ASSEMBLY BILL No. 2372

Introduced by Assembly Member Burke
(Principal coauthor: Assembly Member Waldron)
(Principal coauthor: Senator Hertzberg)

February 18, 2016

An act to amend Section 1367.03 of, and to add Section 1367.693 to, the Health and Safety Code, and to amend Section 10133.5 of, and to add Section 10123.833 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2372, as introduced, Burke. Health care coverage: HIV specialists.

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. A willful violation of the act is 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. Existing law requires the Department of Managed Health Care to develop indicators of timeliness of access to care, including waiting times for appointments with physicians, including primary care and speciality physicians. Existing law requires the Insurance Commissioner to adopt regulations that ensure, among other things, the adequacy of the number of professional providers in relationship to the projected demands for services covered under the group policy.

This bill would define for these purposes "specialty physician" and "professional provider," respectively, to include a physician who meets the criteria for an HIV specialist, as specified. The bill would require a health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2017, to include an HIV specialist, as defined, as an eligible primary care physician, provided that he or she meets the plan's or health insurer's eligibility criteria for all specialists seeking primary care physician status. Because a willful violation of these requirements by a health care service plan 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 1367.03 of the Health and Safety Code is amended to read:

1367.03. (a) ~~Not later than January 1, 2004, the~~ *The* department shall develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner. 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.

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

(1) Clinical appropriateness.

(2) The nature of the specialty.

(3) The urgency of care.

(4) The requirements of other provisions of law, including Section 1367.01 governing utilization review, that may affect timeliness of access.

(c) The department may adopt standards other than the time elapsed between the time an enrollee seeks health care and obtains care. If the department chooses a standard other than the time elapsed between the time an enrollee first seeks health care and obtains it, the department shall demonstrate why that standard is more appropriate. In developing these standards, the department shall consider the nature of the plan network.

(d) The department shall review and adopt standards, as needed, concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care, so that consumers have timely access to care. In so doing, the department shall consider the nature of physician practices, including individual and group practices as well as the nature of the plan 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. If the department finds that health care service plans and health care providers have difficulty meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature pursuant to subdivision (i).

(e) In developing standards under subdivision (a), the department shall consider requirements under federal law, requirements under other state programs, standards adopted by other states, nationally recognized accrediting organizations, and professional associations. The department shall further consider the needs of rural areas, specifically those in which health facilities are more than 30 miles apart and any requirements imposed by the State Department of Health Care Services on health care service plans that contract with the State Department of Health Care Services to provide Medi-Cal managed care.

(f) (1) Contracts between health care service plans and health care providers shall ensure compliance with the standards developed under this section. These contracts shall require reporting by health care providers to health care service plans and

by health care service plans to the department to ensure compliance with the standards.

(2) Health care service plans shall report annually to the department on compliance with the standards in a manner specified by the department. The reported information shall allow consumers to compare the performance of plans and their contracting providers in complying with the standards, as well as changes in the compliance of plans with these standards.

(3) The department may develop standardized methodologies for reporting that shall be used by health care service plans to demonstrate compliance with this section and any regulations adopted pursuant to it. The methodologies shall be sufficient to determine compliance with the standards developed under this section for different networks of providers if a health care service plan uses a different network for Medi-Cal managed care products than for other products or if a health care service plan uses a different network for individual market products than for small group market products. The development and adoption of these methodologies shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until January 1, 2020. The department shall consult with stakeholders in developing standardized methodologies under this paragraph.

(g) (1) When evaluating compliance with the standards, the department shall focus more upon patterns of noncompliance rather than isolated episodes of noncompliance.

(2) The director may investigate and take enforcement action against plans regarding noncompliance with the requirements of this section. Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director may, by order, assess administrative penalties subject to appropriate notice of, and the opportunity for, a hearing in accordance with Section 1397. The plan may provide to the director, and the director may consider, information regarding the plan's overall compliance with the requirements of this section. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45. The director shall periodically evaluate grievances

to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(3) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:

(A) Repeated failure to act promptly and reasonably to assure timely access to care consistent with this chapter.

(B) Repeated failure to act promptly and reasonably to require contracting providers to assure timely access that the plan is required to perform under this chapter and that have been delegated by the plan to the contracting provider when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(C) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

(4) The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(h) The department shall work with the patient advocate to assure that the quality of care report card incorporates information provided pursuant to subdivision (f) regarding the degree to which health care service plans and health care providers comply with the requirements for timely access to care.

(i) The department shall annually review information regarding compliance with the standards developed under this section and shall make recommendations for changes that further protect enrollees. Commencing no later than December 1, 2015, and annually thereafter, the department shall post its final findings from the review on its Internet Web site.

(j) The department shall post on its Internet Web site any waivers or alternative standards that the department approves under this section on or after January 1, 2015.

(k) For purposes of this section, "specialty physician" includes a physician who meets the criteria for an HIV specialist as published by the American Academy of HIV Medicine or the HIV

Medicine Association, or who is contracted to provide outpatient medical care under the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (Public Law 101-381).

SEC. 2. Section 1367.693 is added to the Health and Safety Code, immediately following Section 1367.69, to read:

1367.693. (a) Every health care service plan contract that is issued, amended, or renewed on or after January 1, 2017, that provides hospital, medical, or surgical coverage shall include an HIV specialist as an eligible primary care physician, provided he or she meets the health care service plan's eligibility criteria for all specialists seeking primary care physician status.

(b) For purposes of this section, "primary care physician" means a physician, as defined in Section 14254 of the Welfare and Institutions Code, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.

(c) For purposes of this section, "HIV specialist" means a physician or a nurse practitioner who meets the criteria for an HIV specialist as published by the American Academy of HIV Medicine or the HIV Medicine Association, or who is contracted to provide outpatient medical care under the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (Public Law 101-381).

SEC. 3. Section 10123.833 is added to the Insurance Code, immediately following Section 10123.83, to read:

10123.833. (a) Every health insurance policy that is issued, amended, or renewed on or after January 1, 2017, that provides hospital, medical, or surgical coverage shall include an HIV specialist as an eligible primary care physician, provided he or she meets the health insurer's eligibility criteria for all specialists seeking primary care physician status.

(b) For purposes of this section, "primary care physician" means a physician, as defined in Section 14254 of the Welfare and Institutions Code, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems,

including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.

(c) For purposes of this section, "HIV specialist" means a physician or a nurse practitioner who meets the criteria for an HIV specialist as published by the American Academy of HIV Medicine or the HIV Medicine Association, or who is contracted to provide outpatient medical care under the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (Public Law 101-381).

SEC. 4. Section 10133.5 of the Insurance Code is amended to read:

10133.5. (a) The commissioner ~~shall, on or before January 1, 2004,~~ *shall* 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~~ *ensure* 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:~~ *ensure:*

~~1. Adequacy~~

(1) Adequacy of number and locations of institutional facilities 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.

~~2. Adequacy~~

(2) Adequacy of number of professional providers, and license classifications of such 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.

~~3. The~~

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

~~4.~~

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

(c) 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.

(d) 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 are applicable to Knox-Keene plans, and all other relevant guidelines in an effort to accomplish maximum accessibility within a ~~cost efficient~~ *cost-efficient* system of indemnification. 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.

(e) Health insurers that contract for alternative rates of payment with providers shall report annually 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.

(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) 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.

(h) For purposes of this section, "professional provider" includes a physician who meets the criteria for an HIV specialist as published by the American Academy of HIV Medicine or the HIV Medicine Association, or who is contracted to provide outpatient medical care under the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (Public Law 101-381).

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 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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