SB-1156 Health care service plans and health insurance: 3rd-party payments. (2017-2018)

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CALIFORNIA LEGISLATURE— 2017–2018 REGULAR SESSION

SENATE BILL NO. 1156

Introduced by Senator Leyva

February 14, 2018

An act to add Section 1367.016 to the Health and Safety Code, and to add Section 10176.11 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1156, Leyva. Health care service plans and health insurance: 3rd-party payments.

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. These provisions govern, among other things, procedures by health care service plans and insurers with respect to premium payments.

This bill would require a health care service plan or an insurer that provides a policy of health insurance to accept payments from specified 3rd-party entities, including an Indian tribe or a local, state, or federal government program. The bill would also require a financially interested entity, as defined, other than those entities, that is making a 3rd-party premium payment to provide that assistance in a specified manner and to perform other related duties, including requiring the entity to disclose to the plan or the insurer the name of the enrollee or insured, as applicable, for each plan or policy on whose behalf a 3rd-party premium payment

will be made. The bill would require each plan or insurer to provide to the department information regarding premium payments by financially interested entities and reimbursement for services to providers, and would set forth standards governing the reimbursement of financially interested 3rd parties.

Because a willful violation of these requirements by a health care service plan would be a crime, this 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 Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1367.016 is added to the Health and Safety Code, to read:

1367.016. (a) A health care service plan shall accept premium payments from the following third-party entities without the need to comply with subdivision (c):

(1) A Ryan White HIV/AIDS Program under Title XXVI of the federal Public Health Service Act.

(2) An Indian tribe, tribal organization, or urban Indian organization.

(3) A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf.

(4) Any member of the individual's family, defined for purposes of this section to include the individual's spouse, domestic partner, child, parent, grandparent, and siblings, unless the true source of funds used to make the premium payment originates with a financially interested entity.

(b) Any financially interested entity that is not specified in subdivision (a) and is making third-party premium payments shall comply with all of the following requirements:

(1) It shall provide assistance for the full plan year and notify the enrollee prior to any open enrollment periods, if applicable, if financial assistance will be discontinued. Assistance may be discontinued at the request of an enrollee who obtains other health coverage, or if the enrollee dies during the plan year.

(2) If the entity provides coverage for an enrollee with end stage renal disease, the entity shall agree not to condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device.

(3) It shall inform an applicant of financial assistance, and shall inform a recipient annually, of all available health coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans, if applicable.

(4) It shall agree not to steer, direct, or advise the patient into or away from a specific coverage program option or health care service plan contract.

(5) It shall agree that financial assistance shall not be conditioned on the use of a specific facility or health care provider.

(c) An entity described in subdivision (b) shall not make a third-party premium payment unless the entity complies with both of the following requirements:

(1) Annually provides a statement to the health care service plan that it meets the requirements set forth in subdivision (b), as applicable.

(2) Discloses to the health care service plan, prior to making the initial payment, the name of the enrollee for each health care service plan contract on whose behalf a third-party premium payment described in this section will be made.

(d) If a financially interested entity makes a third-party premium payment to a health care service plan on behalf of an enrollee, reimbursement to a provider who is also a financially interested entity for covered services provided shall be determined by the following:

(1) For a contracted financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the enrollee shall be governed by the terms and conditions of the enrollee's

health care service plan contract or the Medicare reimbursement rate, whichever is lower. Financially interested providers shall not bill the enrollee or seek reimbursement from the enrollee for any services provided, except for cost sharing pursuant to the terms and conditions of the enrollee's health care service plan contract. If an enrollee's contract imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health care service plan pursuant to this paragraph.

