AMENDED IN SENATE APRIL 18, 2012

AMENDED IN SENATE APRIL 10, 2012

SENATE BILL No. 1373

Introduced by Senator Lieu

February 24, 2012

An act to add ~~Section~~ *Sections 1339.586 and* 1371.6 to the Health and Safety Code, and to add Section 10133.68 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1373, as amended, Lieu. Health care coverage: out-of-network coverage.

Existing law provides for the licensure and regulation of health facilities, including hospitals, by the State Department of Public Health and makes a violation of those provisions a misdemeanor. Existing law, the Payers' Bill of Rights, requires a hospital that uses a charge description master to make a written or electronic copy available in accordance with specified provisions and requires the hospital to post a notice that informs patients that the charge description master is available pursuant to specified provisions.

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 requires plans to reimburse noncontracting providers for emergency services and care rendered to enrollees of the plan, as specified. Existing law requires plans to, upon request, provide a list of specified contracting providers within the enrollee's or prospective enrollee's general geographic area. Existing law provides for the regulation of health insurers by the Department of

Insurance and authorizes health insurers to contract for alternative rates of payment with providers. Existing law requires insurers to provide group policyholders with a current roster of institutional and professional providers under contract to provide services at alternative rates under their group policy and to make that list available for inspection during regular business hours at the insurer's principal office.

Under this bill, when a patient seeks services at a hospital for an elective or scheduled procedure and the patient is covered by a specified type of health care service plan contract or health insurance policy that provides out-of-network coverage, the hospital would be required to provide the patient with a notice stating, among other things, that certain hospital-based providers may not be within the network of the patient's plan or insurer. The bill would require that the hospital receive the signature of the patient, or his or her legal representative, on this notice prior to rendering services to the patient. The bill would also require that a health care service plan or health insurer that receives a request from a subscriber, enrollee, policyholder, or insured for a referral to a noncontracting provider based on this hospital notice either authorize the enrollee or subscriber or policyholder or insured to obtain covered services from the noncontracting provider or refer the enrollee to a contracting provider with similar clinical expertise providing similar services in the same geographic region.

~~Under this bill, when an enrollee or insured under a specified type of contract or policy that covers services rendered by noncontracting providers seeks covered services from an individual noncontracting provider at the provider's office or the office of the provider's provider group, or at a health facility for an elective or scheduled procedure, the individual provider or the facility would be required to provide the enrollee or insured a notice containing certain information, as specified. The bill would require the plan or insurer to reimburse the individual noncontracting provider at a rate other than the rate usually paid to a noncontracting provider, unless the plan or insurer determines that the enrollee or insured reasonably should have known that the provider was a noncontracting provider. The bill would provide that the enrollee or insured reasonably should have known that the provider was a noncontracting provider if the provider or the facility provided the notice described above. The~~

The bill would also prohibit a ~~health facility~~ *hospital* or a provider group from holding itself out as being within a plan or provider network unless all of the individual providers providing services at the ~~facility~~

hospital or with the provider group are within the plan or provider network *or the hospital or provider group acknowledges that individual providers within the hospital or provider group may be outside the plan or provider network.*

Because a violation of ~~these~~ *certain of the bill's* requirements ~~with respect to a health care service plan~~ would be a crime, this bill would impose a state-mandated local program by creating a new crime.

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 1339.586 is added to the Health and Safety Code, to read:

1339.586. (a) When a patient seeks services at a hospital for an elective or scheduled procedure, including a planned labor and delivery, and the patient is covered by a point-of-service health care service plan contract, or a health care service plan contract or health insurance policy that provides coverage through a preferred provider organization, the hospital shall provide a written notice to the patient at the earliest possible time after the procedure is scheduled. The notice shall be separate from any other document, shall be in English, Spanish, Vietnamese, Chinese, Korean, Tagalog, Russian, Armenian, Khmer, Arabic, or Hmong, as applicable, and shall include all of the following information:

(1) A statement that hospital-based providers, such as radiologists, anesthesiologists, and pathologists, providing services within the hospital, may not be in the network of the patient's health care service plan or health insurer.

