ASSEMBLY BILL No. 533

Introduced by Assembly Member Bonta

February 23, 2015

An act to add Section 1371.9 to the Health and Safety Code, and to add Section 10112.8 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 533, as introduced, Bonta. Health care coverage: out-of-network coverage.

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. A willful violation of the act is a crime. Existing law requires a health care service plan to reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee. Existing law prohibits a plan from requiring a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical care, as specified.

Existing law also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires a health insurance policy issued, amended, or renewed on or after January 1, 2014, that provides or covers benefits with respect to services in an emergency department of a hospital to cover emergency services without the need for prior authorization, regardless of whether the provider is a participating provider, and subject to the same cost sharing required if the services were provided by a participating provider, as specified.

This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2016, to provide that if an enrollee obtains care from a participating facility, as defined, at which, or as a result of which, the enrollee receives covered services provided by a nonparticipating provider, as defined, the enrollee is required to pay the nonparticipating provider only the same cost sharing required if the services were provided by a participating provider. Because a willful violation of the bill's provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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 1371.9 is added to the Health and Safety Code, to read:

1371.9. (a) (1) A health care service plan contract issued, amended, or renewed on or after January 1, 2016, shall provide that if an enrollee obtains care from a participating facility at which, or as a result of which, the enrollee receives services provided by a nonparticipating provider, the enrollee shall pay the nonparticipating provider no more than the same cost sharing that the enrollee would have paid for the same covered benefits received from a participating provider.

(2) Except as provided in subdivision (d), the plan shall not reimburse a nonparticipating provider for services provided to the enrollee if the nonparticipating provider obtains, or seeks to obtain, more than the in-network cost sharing from the enrollee.

(b) (1) Any cost sharing paid by the enrollee for the services provided by a nonparticipating provider at the participating facility shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006.

(2) Cost sharing shall be counted toward any deductible in the same manner as cost sharing would be attributed to a participating provider.

(c) For purposes of this section, the following definitions shall apply:

(1) "Cost sharing" includes any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the enrollee other than premium or share of premium.

(2) "Nonparticipating provider" means a provider who is not contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.

(3) "Participating facility" means a health facility provider who is contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract. A facility shall include the following providers:

(A) Licensed hospital.

(B) Skilled nursing facility.

(C) Ambulatory surgery.

(D) Laboratory.

(E) Radiology or imaging.

(F) Facilities providing mental health or substance abuse treatment.

(G) Any other provider as the department may by regulation define as a facility for purposes of this section.

(4) "Provider" means a health facility or any person who is licensed by the state to deliver or furnish health care services.

(d) An enrollee may voluntarily consent to the use of a nonparticipating provider. For purposes of this section, consent shall be voluntary if at least 24 hours in advance of the receipt of services, the enrollee is provided a written estimate of the cost of care by the nonparticipating provider and the enrollee consents in writing to both the use of a nonparticipating provider and the estimated additional cost for the services to be provided by the nonparticipating provider. The consent shall inform the enrollee that the cost of the services of the nonparticipating provider will not accrue to the limit on annual out-of-pocket expenses.

(e) This section shall not be construed to require a plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.

SEC. 2. Section 10112.8 is added to the Insurance Code, to read:

10112.8. (a) (1) A health insurance policy issued, amended, or renewed on or after January 1, 2016, shall provide that if an insured obtains care from a participating facility at which, or as a result of which, the insured receives services provided by a nonparticipating provider, the insured shall pay the nonparticipating provider no more than the same cost sharing that the insured would have paid for the same covered benefits received from a participating provider.

(2) Except as provided in subdivision (d), the insurer shall not reimburse a nonparticipating provider for services provided to the insured if the nonparticipating provider obtains, or seeks to obtain, more than the in-network cost sharing from the insured.

(3) This section shall only apply to a health insurer that enters into a contract with a professional or institutional provider to provide services at alternative rates of payment pursuant to Section 10133.

(b) (1) Any cost sharing paid by the insured for the services provided by a nonparticipating provider at the participating facility shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.

(2) Cost sharing shall be counted toward any deductible in the same manner as cost sharing would be attributed to a participating provider.

(c) For purposes of this section, the following definitions shall apply:

(1) “Cost sharing” includes any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the insured other than premium or share of premium.

(2) “Nonparticipating provider” means a provider who is not contracted with the insured’s health insurer to provide services under the insured’s policy.

(3) “Participating facility” means a health facility provider who is contracted with the insured’s health insurer to provide services under the insured’s policy. A facility shall include the following providers:

(A) Licensed hospital.

(B) Skilled nursing facility.

(C) Ambulatory surgery.

(D) Laboratory.

(E) Radiology or imaging.

(F) Facilities providing mental health or substance abuse treatment.

(G) Any other provider as the department may by regulation define as a facility for purposes of this section.

(4) "Provider" means a health facility or any person who is licensed by the state to deliver or furnish health care services.

(d) An insured may voluntarily consent to the use of a nonparticipating provider. For purposes of this section, consent shall be voluntary if at least 24 hours in advance of the receipt of services, the insured is provided a written estimate of the cost of care by the nonparticipating provider and the insured consents in writing to both the use of a nonparticipating provider and the estimated additional cost for the services to be provided by the nonparticipating provider. The consent shall inform the insured that the cost of the services of the nonparticipating provider will not accrue to the limit on annual out-of-pocket expenses.

(e) This section shall not be construed to require an insurer to cover services or provide benefits that are not otherwise covered under the terms and conditions of the policy.

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.

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