(2) For a noncontracting financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the enrollee shall be governed by the terms and conditions of the enrollee's health care service plan contract or the Medicare reimbursement rate, whichever is lower. Financially interested providers shall not bill the enrollee or seek reimbursement from the enrollee for any services provided, except for cost sharing pursuant to the terms and conditions of the enrollee's health care service plan contract. If an enrollee's contract imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health care service plan pursuant to this paragraph. A claim submitted to a health care service plan by a noncontracting financially interested provider may be considered an incomplete claim and contested by the health care service plan pursuant to Section 1371 or 1371.35 if the financially interested provider has not provided the information as required in subdivision (c).

(e) For the purposes of this section, third-party premium payments only include health care service plan premium payments made directly by a provider or other third party, made indirectly through payments to the individual for the purpose of making health care service plan premium payments, or provided to one or more intermediaries with the intention that the funds be used to make health care service plan premium payments for the individuals.

(f) As used in this section, "health care service plan" means any individual or group health care service plan contract that provides medical, hospital, and surgical benefits, except a specialized health care service plan contract. The term does not include coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, long-term care insurance, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation law or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(g) The following shall occur if a health care service plan subsequently discovers that a financially interested entity fails to provide disclosure pursuant to subdivision (c):

(1) The health care service plan shall be entitled to recover 120 percent of the difference between any payment made to a provider and the payment to which the provider would have been entitled pursuant to subdivision (d), including interest on that difference.

(2) The health care service plan shall notify the department of the amount by which the provider was overpaid and shall remit to the department any amount exceeding the difference between the payment made to the provider and the payment to which the provider would have been entitled pursuant to subdivision (d), including interest on that difference that was recovered pursuant to paragraph (1).

(h) Each health care service plan licensed by the department and subject to this section shall provide to the department information regarding premium payments by financially interested entities and reimbursement for services to providers under subdivision (d). The information shall be provided at least annually at the discretion of the department and shall include, to the best of the health care service plan's knowledge, the number of enrollees whose premiums were paid by financially interested entities, disclosures provided to the plan pursuant to subdivision (c), the identities of any providers whose reimbursement rate was governed by subdivision (d), the identities of any providers who failed to provide disclosure as described in subdivision (c), and, at the discretion of the department, additional information necessary for the implementation of this section.

(i) For purposes of this section, "provider" means any professional person, organization, health facility, or other person or institution that delivers or furnishes health care services.

(j) As used in this section, "financially interested" means any entity or provider described by either of the following criteria:

(1) A provider of health care services that receives a direct or indirect financial benefit from a third-party premium payment.

(2) An entity that receives the majority of its funding from one or more financially interested providers of health care services, parent companies of providers of health care services, subsidiaries of health care service providers, or related entities.

(k) For purposes of this section, "enrollee" means an individual whose health care service plan premiums are paid by a financially interested entity.

(l) This section does not limit the authority of the Attorney General to take any action to enforce this section.

(m) This section does not affect a contracted payment rate for a provider who is not financially interested.

SEC. 2. Section 10176.11 is added to the Insurance Code, to read:

10176.11. (a) An insurer that provides a policy of health insurance shall accept premium payments from the following third-party entities without the need to comply with subdivision (c):

(1) A Ryan White HIV/AIDS Program under Title XXVI of the federal Public Health Service Act.

(2) An Indian tribe, tribal organization, or urban Indian organization.

(3) A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf.

(4) Any member of the individual's family, defined for purposes of this section to include the individual's spouse, domestic partner, child, parent, grandparent, and siblings, unless the true source of funds used to make the premium payment originates with a financially interested entity.

(b) Any financially interested entity that is not specified in subdivision (a) and is making third-party premium payments shall comply with all of the following requirements:

(1) It shall provide assistance for the full policy year and notify the insured prior to any open enrollment periods, if applicable, if financial assistance will be discontinued. Assistance may be discontinued at the request of an insured who obtains other health insurance coverage, or if the insured dies during the policy year.

(2) If the entity provides coverage for an insured with end stage renal disease, the entity shall agree not to condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device.

(3) It shall inform an applicant of financial assistance, and shall inform an insured annually, of all available health coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans, if applicable.

