AMENDED IN ASSEMBLY MARCH 28, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 2533

Introduced by Assembly Member Ammiano

February 21, 2014

An act to ~~amend Section 1262.8 of the Health and Safety Code, relating to health facilities~~ *add Sections 1367.031 and 1374.37 to the Health and Safety Code, and to add Sections 10133.51 and 10169.6 to the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2533, as amended, Ammiano. ~~Noncontracting hospitals.~~ *Health care coverage: noncontracting providers.*

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 the Department of Managed Care and the Insurance Commissioner to adopt regulations to ensure that enrollee's and insureds have access to needed health care services in a timely manner, as specified. Existing law authorizes the Department of Managed Care to assess administrative penalties for noncompliance with the requirements, which are paid into the Managed Care Administrative Fines and Penalties Fund.

This bill would require a health care service plan or health insurer to arrange for the provision of a medically necessary service by a licensed noncontracting provider if the plan or insurer is unable to meet timely access standards established by the Department of Managed

Care or the Insurance Commissioner. The bill would require the noncontracting provider to seek reimbursement for the covered service solely from the health care service plan or health insurer, except for allowable copayments, coinsurance, and deductibles. The bill would authorize the Director of Managed Care and the Insurance Commissioner to assess administrative penalties of $1,000 per violation against a health care service plan or health insurer that fails to comply with these requirements. The bill would require that the penalties assessed against health care service plans be deposited into the Managed Care Administrative Fines and Penalties Fund. The bill would establish the Health Insurance Administrative Fines and Penalties Account in the Insurance Fund and would require penalties assessed against health insurers to be deposited into that account to be used, upon appropriation by the Legislature, to support the Department of Insurance.

Existing law establishes independent medical review (IMR) systems to provide enrollees and insureds with the opportunity to seek an IMR whenever health care services have been denied, modified, or delayed by a health care service plan or health insurer, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary.

This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2015, to provide an enrollee or insured with the opportunity to seek an IMR to examine the health insurer's coverage decisions regarding services not offered by the health care service plan contract or health insurance policy and provided by noncontracting providers. If a determination is made that the health care service plan or health insurer shall cover the service rendered by the noncontracting provider, the bill would require the noncontracting provider to seek reimbursement for the covered service solely from the health care service plan or health insurer, except for allowable copayments, coinsurance, and deductibles.

Because a willful violation of these requirements with respect to health care service plans 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.

~~Existing law prohibits a noncontracting hospital, as defined, from billing a patient who is an enrollee of a health care service plan for poststabilization care, except for applicable copayments, coinsurance, and deductible, unless certain conditions are met.~~

~~This bill would make technical, nonsubstantive changes to these provisions.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

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

SECTION 1. Section 1367.031 is added to the Health and Safety Code, immediately following Section 1367.03, to read:

1367.031. (a) If a health care service plan is unable to meet timely access standards established pursuant to Section 1367.03, and is thereby unable to ensure timely access by an enrollee to a medically necessary covered service provided by a contracted provider, the health care service plan shall arrange for the provision of the service by a licensed noncontracting provider in the area of practice appropriate to treat the enrollee's condition.

(1) A noncontracting provider providing a service to an enrollee pursuant to subdivision (a) shall seek reimbursement for a covered service solely from an enrollee's health care service plan, and shall not seek payment from the enrollee for the covered service, except for allowable copayments, coinsurance, and deductibles.

(2) A health care service plan referring an enrollee to a noncontracting provider shall ensure that the location of the facilities of the noncontracting provider is within reasonable proximity of the business or personal residence of the enrollee, and that the hours of operation and provision for after-hours care is reasonable so as not to result in barriers to accessibility.

(3) The health care service plan shall consider referral to a specific noncontracting provider preferred by the enrollee. If the health care service plan does not refer the enrollee to the enrollee's preferred noncontracting provider, the health care service plan shall provide the enrollee with a written explanation outlining the

reasons why the enrollee's preferred noncontracting provider was not selected to provide the covered service.

