AMENDED IN ASSEMBLY APRIL 22, 2014

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 add ~~Sections~~ *Section* 1367.031 ~~and 1374.37~~ to the Health and Safety Code, and to *amend Section 10133.5 of, and to* add ~~Sections~~ *Section* 10133.51 ~~and 10169.6~~ to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2533, as amended, Ammiano. 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 the Department of Insurance, in developing the regulations, to develop indicators of timeliness of access to care considering specified indicators of timeliness of access to care, including

waiting time for appointments with physicians. The bill would require contracts between health insurers that contract with providers for alternative rates and health care providers to assure compliance with the developed standards. The bill would authorize the Insurance Commissioner to investigate and take enforcement action against health insurers regarding noncompliance with the requirements of these provisions, including assessing administrative penalties that would be paid to the Health Insurance Administrative Fines and Penalties Account in the Insurance Fund, which the bill would establish.

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 a minimum* 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~~ *the Health Insurance Administrative Fines and Penalties 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.

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 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 health care service plan shall not impose copayments, coinsurance, or deductibles for a noncontracting provider that exceed those of contracting providers.

~~(1)~~

(2) 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)~~

(3) 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)~~

(4) 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)~~

(5) 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 (f) of Section 1367.03, a health care service plan shall report annually to the department on any and all occurrences of denial of care and on compliance with the requirements of this section. The department shall make this information public on the department's Internet Web site.

~~(b)~~

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

(2) The administrative penalties available to the department pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies as determined by the director for purposes of enforcing this chapter.

~~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. 2. Section 10133.5 of the Insurance Code is amended to read:

10133.5. (a) The commissioner shall, on or before January 1, ~~2004,~~ *2016,* promulgate regulations applicable to health insurers ~~which~~ *that* contract with providers for alternative rates pursuant to Section 10133 to ensure that insureds have the opportunity to access needed health care services in a timely manner.

(b) These regulations shall be designed to assure accessibility of provider services in a timely manner to individuals comprising the insured or contracted group, pursuant to benefits covered under the policy or contract. ~~The regulations shall insure:~~ *In developing these regulations, the department shall develop indicators of timeliness of access to care and, in so doing, shall consider the following as indicators of timeliness of access to care:*

(1) Waiting times for appointments with physicians, including primary care and specialty physicians.

(2) Timeliness of care in an episode of illness, including the timeliness of referrals and obtaining other services, if needed.

(3) Waiting time to speak to a physician, registered nurse, or other qualified health professional acting within his or her scope of practice who is trained to screen or triage an enrollee who may need care.

~~1.~~

(4) Adequacy of number and locations of institutional facilities, *including hospitals,* and professional providers, and consultants in relationship to the size and location of the insured group and

that the services offered are available at reasonable times. *The department shall consider the nature of physician practices, including individual and group practices, and the nature of the provider network. The department shall also consider various circumstances affecting the delivery of care, including urgent care, care provided on the same day, and requests for specific providers.*

~~2.~~

(5) Adequacy of number of professional providers, and license classifications of ~~such~~ *the* providers, in relationship to the projected demands for services covered under the group policy or plan. The department shall consider the nature of the specialty in determining the adequacy of professional providers. *The department shall consider the availability of primary care physicians, specialty physicians, hospital care, and other health care.*

~~3.~~

(6) The policy or contract is not inconsistent with standards of good health care and clinically appropriate care.

~~4.~~

(7) All contracts including contracts with providers, and other persons furnishing services, or facilities shall be fair and reasonable.

(c) In developing these standards for timeliness of access, the department shall consider all of the following:

(1) Clinical appropriateness.

(2) The nature of the specialty.

(3) The urgency of care.

(d) The department may adopt standards other than the time elapsed between an enrollee seeking health care and obtaining care. If the department adopts an alternative standard, it shall demonstrate why that standard is more appropriate. In developing standards pursuant to this subdivision, the department shall consider the nature of the provider network.

~~(c)~~

(e) In developing standards under subdivision (a), the department shall also consider requirements under federal law; requirements under other state programs and law, including utilization review; and standards adopted by other states, national accrediting organizations and professional associations. The department shall further consider the accessability to provider services in rural areas,

specifically those areas in which health facilities are more than 30 miles apart.

~~(d)~~

(f) In designing the regulations the commissioner shall consider the regulations in Title 28, of the California ~~Administrative~~ Code of Regulations, commencing with Section 1300.67.2, ~~which~~ *that* are applicable to Knox-Keene plans, and all other relevant guidelines in an effort to accomplish maximum ~~accessibility within a cost efficient system of indemnification~~ *accessibility*. The department shall consult with the Department of Managed Health Care concerning regulations developed by that department pursuant to Section 1367.03 of the Health and Safety Code and shall seek public input from a wide range of interested parties.

(g) (1) Contracts between health insurers that contract with providers for alternative rates and health care providers shall assure compliance with the standards developed under this section. These contracts shall require reporting by health care providers to health insurers that contract with providers for alternative rates and by health insurers that contract with providers for alternative rates to the department to ensure compliance with the standards.

~~(e)~~

(2) Health insurers that contract for alternative rates of payment with providers shall report annually *on the number of occurrences of denial of care and* on complaints received by the insurer regarding timely access to care. The department shall review these complaints and any complaints received by the department regarding timeliness of care and shall make public this information *on the department's Internet Web site*.

~~(f) The department shall report to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature on March 1, 2003, and on March 1, 2004, regarding the progress towards the implementation of this section.~~

~~(g)~~

(h) Every three years, the commissioner shall review the latest version of the regulations adopted pursuant to subdivision (a) and shall determine if the regulations should be updated to further the intent of this section.

(i) (1) The commissioner may investigate and take enforcement action against plans regarding noncompliance with the requirements of this section. When substantial harm to an insured

has occurred as a result of plan noncompliance, the commissioner may, by order, assess administrative penalties subject to appropriate notice of, 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.

(2) The administrative penalties available to the commissioner pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies as determined by the commissioner for purposes of enforcing this chapter.

(3) The administrative penalties shall be paid to the Health Insurance Administrative Fines and Penalties Account in the Insurance Fund.

(j) 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. 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 health insurer shall not impose copayments, coinsurance, or deductibles for a noncontracting provider that exceed those of contracting providers in the event that an insured receives services from a noncontracting provider because a health insurer was unable to ensure timely access to a medically necessary, covered service by a contracted provider.

~~(1)~~

(2) 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)~~

(3) 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)~~

(4) 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)~~

(5) 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 a minimum* 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.~~

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 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.

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