ASSEMBLY BILL No. 1086

Introduced by Assembly Member Dababneh

February 27, 2015

An act to add Section 1371.34 to the Health and Safety Code, and to add Section 10133.75 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1086, as introduced, Dababneh. Assignment of reimbursement rights.

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 that act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

Existing law requires, on and after January 1, 1994, every group health care service plan, that provides hospital, medical, or surgical expense benefits for plan members and their dependents to authorize and permit assignment of the enrollee's or subscriber's right to any reimbursement for health care services covered under the plan contract to the State Department of Health Care Services when health care services, excepting specified contracted services, are provided to a Medi-Cal beneficiary.

This bill would prohibit certain health care service plans and disability insurers from prohibiting an enrollee, subscriber, or insured from making an assignment of his or her reimbursement rights for covered health care services to the physician and surgeon who furnished those services. The bill would require a physician and surgeon seeking payment from a health care service plan or disability insurer under the provisions of

the bill to provide the plan or insurer with specified documentation and information, including an itemized bill for service. This bill would require the physician and surgeon to provide a written agreement authorizing the assignment of the enrollee's, subscriber's, or insured's reimbursement rights, and would specify the form and content of that agreement.

Because a willful violation of the bill's requirements relative to health care service plans 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 1371.34 is added to the Health and Safety Code, to read:

1371.34. (a) A health care service plan that provides medical or surgical expense benefits for plan members and their dependents shall not prohibit an enrollee or subscriber from making an assignment of the enrollee's or subscriber's right to any reimbursement for health care services covered under the plan contract to the physician and surgeon who furnished the health care services.

(b) When seeking payment from a health care service plan pursuant to subdivision (a), a physician and surgeon shall provide the plan with the physician and surgeon's itemized bill for service, the name and address of the person to be reimbursed, and the name and contract number of the enrollee.

(c) The written agreement authorizing assignment of the enrollee's or subscriber's right to any reimbursement for health care services covered under subdivision (a) shall do all of the following:

(1) Be written in plain language.

(2) Be made available by the physician and surgeon in the primary languages of the two largest groups seen by the physician

and surgeon who either do not speak English or who are unable to effectively communicate in English because it is not their native language, and who comprise 5 percent or more of the patients served by the physician.

(3) Be printed in at least 12-point font. The agreement shall disclose in boldface type or a font a minimum of two points larger than the rest of the agreement, exclusive of the heading, all of the following information:

(A) "The enrollee or subscriber remains responsible for costs, including any provider fees, copayments, and coinsurance exceeding the amount of the benefit covered by the policy and paid by the health plan."

(B) "The enrollee or subscriber is entitled to a summary of benefits and coverage from the health care service plan pursuant to Section 300gg-15 of Title 42 of the United States Code to help in better understanding benefit design, level of financial protection, and costs related to out-of-network services."

(C) "The enrollee or subscriber is entitled to information from the health care service plan that explains how the health plan determines the amount it pays for out-of-network services. Your actual out-of-pocket costs may vary based on factors specific to your health plan. Some plans base their reimbursement rates on a percentage of "usual, customary, and reasonable" charges, which is referred to as "UCR." Others use a formula based on the Medicare fee schedule that is published by the United States Department of Health and Human Services. To learn how your health plan determines out-of-network reimbursement rates and covered services, call the number listed on the back of your insurance card. Then, to estimate your out-of-pocket costs, visit the following Internet Web site http://fairhealthconsumer.org, which will, using the method that your plan uses to calculate reimbursement, allow you to estimate your out-of- pocket costs."

(4) Be signed and dated by the enrollee or subscriber.

(d) This section applies only to a preferred provider organization, point of service plan, or any other plan contract that provides for out-of-network coverage and services. This section does not apply to a plan providing benefits pursuant to a specialized health care service plan contract, as defined in subdivision (o) of Section 1345.

SEC. 2. Section 10133.75 is added to the Insurance Code, to read:

10133.75. (a) On and after January 1, 2013, a disability insurer shall pay individual insurance benefits contingent upon, or for expenses incurred on account of, medical or surgical aid to the physician and surgeon having provided the medical or surgical aid where that physician and surgeon has qualified for reimbursement by submitting the items and information specified in subdivision (b).

(b) When seeking payment from a disability insurer pursuant to subdivision (a), a person shall provide the insurer with the provider's itemized bill for service, the name and address of the person to be reimbursed, and the name and policy number of the insured.

(c) The written agreement authorizing assignment of the insured's right to any reimbursement for health care services covered under subdivision (a) shall do all of the following:

(1) Be written in plain language.

(2) Be made available by the physician and surgeon in the primary languages of the two largest groups seen by the physician and surgeon who either do not speak English or who are unable to effectively communicate in English because it is not their native language, and who comprise 5 percent or more of the patients served by the physician and surgeon.

(3) Be printed in at least 12-point font. The agreement shall disclose in boldface type or a font a minimum of two points larger than the rest of the agreement, exclusive of the heading, the following information:

(A) "The insured remains responsible for costs, including any provider fees, copayments, and coinsurance exceeding the amount of the benefit covered by the policy and paid by the insurer."

(B) "The insured is entitled to a summary of benefits and coverage from the insurer pursuant to Section 300gg-15 of Title 42 of the United States Code to help in better understanding benefit design, level of financial protection, and costs related to out-of-network services."

(C) "The insured is entitled to information from the insurer that explains how the insurer determines the amount it pays for out-of-network services. Your actual out-of-pocket costs may vary based on factors specific to your health plan. Some plans base their reimbursement rates on a percentage of "usual, customary, and reasonable" charges, which is referred to as "UCR." Others use a

formula based on the Medicare fee schedule that is published by the United States Department of Health and Human Services. To learn how your health plan determines out of-network reimbursement rates and covered services, call the number listed on the back of your insurance card. Then, to estimate your out-of-pocket costs, visit the following Internet Web site http://fairhealthconsumer.org, which will, using the method that your plan uses to calculate reimbursement, allow you to estimate your out-of-pocket costs."

(4) Be signed and dated by the insured.

(d) This section shall not apply to an insurer providing benefits pursuant to a specialized health insurance policy, as defined in subdivision (c) of Section 106.

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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