
12 insurer or one of the insurer’s contracting provider groups. A  
13 terminated provider is not a provider who voluntarily leaves the  
14 insurer or contracting provider group.

15 (f) This section shall not require an insurer or provider group  
16 to provide for the completion of covered services by a provider  
17 whose contract with the insurer or provider group has been  
18 terminated or not renewed for reasons relating to medical  
19 disciplinary cause or reason, as defined in paragraph (6) of  
20 subdivision (a) of Section 805 of the Business and Professions  
21 Code, or fraud or other criminal activity.

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

25 (h) The provisions contained in this section are in addition to  
26 any other responsibilities of insurers to provide continuity of care  
27 pursuant to this chapter. Nothing in this section shall preclude an  
28 insurer from providing continuity of care beyond the requirements  
29 of this section.

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

36 (A) The newly covered insured’s prior coverage was terminated  
37 under subdivision (d) or (e) of Section 10273.6 *or paragraph (5)*  
38 *or (6) of subdivision (a) of Section 1365 of the Health and Safety*  
39 *Code between December 1, 2013, and March 31, 2014, inclusive.*

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

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

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

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

34 (C) *A provider's agreement to contractual terms and conditions*  
35 *and acceptance of payment rates to provide the completion of*  
36 *covered services to an insured pursuant to this subdivision shall*  
37 *not be construed as an agreement to contractual terms and*  
38 *conditions or acceptance of payment rates for any other insureds*  
39 *or for any services other than covered services pursuant to this*

1 *subdivision, nor shall it be construed as agreement to any other*  
2 *contract.*

3 ~~SEC. 3. It is the intent of the Legislature that a nonparticipating~~  
4 ~~provider whose services are continued pursuant to Section~~  
5 ~~10133.56 of the Insurance Code accept the reimbursement provided~~  
6 ~~under that section as payment in full and not bill the insured for~~  
7 ~~any amount in excess of the reimbursement rate, with the exception~~  
8 ~~of copayments and deductibles pursuant to subdivision (c) of~~  
9 ~~Section 10133.56.~~

10 ~~SEC. 4.~~

11 *SEC. 3.* No reimbursement is required by this act pursuant to  
12 Section 6 of Article XIII B of the California Constitution because  
13 the only costs that may be incurred by a local agency or school  
14 district will be incurred because this act creates a new crime or  
15 infraction, eliminates a crime or infraction, or changes the penalty  
16 for a crime or infraction, within the meaning of Section 17556 of  
17 the Government Code, or changes the definition of a crime within  
18 the meaning of Section 6 of Article XIII B of the California  
19 Constitution.

20 ~~SEC. 5.~~

21 *SEC. 4.* This act is an urgency statute necessary for the  
22 immediate preservation of the public peace, health, or safety within  
23 the meaning of Article IV of the Constitution and shall go into  
24 immediate effect. The facts constituting the necessity are:

25 Many health care service plans and health insurers terminated  
26 health plans between December 1, 2013, and March 31, 2014, in  
27 anticipation of compliance with the federal Patient Protection and  
28 Affordable Care Act. In order to allow an individual enrolled in  
29 such a plan who was receiving covered treatment under the plan  
30 from a provider for a certain condition to continue to receive  
31 services from that provider for the condition, it is necessary that  
32 this act take effect immediately.