(4) If an enrollee prefers to wait for a contracted provider to provide the covered service, the health care service plan shall accommodate the enrollee's preference.

(b) Pursuant to subdivision (g) of Section 1367.03, the department may assess an administrative penalty of one thousand dollars ($1,000) per violation against any health care service plan that fails to comply with this section.

SEC. 2. Section 1374.37 is added to the Health and Safety Code, immediately following Section 1374.36, to read:

1374.37. (a) Every health care service plan contract that is issued, amended, renewed, or delivered on or after January 1, 2015, shall provide an enrollee with an opportunity to seek an independent medical review under the process established pursuant to this article to examine the plan's coverage decisions regarding services not covered by the health care service plan contract and provided by noncontracting providers.

(b) If a health care service plan modifies, delays, or denies a claim for a service rendered by a noncontracting provider because the provision of the service is excluded as a covered benefit, the enrollee may appeal the modification, delay, or denial by submitting a written statement from the enrollee's attending physician, who shall be a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat the enrollee for the health care service sought, certifying that the service provided by the noncontracting provider is medically necessary.

(c) Claims for services rendered by a noncontracting provider that are modified, delayed, or denied because the service is excluded as a covered benefit shall qualify for the independent medical review process established pursuant to this article if the enrollee's physician, as specified in subdivision (b), certifies the service is medically necessary.

(d) If a health care service plan modifies, delays, or denies a claim for a service rendered by a noncontracting provider because the health care service plan offers an alternative service that is included as a covered benefit and provided by a contracting provider, the enrollee of the health care service plan may appeal

the modification, delay, or denial of the claim by submitting both of the following:

(1) A written statement from the enrollee's attending physician, who shall be a licensed, board-certified, or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the health service sought, that the service provided by the noncontracting provider is materially different from a health care service the health care service plan approved to treat the enrollee.

(2) Two documents from the available medical and scientific evidence that the service provided by the noncontracting provider is likely to be more beneficial to the enrollee than the alternate service recommended by the health care service plan.

(e) An external appeal agent shall review the health care service plan's coverage decision to modify, delay, or deny claims for services described in subdivision (a), and shall make a determination within seven days of receipt of the appeal as to whether the claim for the service rendered by a noncontracting provider shall be covered by the plan. The external appeal agent shall make a determination within 48 hours in cases where an enrollee has an imminent need for the services in question.

(f) If a determination is made by the external appeal agent that the service rendered by the noncontracting provider is materially different from, and more beneficial than, the alternate service recommended by the plan, the health care service plan shall cover the service rendered by the noncontracting provider.

(g) The noncontracting provider providing a service to an enrollee that is required to be covered by the health care service plan as a result of an independent medical review pursuant to this section shall seek reimbursement for the service solely from the enrollee's health care service plan, and shall not seek payment from the enrollee for the covered service, except for allowable copayments, coinsurance, and deductibles.

SEC. 3. Section 10133.51 is added to the Insurance Code, immediately following Section 10133.5, to read:

10133.51. (a) If a health insurer that contracts with providers for alternative rates pursuant to Section 10133 is unable to meet timely access standards established pursuant to Section 10133.5, and is thereby unable to ensure timely access by an insured to a medically necessary covered service provided by a contracted

provider, the health insurer shall arrange for the provision of the service by a licensed noncontracting provider in the area of practice appropriate to treat the insured's condition.

(1) A noncontracting provider providing a service to an insured pursuant to subdivision (a) shall seek reimbursement for the covered service solely from the insured's health insurer, and shall not seek payment from the insured for the covered service, except for allowable copayments, coinsurance, and deductibles.

(2) A health insurer referring an insured to a noncontracting provider shall ensure that the location of the facilities of the noncontracting provider is within reasonable proximity of the business or personal residence of the insured, and that the hours of operation and provision for after-hours care is reasonable so as not to result in barriers to accessibility.

