

Assembly Bill No. 1152

CHAPTER 504

An act to add Section 1373.95 to the Health and Safety Code, and to add Section 10133.55 to the Insurance Code, relating to health coverage.

[Approved by Governor October 3, 1995. Filed
with Secretary of State October 4, 1995.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1152, Bordonaro. Health coverage: reimbursement of traditional or terminated provider.

Existing law provides for the licensure and regulation of health care service plans administered by the Commissioner of Corporations. Under existing law, willful violation of any of these provisions is a misdemeanor. Existing law also provides for the regulation of policies of disability insurance and nonprofit hospital service plan contracts administered by the Insurance Commissioner. Existing law requires that health care service plans, disability insurers, and nonprofit hospital service plans provide coverage for certain benefits and services.

The bill would require, by July 1, 1996, health care service plans that provide coverage on a group basis, certain group disability insurance policies that provide coverage for hospital, medical, or surgical benefits, and certain nonprofit hospital service plan contracts that provide coverage on a group basis to file a written policy with the Department of Corporations or Department of Insurance regarding coverage for enrollees, insureds, or subscribers receiving services during a current episode of care from a noncontracting provider. The bill would provide that the written policy shall include, among other things, a description of the process used to facilitate the continuity of patient care, and the review process of requests to continue services with an existing provider. The bill would require that a copy of the policy be provided to enrollees, insureds, and subscribers.

By changing the definition of the crime applicable to health care service plans, 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.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) The health care delivery system in California is increasingly relying upon various forms of managed care to control the costs of providing health care.

(b) Strong provider-patient relationships, particularly for patients with acute medical conditions, may enhance the curative process.

(c) Maintaining continuity of care as patients change providers and health plans is important to the health and well-being of the enrollees of managed care plans.

SEC. 2. Section 1373.95 is added to the Health and Safety Code, immediately following Section 1373.9, to read:

1373.95. (a) On or before July 1, 1996, every health care service plan that provides coverage on a group basis shall file with the Department of Corporations, a written policy describing how the health plan shall facilitate the continuity of care for new enrollees receiving services during a current episode of care for an acute condition from a nonparticipating provider. This written policy shall describe the process used to facilitate the continuity of care, including the assumption of care by a participating provider. Notice of the policy and information regarding how enrollees may request a review under the policy shall be provided to all new enrollees, except those enrollees who are not eligible as described in subdivision (e). A copy of the written policy shall be provided to eligible enrollees upon request.

(b) The written policy shall describe how requests to continue services with an existing provider are reviewed by the plan. The policy shall ensure that reasonable consideration is given to the potential clinical effect that a change of provider would have on the enrollee's treatment for the acute condition.

(c) A health care service plan may require any nonparticipating provider whose services are continued pursuant to the written policy to agree in writing to meet the same contractual terms and conditions that are imposed upon the plan's participating providers, including location within the plan's service area, reimbursement methodologies, and rates of payment. If the health care service plan determines that a patient's health care treatment should temporarily continue with the patient's existing provider, the health care service plan shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provision of services by the existing provider.

(d) Nothing in this section shall require a health care service plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.



(e) The written policy shall not apply to any enrollee who is offered an out-of-network option, or who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.

(f) This section shall not apply to health plan contracts that include out-of-network coverage under which the enrollee is able to obtain services from the enrollee's existing provider.

(g) For purposes of this section, "provider" refers to a person who is described in subdivision (f) of Section 900 of the Business and Professions Code.

SEC. 3. Section 10133.55 is added to the Insurance Code, to read:

10133.55. (a) On or before July 1, 1996, every disability insurer covering hospital, medical, and surgical expenses on a group basis, or nonprofit hospital service plan providing coverage on a group basis, that contracts with providers for alternative rates pursuant to Section 10133 or Section 11512 and limit payments under those policies and plans to services secured by insureds and subscribers from providers charging alternative rates pursuant to these contracts, shall file with the Department of Insurance, a written policy describing how the health plan shall facilitate the continuity of care for new insureds or enrollees receiving services during a current episode of care for an acute condition from a noncontracting provider. This written policy shall describe the process used to facilitate continuity of care, including the assumption of care by a contracting provider. Notice of the policy and information regarding how insureds and subscribers may request a review under the policy shall be provided to all new insureds and subscribers, except those insureds or subscribers who are not eligible as described in subdivision (e). A copy of the written policy shall be provided to eligible insureds and subscribers upon request.

(b) The written policy shall describe how requests to continue services with an existing noncontracting provider are reviewed by the insurer or plan. The policy shall ensure that reasonable consideration is given to the potential clinical effect that a change of provider would have on the insured's or subscriber's treatment for the acute condition.

(c) An insurer or plan may require any nonparticipating provider whose services are continued pursuant to the written policy to agree in writing to meet the same contractual terms and conditions that are imposed upon the insurer's or plan's participating providers, including location within the plan's service area, reimbursement methodologies, and rates of payment. If the insurer or plan determines that a patient's health care treatment should temporarily continue with the patient's existing provider, the insurer or plan shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provision of services by the existing provider.



(d) Nothing in this section shall require an insurer or plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the policy or plan contract.

(e) The written policy shall not apply to any insured or subscriber who is offered an out-of-network option, or who had the option to continue with his or her previous health benefits carrier or provider and instead voluntarily chose to change health plans.

(f) This section shall not apply to health plan contracts that include out-of-network coverage under which the insured or subscriber is able to obtain services from the insured's or subscriber's existing provider.

(g) For purposes of this section, "provider" refers to a person who is described in subdivision (f) of Section 900 of the Business and Professions Code.

(h) This section shall only apply to a group disability insurance policy if it provides coverage for hospital, medical, or surgical benefits.

SEC. 4. 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.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

