



Agenda Item 6

June 17, 2014

ITEM NAME: Assembly Bill 2533 (Ammiano) -- Health Care Plans Timeliness Standards

As Amended May 6, 2014

Sponsor: California Nurses Association

PROGRAM: Legislation

ITEM TYPE: Action

RECOMMENDATION

Adopt an **Oppose** position on Assembly Bill (AB) 2533 because the bill would impose potentially burdensome and costly requirements on health plans and insurers by largely duplicating existing law with minimal or potentially negative impacts on health care consumers. This bill may also prevent health plans and insurers from designing provider networks that help control costs.

EXECUTIVE SUMMARY

The bill requires health plans and insurers that are unable to provide enrollees access to a contracted provider within the time frame required by law, to arrange for the services from a non-contracting provider. AB 2533 also prohibits copayments, coinsurance, or deductibles that exceed what the enrollee would have paid if the contracted provider were available, while imposing additional reporting requirements on the health plans and insurers relating to accessible and timely access of care. However, the bill fails to address how reimbursement will be handled between the non-contracting providers and the health plans and insurers.

STRATEGIC PLAN

This item relates to Goal A of the CalPERS Strategic Plan, to improve long-term pension and health benefit sustainability, as it deals with a legislative proposal that would potentially have an impact on the costs associated with health care delivery.

BACKGROUND

1. Existing Law

Chapter 797, Statutes of 2002 (AB 2179, Cohn) required the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) to develop regulations that establish standards for health plans and insurers to provide access to needed health care services in a timely manner. The DMHC

adopted regulations in 2010 which established timeliness standards for non-emergency health care services. The CDI adopted regulations relating to provider network access, imposing specific geographic time and distance standards. CDI is in the process of reviewing and potentially revising its regulations to be more aligned with the DMHC.

Health plans under the DMHC must ensure that subscribers and enrollees receive available and accessible services in a manner providing for continuity of care and ready referral of patients to other providers consistent with good professional practice. They must offer a complete network of contracting or employed primary care and specialist physicians each of whom has contracting privileges with at least one contracting hospital, comply with minimum ratios for number of physician providers for the number of enrollees in the health plan (one physician for every 1,200 enrollees and one Primary Care Physician (PCP) for every 2,000 enrollees. Plans must ensure accessibility of providers within prescribed geographic distances (for PCPs within 30 minutes or 15 miles of an enrollee's residence or workplace), and ensure that the contracted networks have adequate capacity and availability of licensed providers to offer enrollees appointments in a timely manner in compliance with specified timeframes and appointment waiting times. Plans must maintain a system to monitor and report on timely access compliance and access to care.

Health insurers offering contracted networks under the CDI must ensure accessibility of provider services in a timely manner and ensure that providers are sufficient, in number and size, to be capable of furnishing the health care services covered by the insurance contract, taking into account the characteristics and medical needs of insured persons. Insurers must also ensure accessibility of providers within prescribed geographic distances (for PCPs within 30 minutes or 15 miles of an enrollee's residence or workplace), and comply with minimum ratios for number of physician providers based on the number of covered persons (one physician for every 1,200 enrollees and one PCP for every 2,000 enrollees). Insurers must monitor waiting times for appointments as part of the overall system the insurer must maintain to monitor access.

2. Current enforcement of existing regulations

The DMHC adopted regulations on timely access to non-emergency care in 2010. According to the DMHC website, there have been three instances of enforcement action taken by the DMHC. On March 23, 2011, Health Net agreed to pay an administrative assessment over 27 grievances for timely access and other grounds that amounted to \$81,000 (\$3,000 per grievance). The appendix listing the nature of the grievances was not included in the file.

On August 9, 2011, Kern Health Systems Group Health Plans (Kern) settled an enforcement action with DMHC over allegations that included timely access. No

monetary penalties were paid by Kern, but they agreed to spend \$250,000 to enhance their provider network, develop and implement a comprehensive telehealth program within six months, and expand Kern's contracted specialty and primary care network.

Kaiser Permanente was assessed a \$4 million administrative penalty on June 24, 2013, for a number of deficiencies including violating the regulation regarding timely access. The causes for discipline included inadequately monitoring wait times, using a methodology that used average wait times instead of monitoring actual wait times, and failure to respond to identified deficiencies in timely access.