(3) The health insurer shall consider referral to a specific noncontracting provider preferred by the insured. If the health insurer does not refer the insured to the insured's preferred noncontracting provider, the health insurer shall provide the insured with a written explanation outlining the reasons why the insured's preferred noncontracting provider was not selected to provide the covered service.

(4) If an insured prefers to wait for a contracted provider to provide the covered service, the health insurer shall accommodate the insured's preference.

(b) (1) The commissioner may investigate and take enforcement action against health insurers regarding noncompliance with the requirements of this section.

(2) The commissioner may, by order, assess an administrative penalty of one thousand dollars ($1,000) per violation against a health insurer that fails to comply with this section, subject to appropriate notice and the opportunity for a hearing in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The health insurer may provide to the commissioner, and the commissioner may consider, information regarding the health insurer's overall compliance with the requirements of this section. The administrative penalties shall not be deemed an exclusive remedy available to the commissioner.

(3) There is hereby created the Health Insurance Administrative Fines and Penalties Account in the Insurance Fund established

pursuant to Section 12975.7. All moneys in the account shall be subject to annual appropriation each fiscal year for the support of the Department of Insurance.

SEC. 4. Section 10169.6 is added to the Insurance Code, immediately following Section 10169.5, to read:

10169.6. (a) Every health insurance policy that is issued, amended, renewed, or delivered on or after January 1, 2015, shall provide an insured with an opportunity to seek an independent medical review under the process established pursuant to this article to examine the health insurer's coverage decisions regarding services not covered by the health insurance policy and provided by noncontracting providers.

(b) If a health insurer modifies, delays, or denies a claim for a service rendered by a noncontracting provider because the provision of the service is excluded as a covered benefit, the insured may appeal the modification, delay, or denial by submitting a written statement from the insured's attending physician, who shall be a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat the insured for the health care service sought, certifying that the service provided by the noncontracting provider is medically necessary.

(c) Claims for services rendered by a noncontracting provider that are modified, delayed, or denied because the service is excluded as a covered benefit shall qualify for the independent medical review process established pursuant to this article if the insured's physician, as specified in subdivision (b), certifies the service is medically necessary.

(d) If a health insurer modifies, delays, or denies a claim for a service rendered by a noncontracting provider because the health insurer offers an alternative service that is included as a covered benefit and provided by a contracting provider, the insured of the health insurance policy may appeal by the modification, delay, or denial of the claim by submitting both of the following:

(1) A written statement from the insured's attending physician, who shall be a licensed, board-certified, or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, that the service provided by the noncontracting provider is materially

different from a health care service the health insurer approved to treat the insured.

(2) Two documents from the available medical and scientific evidence that the service provided by the noncontracting provider is likely to be more beneficial to the insured than the alternate service recommended by the health insurer.

(e) An external appeal agent shall review the health insurer's coverage decision to modify, delay, or deny claims for services described in subdivision (a), and shall make a determination within seven days of receipt of the appeal as to whether the claim for the service rendered by a noncontracting provider shall be covered by the health insurer. The external appeal agent shall make a determination within 48 hours in cases where an insured has an imminent need for the services in question.

(f) If a determination is made by the external appeal agent that the service rendered by the noncontracting provider is materially different from, and more beneficial than, the alternate service recommended by the health insurer, the health insurer shall cover the service rendered by the noncontracting provider.

(g) The noncontracting provider providing a service to an insured that is required to be covered by the health insurer as a result of an independent medical review pursuant to this section shall seek reimbursement for the service solely from the insured's health care service plan, and shall not seek payment from the insured for the covered service, except for allowable copayments, coinsurance, and deductibles.

SEC. 5. 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 are the result of a program for which legislative authority was requested by that local agency or school district, within the meaning of Section 17556 of the Government Code and Section 6 of Article XIII B of the California Constitution.

