

Senate Bill No. 1135

CHAPTER 500

An act to add Section 1367.031 to the Health and Safety Code, and to add Section 10133.53 to the Insurance Code, relating to health care coverage.

[Approved by Governor September 23, 2016. Filed with Secretary of State September 23, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1135, Monning. Health care coverage: notice of timely access to 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 each department to develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires each prepaid health plan to establish a grievance procedure under which enrollees may submit their grievances.

This bill would require a health care service plan contract or a health insurance policy that provides benefits through contracts with providers for alternative rates that is issued, renewed, or amended on or after July 1, 2017, to provide information to enrollees and insureds regarding the standards for timely access to health care services and other specified health care access information, including information related to receipt of interpreter services in a timely manner, no less than annually, and would make these provisions applicable to Medi-Cal managed care plans. The bill would also require a health care service plan or a health insurer that contracts with providers for alternative rates of payment to provide a contracting health care provider with specified information relating to the provision of referrals or health care services in a timely manner.

Because a willful violation of the bill's provisions 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.

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

SECTION 1. Section 1367.031 is added to the Health and Safety Code, to read:

1367.031. (a) A health care service plan contract that is issued, renewed, or amended on or after July 1, 2017, shall provide information to an enrollee regarding the standards for timely access to care adopted pursuant to Section 1367.03 and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(b) A health care service plan at a minimum shall provide information regarding appointment wait times for urgent care, nonurgent primary care, nonurgent specialty care, and telephone screening established pursuant to Section 1367.03 to enrollees and contracting providers. The information shall also include notice of the availability of interpreter services at the time of the appointment pursuant to Section 1367.04. A health care service plan may indicate that exceptions to appointment wait times may apply if the department has found exceptions to be permissible.

(c) The information required to be provided pursuant to this section shall be provided to an enrollee with individual coverage upon initial enrollment and annually thereafter upon renewal, and to enrollees and subscribers with group coverage upon initial enrollment and annually thereafter upon renewal. A health care service plan may include this information with other materials sent to the enrollee. The information shall also be provided in the following manner:

(1) In a separate section of the evidence of coverage titled “Timely Access to Care.”

(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the plan’s enrollees.

(3) Commencing January 1, 2018, in a separate section of the provider directory published and maintained by the health care service plan pursuant to Section 1367.27. The separate section shall be titled “Timely Access to Care.”

(4) On the Internet Web site published and maintained by the health care service plan, in a manner that allows enrollees and prospective enrollees to easily locate the information.

(d) (1) A health care service plan shall provide the information required by this section to contracting providers on no less than an annual basis.

(2) A health care service plan shall also inform a contracting provider of all of the following:

(A) Information about a health care service plan’s obligation under California law to provide or arrange for timely access to care.

(B) How a contracting provider or enrollee can contact the health care service plan to obtain assistance if a patient is unable to obtain a timely referral to an appropriate provider.

(C) The toll-free telephone number for the Department of Managed Health Care where providers and enrollees can file a complaint if they are unable to obtain a timely referral to an appropriate provider.

(3) A health care service plan may comply with this subdivision by including the information with an existing communication with a contracting provider.

(e) This section shall apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 2. Section 10133.53 is added to the Insurance Code, to read:

10133.53. (a) A health insurance policy that is issued, renewed, or amended on or after July 1, 2017, that provides benefits through contracts with providers for alternative rates pursuant to Section 10133 shall provide information to an insured regarding the standards for timely access to care adopted pursuant to Section 10133.5 and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(b) A health insurer that contracts with providers for alternative rates of payment pursuant to Section 10133 shall, at a minimum, provide information regarding appointment wait times for urgent care, nonurgent primary care, nonurgent specialty care, and telephone screening established pursuant to Section 10133.5 to insureds and contracting providers. The information shall also include notice of the availability of interpreter services at the time of the appointment pursuant to Section 10133.8. A health insurer may indicate that exceptions to appointment wait times may apply if the department has found exceptions to be permissible.

(c) The information required to be provided pursuant to this section shall be provided to an insured with individual coverage upon initial enrollment and annually thereafter upon renewal, and to insureds and group policyholders with group coverage upon initial enrollment and annually thereafter upon renewal. An insurer may include this information with other materials sent to the insured. The information shall also be provided in the following manner:

(1) In a separate section of the evidence of coverage titled “Timely Access to Care.”

(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the policy’s insureds.

(3) Commencing January 1, 2018, in a separate section of the provider directory published and maintained by the insurer pursuant to Section 10133.15. The separate section shall be titled “Timely Access to Care.”

(4) On the Internet Web site published and maintained by the insurer, in a manner that allows insureds and prospective insureds to easily locate the information.

(d) (1) A health insurer shall provide the information required by this section to contracting providers on no less than an annual basis.

(2) A health insurer shall also inform a contracting provider of all of the following:

(A) Information about a health insurer’s obligation under California law to provide or arrange for timely access to care.

(B) How a contracting provider or insured can contact the health insurer to obtain assistance if a patient is unable to obtain a timely referral to an appropriate provider.

(C) The toll-free telephone number for the Department of Insurance where providers and insureds can file a complaint if they are unable to obtain a timely referral to an appropriate provider.

(3) A health insurer may comply with this subdivision by including the information with an existing communication with a contracting provider.

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.