(2) A statement that services rendered by the hospital-based providers described in paragraph (1) may not be covered by the patient's health care service plan contract or health insurance policy.

(3) A statement that recommends that the patient contact his or her health care service plan or health insurer in order to obtain

a referral for services from an in-network provider or a provider otherwise authorized by the plan or insurer.

(4) A written estimate of the cost to the patient for the services rendered by the hospital-based providers described in paragraph (1). The estimate shall be based on the providers' usual and customary charges.

(5) The toll-free telephone numbers of the Department of Managed Health Care and the Department of Insurance.

(b) Prior to rendering the services sought pursuant to subdivision (a), a hospital shall require that the patient, or the legal representative thereof, sign the notice provided pursuant to subdivision (a), acknowledging that he or she is aware that specified providers may be outside the network of his or her health care service plan or health insurer.

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

(1) "Health care service plan" has the same meaning as that term is defined in Section 1345.

(2) "Health care service plan contract" has the same meaning as that term is defined in Section 1345.

(3) "Health insurance policy" means a policy of health insurance, as defined in Section 106 of the Insurance Code.

(4) "Health insurer" means an insurer that issues policies of health insurance, as defined in Section 106 of the Insurance Code.

(5) "Hospital" means a hospital as defined in subdivision (a), (b), or (f) of Section 1250.

(6) "Point-of-service health care service plan contract" means a "point-of-service plan contract" as defined in Section 1374.60.

~~SECTION 1.~~

SEC. 2. Section 1371.6 is added to the Health and Safety Code, to read:

1371.6. (a) In enacting this section, it is the intent of the Legislature to ensure that consumers have an adequate opportunity to obtain medically necessary care within their plan network.

~~(b) When an enrollee of a preferred provider organization plan contract or a point-of-service plan contract receives services for covered benefits from an individual noncontracting provider at the provider's office or the office of the provider's provider group, or at a health facility during an elective or scheduled procedure, including a planned labor and delivery, a plan shall pay claims~~

~~from the individual noncontracting provider at a rate other than the~~

~~rate usually paid to an individual noncontracting provider who renders similar services on a noncapitated basis and who is practicing in the same or similar geographic region, unless the plan determines that the enrollee reasonably should have known that the provider was a noncontracting provider as described in subdivision (c). This subdivision shall apply only to health care service plan contracts issued, amended, or renewed on or after January 1, 2013.~~

~~(c) For purposes of subdivision (b), the following provisions shall apply:(1) If an enrollee receives services from an individual noncontracting provider at the provider's office or the office of the provider's provider group, the enrollee reasonably should have known that the provider was a noncontracting provider if the provider documents to the plan that he or she provided the notice as required under subdivision (d).~~

~~(2) If an enrollee receives services from an individual noncontracting provider at a health facility during an elective or scheduled procedure, including a planned labor and delivery, the enrollee reasonably should have known that the provider was a noncontracting provider if the facility documents to the plan that it provided the notice as required under subdivision (e).~~

~~(d) When an enrollee of a preferred provider organization plan contract or a point-of-service plan contract seeks services for covered benefits from an individual noncontracting provider at the provider's office or the office of the provider's provider group, the provider shall, at the point of entry, provide a written notice to the enrollee in English, Spanish, Vietnamese, Chinese, Korean, Tagalog, Russian, Armenian, Khmer, Arabic, or Hmong, as applicable, that includes all of the following information:~~

~~(1) A statement that the provider is not in the enrollee's plan network.~~

~~(2) A statement that services rendered by the provider may not be covered by the enrollee's plan contract.~~

~~(3) A statement referring the enrollee to his or her health care service plan in order to obtain services from an in-network provider or a provider otherwise authorized by the plan.~~

~~(4) A written estimate of the cost to the enrollee for the services to be rendered by the provider. This estimate shall be based on the provider's usual and customary charges for the care to be provided.~~