~~SECTION 1. Section 1262.8 of the Health and Safety Code is amended to read:~~

~~1262.8. (a) A noncontracting hospital shall not bill a patient who is an enrollee of a health care service plan for poststabilization care, except for applicable copayments, coinsurance, and deductibles, unless one of the following conditions are met:~~

~~(1) The patient or the patient's spouse or legal guardian refuses to consent, pursuant to subdivision (f), for the patient to be transferred to the contracting hospital as requested and arranged for by the patient's health care service plan.~~

~~(2) The hospital is unable to obtain the name and contact information of the patient's health care service plan as provided in subdivision (c).~~

~~(b) If a patient with an emergency medical condition, as defined by Section 1317.1, is covered by a health care service plan that requires prior authorization for poststabilization care, a noncontracting hospital, except as provided in subdivision (n), shall, prior to providing poststabilization care, do all of the following once the emergency medical condition has been stabilized, as defined by Section 1317.1:~~

~~(1) Seek to obtain the name and contact information of the patient's health care service plan. The hospital shall document its attempt to ascertain this information in the patient's medical record, which shall include requesting the patient's health care service plan member card or asking the patient, or a family member or other person accompanying the patient, if he or she can identify the patient's health care service plan, or any other means known to the hospital for accurately identifying the patient's health care service plan.~~

~~(2) Contact the patient's health care service plan, or the health plan's contracting medical provider, for authorization to provide poststabilization care, if identification of the plan was obtained pursuant to paragraph (1).~~

~~(A) The hospital shall make the contact described in this subparagraph by either following the instructions on the patient's health care service plan member card or using the contact information provided by the patient's health care service plan pursuant to subdivision (j) or (k).~~

~~(B) A representative of the hospital shall not be required to make more than one telephone call to the health care service plan, or its contracting medical provider, provided that in all cases the health care service plan, or its contracting medical provider, shall be able to reach a representative of the hospital upon returning the call, should the plan, or its contracting medical provider, need to call back. The representative of the hospital who makes the~~

~~telephone call may be, but is not required to be, a physician and surgeon.~~

~~(3) Upon request of the patient's health care service plan, or the health plan's contracting medical provider, provide to the plan, or its contracting medical provider, the treating physician and surgeon's diagnosis and any other relevant information reasonably necessary for the health care service plan or the plan's contracting medical provider to make a decision to authorize poststabilization care or to assume management of the patient's care by prompt transfer.~~

~~(c) A noncontracting hospital that is not able to obtain the name and contact information of the patient's health care service plan pursuant to subdivision (b) is not subject to the requirements of this section.~~

~~(d) (1) A health care service plan, or its contracting medical provider, that is contacted by a noncontracting hospital pursuant to paragraph (2) of subdivision (b), shall, within 30 minutes from the time the noncontracting hospital makes the initial contact, do either of the following:~~

~~(A) Authorize poststabilization care.~~

~~(B) Inform the noncontracting hospital that it will arrange for the prompt transfer of the enrollee to another hospital.~~

~~(2) If the health care service plan, or its contracting medical provider, does not notify the noncontracting hospital of its decision pursuant to paragraph (1) within 30 minutes, the poststabilization care shall be deemed authorized, and the health care service plan, or its contracting medical provider, shall pay charges for the care, in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) and any regulation adopted thereunder.~~

~~(3) If the health care service plan, or its contracting medical provider, notified the noncontracting hospital that it would assume management of the patient's care by prompt transfer, but either the health care service plan or its contracting medical provider fails to transfer the patient within a reasonable time, the poststabilization care shall be deemed authorized, and the health care service plan, or its contracting medical provider, shall pay charges, in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340)~~

~~of Division 2 of the Health and Safety Code) and any regulation adopted thereunder, for the care until the enrollee is transferred.~~

~~(4) If the health care service plan, or its contracting medical provider, provides authorization to the noncontracting hospital for specified poststabilization care and services, the health care service plan, or its contracting medical provider, shall be responsible to pay for that authorized care.~~

