

AMENDED IN SENATE APRIL 3, 2014

SENATE BILL

No. 1100

Introduced by Senator Hernandez

February 19, 2014

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.

LEGISLATIVE COUNSEL'S DIGEST

SB 1100, as amended, Hernandez. 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 provider termination. Existing law also requires a health care service plan *or a health insurer, at the request of a newly covered enrollee or insured*, to provide for the completion of covered services by a nonparticipating provider ~~to a newly covered enrollee who, if~~, at the time his or her coverage became effective, *the newly covered enrollee or insured* was receiving services from that provider for a specified condition *and if his or her prior coverage was terminated as provided*. Existing law requires a health care service plan to provide a disclosure form regarding the benefits, services, and terms of a plan contract and requires the disclosure form to include a

description of how an enrollee can request continuity of care under the provisions described above.

This bill would also require a health care service plan to include notice of the process to obtain continuity of care in every evidence of coverage issued after January 1, 2015. The bill would also require a plan to provide a written copy of this information to its contracting providers and provider groups, as well as a copy to its enrollees upon request. *The bill would delete the conditions that needed to be fulfilled in order for a health care service plan or health insurer, upon request of a newly covered enrollee or insured, to be required to provide for the completion of covered services for a specified condition by a nonparticipating provider.* The bill would make other technical changes to the provisions governing health insurers and continuity of care. Because a willful violation of the bill's requirements by a health care service plan 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:

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 (e).~~

29 (j) Except as provided in subdivision (l), this section shall not
30 apply to a newly covered enrollee who is offered an out-of-network
31 option or to a newly covered enrollee who had the option to
32 continue with his or her previous health plan or provider and
33 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) ~~(H)~~—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 forth
2 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:~~ *subdivision (c)*.

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 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 (n) *Notice as to the process by which an enrollee may request*
32 *completion of covered services pursuant to this section shall be*
33 *provided in every disclosure form as required under Section 1363*
34 *and in any evidence of coverage issued after January 1, 2015. A*
35 *plan shall provide a written copy of this information to its*
36 *contracting providers and provider groups. A plan shall also*
37 *provide a copy to its enrollees upon request.*

38 SEC. 2. *Section 10133.56 of the Insurance Code is amended*
39 *to read:*

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

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

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

26 (C) A pregnancy. A pregnancy is the three trimesters of
27 pregnancy and the immediate postpartum period. Completion of
28 covered services shall be provided for the duration of the
29 pregnancy.

30 (D) A terminal illness. A terminal illness is an incurable or
31 irreversible condition that has a high probability of causing death
32 within one year or less. Completion of covered services shall be
33 provided for the duration of a terminal illness, which may exceed
34 12 months from the contract termination date or 12 months from
35 the effective date of coverage for a new insured.

36 (E) The care of a newborn child between birth and age 36
37 months. Completion of covered services under this paragraph shall
38 not exceed 12 months from the contract termination date or 12
39 months from the effective date of coverage for a newly covered
40 insured.

1 (F) Performance of a surgery or other procedure that has been
2 recommended and documented by the provider to occur within
3 180 days of the contract's termination date or within 180 days of
4 the effective date of coverage for a newly covered insured.

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

15 (3) Unless otherwise agreed upon between the terminated
16 provider and the insurer or between the terminated provider and
17 the provider group, the agreement shall be construed to require a
18 rate and method of payment to the terminated provider, for the
19 services rendered pursuant to this subdivision, that are the same
20 as the rate and method of payment for the same services while
21 under contract with the insurer and at the time of termination. The
22 provider shall accept the reimbursement as payment in full and
23 shall not bill the insured for any amount in excess of the
24 reimbursement rate, with the exception of copayments and
25 deductibles pursuant to subdivision (c).

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

33 (c) The payment of copayments, deductibles, or other
34 cost-sharing components by the insured during the period of
35 completion of covered services with a terminated provider pursuant
36 to subdivision (a) or a nonparticipating provider pursuant to
37 subdivision (i) shall be the same copayments, deductibles, or other
38 cost-sharing components that would be paid by the insured when
39 receiving care from a provider currently contracting with the
40 insurer.

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

4 (e) For the purposes of this section, the following terms have
5 the following meanings: *definitions apply*:

6 (1) “Provider” means a person who is a licentiate as defined in
7 Section 805 of the Business and Professions Code or a person
8 licensed under Chapter 2 (commencing with Section 1000) of
9 Division 2 of the Business and Professions Code.

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

12 (3) “Nonparticipating provider” means a provider who is not
13 contracted with the insured’s health insurer to provide services
14 under the insured’s policy. A nonparticipating provider does not
15 include a terminated provider.

16 (4) “Terminated provider” means a provider whose contract to
17 provide services to insureds is terminated or not renewed by the
18 insurer or one of the insurer’s contracting provider groups. A
19 terminated provider is not a provider who voluntarily leaves the
20 insurer or contracting provider group.

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

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

31 (h) The provisions contained in this section are in addition to
32 any other responsibilities of insurers to provide continuity of care
33 pursuant to this chapter. Nothing in this section shall preclude an
34 insurer from providing continuity of care beyond the requirements
35 of this section.

36 (i) (1) A health insurer shall, at the request of a newly covered
37 insured under an individual insurance policy, arrange for the
38 completion of covered services as set forth in this section by a
39 nonparticipating provider for one of the conditions described in

1 ~~subdivision (a) if the newly covered insured meets both of the~~
2 ~~following: subdivision (a).~~

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

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

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

14 ~~(3)~~

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

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

1 (C) A provider’s agreement to contractual terms and conditions
2 and acceptance of payment rates to provide the completion of
3 covered services to an insured pursuant to this subdivision shall
4 not be construed as an agreement to contractual terms and
5 conditions or acceptance of payment rates for any other insureds
6 or for any services other than covered services pursuant to this
7 subdivision, nor shall it be construed as agreement to any other
8 contract.

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

18
19
20 **All matter omitted in this version of the bill**
21 **appears in the bill as introduced in the**
22 **Senate, February 19, 2014. (JR11)**
23