~~(5) The toll-free telephone number of the department.~~

~~(e) When an enrollee of a preferred provider organization plan contract or a point-of-service plan contract seeks covered services for an elective or scheduled procedure, including a planned labor and delivery, from a health facility in which individual providers providing services within the facility are not known to the facility to be contracting providers, the facility shall, at the earliest possible time after the procedure is scheduled, provide a notice to the enrollee in English, Spanish, Vietnamese, Chinese, Korean, Tagalog, Russian, Armenian, Khmer, Arabic, or Hmong, as applicable, that includes all of the following information:~~

~~(1) A statement that specific categories of providers providing services within the facility may not be in the enrollee's plan network.~~

~~(2) A statement that services rendered by individual noncontracting providers within the facility may not be covered by the enrollee's plan contract.~~

~~(3) A statement that refers the enrollee to his or her health care service plan in order to obtain services from an in-network provider or a provider otherwise authorized by the plan.~~

~~(4) A written estimate of the cost to the enrollee for the services rendered by the categories of providers described in paragraph (1). The estimate shall be based on the providers' usual and customary charges.~~

~~(5) The toll-free telephone number of the department.~~

(b) If a plan receives a request from an enrollee or subscriber for a referral to receive covered services from an individual noncontracting provider based on the notice provided pursuant to Section 1339.586, the plan shall either refer the enrollee or subscriber to a contracting provider with similar clinical expertise providing similar services in the same geographic region or authorize the enrollee or subscriber to obtain the covered services from the noncontracting provider. Appointments shall be arranged consistent with Section 1367.03 and the regulations adopted thereunder.

~~(f)~~

(c) A provider group shall not hold itself out as being within a plan's network unless ~~all~~ *one of the following applies:*

(1) All of the individual providers providing services with the provider group are within the plan network.

(2) The provider group acknowledges that individual providers within the provider group may be outside the enrollee's plan network.

~~(g)~~

(d) A ~~health facility~~ *hospital* shall not hold itself out as being within a plan's network unless ~~all~~ *one of the following applies:*

(1) All of the individual providers providing services within the ~~facility~~ *hospital* are within the plan network.

~~(h) This section shall not apply when an enrollee seeks emergency services and care required to be reimbursed by a plan pursuant to Section 1371.4. Consistent with Section 1371.4, this section shall apply to services and care provided after an enrollee is stabilized following an emergency.~~

(2) The hospital acknowledges that individual providers providing services within the hospital may be outside the enrollee's plan network.

~~(i)~~

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

(1) ~~"Health facility" has the same meaning as that term is~~ *"Hospital" means a hospital as* defined in *subdivision (a), (d), or (f) of* Section 1250.

(2) "Noncontracting provider" means a provider who is not employed by, under contract with, or otherwise affiliated with a health care service plan to provide services to the enrollee.

(3) "Provider group" means a medical group, independent practice association, or any other similar organization.

~~SEC. 2.~~

SEC. 3. Section 10133.68 is added to the Insurance Code, to read:

~~10133.68. (a) When an insured receives services for covered benefits from an individual noncontracting provider at the provider's office or the office of the provider's provider group, or at a health facility during an elective or scheduled procedure, including a planned labor and delivery, an insurer that contracts with institutional and professional providers for alternative rates~~

~~pursuant to Section 10133 and does not limit payments to those providers as described in subdivision (c) of Section 10133, shall pay claims from the individual noncontracting provider at a rate other than the rate usually paid to an individual noncontracting provider who renders similar services and who is practicing in the same or similar geographic region, unless the insurer determines that the insured reasonably should have known that the provider was a noncontracting provider as described in subdivision (b). This subdivision shall apply only to health insurance policies issued, amended, or renewed on or after January 1, 2013.~~

~~(b) For purposes of subdivision (a), the following provisions shall apply:~~

~~(1) If an insured receives services from an individual noncontracting provider at the provider's office or the office of the provider's provider group, the insured reasonably should have known that the provider was a noncontracting provider if the provider documents to the insurer that he or she provided the notice as required under subdivision (c).~~