~~(e) If a health care service plan, or its contracting medical provider, decides to assume management of the patient's care by prompt transfer, the health care service plan, or its contracting medical provider, shall do all of the following:~~

~~(1) Arrange and pay the reasonable charges associated with the transfer of the patient.~~

~~(2) Pay for all of the immediately required medically necessary care rendered to the patient prior to the transfer in order to maintain the patient's clinical stability.~~

~~(3) Be responsible for making all arrangements for the patient's transfer, including, but not limited to, finding a contracted facility available for the transfer of the patient.~~

~~(f) (1) If the patient, or the patient's spouse or legal guardian refuses to consent to the patient's transfer under subdivision (e), the noncontracting hospital shall promptly provide a written notice to the patient or the patient's spouse or legal guardian indicating that the patient will be financially responsible for any further poststabilization care provided by the hospital.~~

~~(2) For patients whose primary language is one of the Medi-Cal threshold languages, the notice shall be delivered to them in their primary language.~~

~~(3) The Department of Managed Health Care shall translate the notice required by this subdivision in all Medi-Cal threshold languages and make the translations available to the hospitals subject to this section.~~

~~(4) The written notice provided pursuant to this subdivision shall include the following statement:~~

~~THIS NOTICE MUST BE PROVIDED TO YOU UNDER CALIFORNIA LAW~~

~~"You have received emergency care at a hospital that is not a part of your health plan's provider network. Under state law, emergency care must be paid by your health plan no matter where you get that care. The doctor who is caring for you has decided~~

~~that you may be safely moved to another hospital for the additional care you need. Because you no longer need emergency care, your health plan has not authorized further care at this hospital. Your health plan has arranged for you to be moved to a hospital that is in your health plan's provider network.~~

~~If you agree to be moved, your health plan will pay for your care at that hospital. You will only have to pay for your deductible, copayments, or coinsurance for care. You will not have to pay for your deductible, copayments, or coinsurance for transportation costs to another hospital that is covered by your health plan.~~

~~IF YOU CHOOSE TO STAY AT THIS HOSPITAL FOR YOUR ADDITIONAL CARE, YOU WILL HAVE TO PAY THE FULL COST OF CARE NOW THAT YOU NO LONGER NEED EMERGENCY CARE. This cost may include the cost of the doctor or doctors, the hospital, and any laboratory, radiology, or other services that you receive.~~

~~If you do not think you can be safely moved, talk to the doctor about your concerns. If you would like additional help, you may contact:~~

~~Your health plan member services department. Look on your health plan member card for that phone number. You can file a grievance with your plan.~~

~~The HMO Helpline at 888-HMO-2219. The HMO Helpline is available 24 hours a day, 7 days a week. The HMO Helpline can work with your health plan to address your concerns, but you may still have to pay the full cost of care at this hospital if you stay."~~

~~(5) The hospital shall give one copy of the written notice required by this subdivision to the patient, or the patient's spouse or legal guardian, for signature and may retain a copy in the patient's medical record.~~

~~(6) The hospital shall ensure prompt delivery of the notice to the patient or his or her spouse or legal guardian. The hospital shall obtain signed acceptance of the written notice required by this subdivision, and signed acceptance of any other documents the hospital requires for any further poststabilization care, from the patient or the patient's spouse or legal guardian, and shall provide the health care service plan, or its contracting medical provider, with confirmation of the patient's, or his or her spouse or legal guardian's, receipt of the written notice.~~

~~(7) If the noncontracting hospital fails to meet the requirements of this subdivision, the hospital shall not bill the patient or the patient's health care service plan, or its contracting medical provider, for poststabilization care provided to the patient.~~

~~(8) If the patient, or the patient's spouse or legal guardian, refuses to sign the notice, the noncontracting hospital shall document in the patient's medical record that the notice was provided and signature was refused. Upon the patient's refusal to sign, the patient shall assume financial responsibility for any further poststabilization care provided by the hospital.~~