ANALYSIS

1. Proposed changes

Specifically, AB 2533 would:

- Require health service plans and insurers to arrange for, or assist the enrollee in arranging for, medically necessary services from a non-contracting provider if such services are not available in a timely manner from a contracted provider
- Prohibit health plans or insurers from imposing additional copayments, coinsurance, or deductibles than what would have been charged for an in-network provider
- Require health care plans and insurers to report annually to the respective department on the occurrence of denial of care and complaints received by the plan or insurer regarding accessible and timely access to care
- Require the DMHC and the CDI to review these complaints as well as any complaints received by the Department regarding accessibility or timeliness of care; each department will prepare and post an annual report on its website
- Require the Commissioner of the CDI to promulgate implementing regulations and to update them every three years; the Commissioner would be authorized to investigate and assess administrative penalties of unspecified amounts against insurers for violating either existing or newly-promulgated provisions relating to timely access to care
- Authorize the CDI to investigate and take enforcement actions against insurers regarding noncompliance with the provisions of this bill and assess administrative penalties for violations; authorizes insurers to provide the commissioner, and the commissioner to consider, the insurer's overall compliance with the requirements

2. Arguments in Support

According to the author's Fact Sheet:

"AB 2533 aims to protect patients from high out-of-pocket costs for out-of-network services sought by patients when their plans or insurers fail to meet accessible and timely access standards by requiring plans to arrange for the

service by an assessable and timely non-contracting provider, and requiring plans to impose the same co-payments, co-insurance, or deductibles for out-of-network services as in-network services.”

Further, “Current timely access regulations require plans to arrange for the provision of specialty services from specialists outside of the plan’s contracted network if unavailable through the network, and limits enrollee out-of-pocket costs to co-payments, co-insurance and deductibles. AB 2533 would largely codify these regulations and bolster them by making it clear that the out-of-network cannot balance bill the patient . . . ”

The California Nurses Association, the bill’s sponsor, states:

“Having an insurance card means nothing if you are unable to find a provider to get care when you need it. Network adequacy is an extremely important issue, and having access to a high-quality network of providers is critical. Some consumers may be forced to opt for a smaller network in exchange for a lower-cost plan. But these consumers may be taking a big financial risk if limited access forces them to go out of network for care.”

“California law conforms to ACA limits on out-of-pocket costs patients can pay towards their care. However, those limits only apply to care provided by doctors and hospitals in their plan or policy’s provider network. There may be separate out-of-pocket limit for out-of-network services, or no limit at all. ”

“AB 2533 (Ammiano) aims to protect patients from these high out-of-pocket costs . . . ”

3. Arguments in Opposition

America’s Health Insurance Plans claim that insurers control costs by contracting with providers who meet credentialing requirements and that AB 2533 would prevent health plans from implementing safety and quality standards through contracting. Also, requiring coverage through non-contracted providers acts as a disincentive to providers to sign up for contracted networks. Further, AB 2533 would increase the administrative burden and result in higher costs for consumers. AB 2533 harms the ability of health plans to provide lower cost options by expanding access to non-contracted providers.

The California Association of Health Plans (CAHP) views AB 2533 as “a significant unraveling of the managed care system in California because it statutorily requires the arrangement of out-of-network care by non-contracting providers.” CAHP also points out that timely access to non-emergency care is required by law and that DMHC is already authorized to take action against violators, thus it has not been shown that this legislative remedy is necessary. The California Chamber of Commerce opposes the bill because it would undo the

managed care model by requiring health plans to pay for non-contracted providers and will unnecessarily drive up health care costs while potentially reducing quality.

The California Medical Association and the California Chapter of the American College of Emergency Physicians argue that AB 2533 eviscerates current law which requires insurers to provide adequate networks and turns the law on its head by absolving insurers of their responsibility to offer sufficient provider networks.

BUDGET AND FISCAL IMPACTS

1. Benefit Costs

Likely increase in benefit costs due to CalPERS health plans making payments to non-contracting providers at levels higher than contracted rates. To the extent that health care providers can also avoid negotiating lower payments or participate in health plans' provider networks, plans will be forced to reimburse all providers at higher rates, which will significantly increase CalPERS health benefit costs.

2. Administrative Costs

There are no anticipated administrative costs for CalPERS.

BENEFITS/RISKS

1. Benefits of Bill Becoming Law

- Provides enrollees and insured with more timely access to health care providers.

2. Risks of Bill Becoming Law

- Discourages health plans from creating adequate provider networks.
- Requires plans and insurers to pay for enrollee/insured treatment by out-of-network physicians over which plans and insurers have to quality control.

ATTACHMENTS

Attachment 1 – Legislative History

Attachment 2 – Support and Opposition

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