~~(2) If an insured receives services from an individual noncontracting provider at a health facility during an elective or scheduled procedure, including a planned labor and delivery, the insured reasonably should have known that the provider was a noncontracting provider if the facility documents to the insurer that it provided the notice as required under subdivision (d).~~

~~(c) When an insured of a preferred provider organization health insurance policy seeks services for covered benefits from an individual noncontracting provider at the provider's office or the office of the provider's provider group, the provider shall, at the point of entry, provide a written notice to the insured in English, Spanish, Vietnamese, Chinese, Korean, Tagalog, Russian, Armenian, Khmer, Arabic, or Hmong, as applicable, that includes all of the following information:~~

~~(1) A statement that the provider is not in the insured's provider network.~~

~~(2) A statement that services rendered by the provider may not be covered by the insured's policy.~~

~~(3) A statement referring the insured to his or her health insurer in order to obtain services from an in-network provider or a provider otherwise authorized by the insurer.~~

~~(4) A written estimate of the cost to the insured for the services to be rendered by the provider. This estimate shall be based on the provider's usual and customary charges for the care to be provided.~~

~~(5) The toll-free telephone number of the department.~~

~~(d) When an insured of a preferred provider organization health insurance policy seeks covered services for an elective or scheduled procedure, including a planned labor and delivery, from a health facility in which individual providers providing services within the facility are not known to the facility to be contracting providers, the facility shall, at the earliest possible time after the procedure is scheduled, provide a notice to the insured in English, Spanish, Vietnamese, Chinese, Korean, Tagalog, Russian, Armenian, Khmer, Arabic, or Hmong, as applicable, that includes all of the following information:~~

~~(1) A statement that specific categories of providers providing services within the facility may not be in the insured's provider network.~~

~~(2) A statement that services rendered by individual noncontracting providers within the facility may not be covered by the insured's policy.~~

~~(3) A statement that refers the insured to his or her health insurer in order to obtain services from an in-network provider or a provider otherwise authorized by the insurer.~~

~~(4) A written estimate of the cost to the insured for the services rendered by the categories of providers described in paragraph (1). The estimate shall be based on the providers' usual and customary charges.~~

~~(5) The toll-free telephone number of the department.~~

10133.68. (a) If a health insurer receives a request from a policyholder or insured for a referral to receive covered services from an individual noncontracting provider based on the notice provided pursuant to Section 1339.586 of the Health and Safety Code, the insurer shall either refer the policyholder or insured to a contracting provider with similar clinical expertise providing similar services in the same geographic region or authorize the policyholder or insured to obtain the covered services from the noncontracting provider. Appointments shall be arranged consistent with Section 10133.5 and the regulations adopted thereunder.

~~(e)~~

(b) A provider group shall not hold itself out as being within a provider network unless ~~all~~ *one of the following applies:*

(1) All of the individual providers providing services with the provider group are within the provider network.

(2) The provider group acknowledges that individual providers within the provider group may be outside the insured's provider network.

~~(f)~~

(c) A ~~health facility~~ *hospital* shall not hold itself out as being within a provider network unless ~~all~~ *one of the following applies:*

(1) All of the individual providers providing services within the ~~facility~~ *hospital* are within the provider network.

(2) The hospital acknowledges that individual providers providing services within the hospital may be outside the enrollee's plan network.

~~(g) This section shall not apply when an insured seeks emergency services and care. This section shall apply to care provided after an insured is stabilized following an emergency.~~

~~(h)~~

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

(1) ~~"Health facility" has the same meaning as that term is~~ *"Hospital" means a hospital* defined in *subdivision (a), (d), or (f) of* Section 1250 of the Health and Safety Code.

(2) "Noncontracting provider" means a provider who has not entered into a contract with an insurer for alternative rates of payment pursuant to Section 10133.

(3) "Provider group" means a medical group, independent practice association, or any other similar organization.

~~SEC. 3.~~

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.

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