AMENDED IN SENATE AUGUST 19, 2014

AMENDED IN ASSEMBLY MAY 6, 2014

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 Section 1367.031 to the Health and Safety Code, and to add Section 10133.51 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 *Health* Care and the Insurance Commissioner to adopt regulations to ensure that enrollees and insureds have access to needed health care services in a timely manner, as specified. Existing law authorizes the Department of Managed *Health* 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 that contracts for alternative rates of payment to arrange for, or assist in arranging for, an enrollee or insured who is unable to obtain a medically necessary covered service to receive the care or service from a noncontracting provider in an accessible and timely manner. The bill would prohibit the health care service plan or health insurer from imposing copayments, coinsurance, or deductibles on an enrollee or insured that exceed what the enrollee or insured would pay for services from a contracting provider. *The bill would also prohibit a noncontracting provider that agrees to provide services under these provisions from billing an enrollee or insured for any amount in excess of the in-network reimbursement rate, except as specified.* The bill would require a health care service plan or health insurer to report annually to the respective department on the occurrences of denial of care and complaints received by the plan or insurer regarding accessible and timely access to care. The bill would require each department to review those complaints and any complaints received by the department regarding accessibility or timeliness of care and annually prepare and post on its Internet Web site a report of the information received.

This bill would authorize the Insurance Commissioner to investigate and take enforcement action against insurers regarding noncompliance with these provisions and would authorize the commissioner to assess administrative penalties for violations, as specified. The bill would require the commissioner, on or before January 1, 2016, to promulgate related regulations and review the regulations every 3 years to determine if the regulations should be updated.

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 an enrollee is unable to obtain a medically necessary covered service in an accessible and timely manner, as required under Section 1367.03, from a contracted provider, the health care service plan shall arrange for, or assist the enrollee in arranging for, the enrollee to receive the care or service in an accessible and timely manner from a noncontracting provider, and shall not impose copayments, coinsurance, or deductibles on the enrollee that exceed what the enrollee would pay for services from a contracting provider.

(b) A noncontracting provider that agrees to provide services pursuant to this section shall not bill the enrollee for any amount in excess of the in-network reimbursement rate, with the exception of copayments and deductibles pursuant to subdivision (a).

~~(b)~~

(c) In addition to any reporting requirements in 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 complaints received by the health care service plan regarding accessible and timely access to care. The department shall review these complaints and any complaints received by the department regarding accessibility or timeliness of care and annually prepare and post on the department's Internet Web site a report on the information received.

SEC. 2. Section 10133.51 is added to the Insurance Code, to read:

10133.51. (a) This section shall apply to insurers that contract for alternative rates of payment pursuant to Section 10133.

(b) If an insured is unable to obtain a medically necessary covered service in an accessible and timely manner, as required under Section 10133.5, from a contracted provider, the health insurer shall arrange for, or assist the insured in arranging for, the insured to receive the care or service in an accessible and timely manner from a noncontracting provider, and shall not impose copayments, coinsurance, or deductibles on the insured that exceed what an insured would pay for services from a contracting provider.

(c) A noncontracting provider that agrees to provide services pursuant to this section shall not bill the insured for any amount in excess of the in-network reimbursement rate, with the exception of copayments and deductibles pursuant to subdivision (b).

~~(c)~~

(d) In addition to the reporting requirements in Section 10133.5, health insurers shall report annually to the department on any and all occurrences of denial of care and on complaints received by the insurer regarding accessible and timely access to care. The department shall review these complaints and any complaints received by the department regarding accessibility or timeliness of care and annually prepare and post on the department's Internet Web site a report on the information received.

~~(d)~~

(e) The commissioner shall, on or before January 1, 2016, promulgate regulations pursuant to this section and Section 10133.5 to ensure that insureds have the opportunity to access medically necessary health care services in an accessible and timely manner. Every three years, the commissioner shall review the latest version of the regulations adopted pursuant to this section and determine if the regulations should be updated to further the intent of this section.

~~(e)~~

(f) The commissioner may investigate and take enforcement action against insurers regarding noncompliance with the requirements of this section and Section 10133.5. The commissioner may, by order, assess administrative penalties for violations of this section and Section 10133.5, 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 insurer may provide to the commissioner, and the commissioner may consider, information regarding the insurer's overall compliance with the requirements of this section. 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.

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.

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