~~(9) The Department of Managed Health Care may, by regulation, modify the wording of the notice required under this subdivision for clarity, readability, and accuracy of the information provided.~~

~~(10) The Department of Managed Health Care may, in conjunction with consumer groups, health care service plans, and hospitals, modify the wording of the notice to include language regarding Medicare beneficiaries, if appropriate under Medicare rules. The initial modification shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340, et. seq.) of Part 1 of Division 3 of Title 2 of the Government Code).~~

~~(g) If poststabilization care has been authorized by the health care service plan, the noncontracting hospital shall request the patient's medical record from the patient's health care service plan or its contracting medical provider.~~

~~(h) The health care service plan, or its contracting medical provider, shall, upon conferring with the noncontracting hospital, transmit any appropriate portion of the patient's medical record, if the records are in the plan's possession, via facsimile transmission or electronic mail, whichever method is requested by the noncontracting hospital's representative or the noncontracting physician and surgeon. The health care service plan, or its contracting medical provider, shall transmit the patient's medical record in a manner that complies with all legal requirements to protect the patient's privacy.~~

~~(i) A health care service plan, or its contracting medical provider, that requires prior authorization for poststabilization care shall provide 24-hour access for patients and providers, including noncontracting hospitals, to obtain timely authorization for medically necessary poststabilization care.~~

~~(j) A health care service plan shall provide all noncontracting hospitals in the state with specific contact information needed to make the contact required by this section. The contact information provided to hospitals shall be updated as necessary, but no less than once a year.~~

~~(k) In addition to meeting the requirements of subdivision (j), a health care service plan shall provide the contact information described in subdivision (j) to the Department of Managed Health Care. The contact information provided pursuant to this subdivision shall be updated as necessary, but no less than once a year. The receiving department shall post this contact information on its Internet Web site no later than January 1 of each calendar year.~~

~~(*l*) This section shall only apply to a noncontracting hospital.~~

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

~~(1) "Health care service plan" means a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 that covers hospital, medical, or surgical expenses.~~

~~(2) "Noncontracting hospital" means a general acute care hospital, as defined in subdivision (a) of Section 1250 or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that does not have a written contract with the patient's health care service plan to provide health care services to the patient.~~

~~(3) "Poststabilization care" means medically necessary care provided after an emergency medical condition has been stabilized, as defined by subdivision (j) of Section 1317.1.~~

~~(4) "Contracting medical provider" means a medical group, independent practice association, or any other similar organization that, pursuant to a signed written contract, has agreed to accept responsibility for provision or reimbursement of a noncontracting hospital for emergency and poststabilization services provided to a health plan's enrollees.~~

~~(n) Subdivisions (b) to (h), inclusive, shall not apply to minor treatment procedures, if all of the following apply:~~

~~(1) The procedure is provided in the treatment area of the emergency department.~~

~~(2) The procedure concludes the treatment of the presenting emergency medical condition of a patient and is related to that condition, even though the treatment may not resolve the underlying medical condition.~~

~~(3) The procedure is performed according to accepted standards of practice.~~

~~(4) The procedure would result in the direct discharge or release of the patient from the emergency department following this care.~~

~~(o) This section shall not prevent a health care service plan or its contracting medical provider from assuming management of the patient's care at any time after the initial provision of poststabilization care by the noncontracting hospital before the patient has been discharged. Upon the request of the health care service plan or its contracting medical provider, the noncontracting hospital shall provide the health care service plan or its contracting medical provider with any information specified in paragraph (3) of subdivision (b).~~

~~(p) This section shall not authorize a provider of health care services to bill a Medi-Cal beneficiary enrolled in a Medi-Cal managed care plan or otherwise alter the provisions of subdivision (a) of Section 14019.3 of the Welfare and Institutions Code.~~

O