(4) It shall agree not to steer, direct, or advise the insured into or away from a specific coverage program option or health coverage.

(5) It shall agree that financial assistance shall not be conditioned on the use of a specific facility or health care provider.

(c) An entity described in subdivision (b) shall not make a third-party premium payment unless the entity complies with both of the following requirements:

(1) Annually provides a statement to the health insurer that it meets the requirements set forth in subdivision (b), as applicable.

(2) Discloses to the health insurer, prior to making the initial payment, the name of the insured for each policy on whose behalf a third-party premium payment described in this section will be made.

(d) If a financially interested entity makes a third-party premium payment to a health insurer on behalf of an insured, reimbursement to a financially interested provider for covered services shall be determined by the following:

(1) For a contracted financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the insured shall be governed by the terms and conditions of the insured's health insurance policy or the Medicare reimbursement rate, whichever is lower. Financially interested providers shall not bill the insured or seek reimbursement from the insured for any services provided, except for cost sharing pursuant to the terms and conditions of the insured's health insurance policy. If an insured's policy imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health insurer pursuant to this paragraph.

(2) For a noncontracting financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the insured shall be governed by the terms and conditions of the insured's health insurance policy or the Medicare reimbursement rate, whichever is lower. Financially interested providers shall not bill the insured or seek reimbursement from the insured for any services provided, except for cost sharing pursuant to the terms and conditions of the insured's health insurance policy. If the insured's policy imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health insurer pursuant to this paragraph. A claim submitted to a health insurer by a noncontracting financially interested provider may be considered an

incomplete claim and contested by the health insurer pursuant to Section 10123.13 or 10123.147 if the financially interested provider has not provided the information as required in subdivision (c).

(e) For the purposes of this section, third-party premium payments only include health insurance premium payments made directly by a provider or other third party, made indirectly through payments to the individual for the purpose of making health insurance premium payments, or provided to one or more intermediaries with the intention that the funds be used to make health insurance premium payments for the individuals.

(f) As used in this section, “health insurance” means any individual or group health insurance policy as defined in subdivision (b) of Section 106. The term does not include coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, or specialized health insurance coverage as described in subdivision (c) of Section 106.

(g) The following shall occur if a health insurer subsequently discovers that a financially interested entity fails to provide disclosure pursuant to subdivision (c):

(1) The health insurer shall be entitled to recover 120 percent of the difference between any payment made to a provider and the payment to which the provider would have been entitled pursuant to subdivision (d), including interest on that difference.

(2) The health insurer shall notify the department of the amount by which the provider was overpaid and shall remit to the department any amount exceeding the difference between the payment made to the provider and the payment to which the provider would have been entitled pursuant to subdivision (d), including interest on that difference that was recovered pursuant to paragraph (1).

(h) Each health insurer licensed by the department and subject to this section shall provide to the department information regarding premium payments by financially interested entities and reimbursement for services to providers under subdivision (d). The information shall be provided at least annually at the discretion of the department and shall include, to the best of the health insurer’s knowledge, the number of insureds whose premiums were paid by financially interested entities, disclosures provided to the insurer pursuant to subdivision (c), the identities of any providers whose reimbursement rate was governed by subdivision (d), the identities of any providers who failed to provide disclosure as described in subdivision (c), and, at the discretion of the department, additional information necessary for the implementation of this section.

(i) For purposes of this section, “provider” means any professional person, organization, health facility, or other person or institution that delivers or furnishes health care services.

(j) As used in this section, “financially interested” means any entity or provider described by either of the following criteria:

(1) A provider of health care services that receives a direct or indirect financial benefit from a third-party premium payment.

(2) An entity that receives the majority of its funding from one or more financially interested providers of health care services, parent companies of providers of health care services, subsidiaries of health care service providers, or related entities.

(k) For purposes of this section, “insured” means an individual whose health insurance premiums are paid by a financially interested entity.

(l) This section does not limit the authority of the Attorney General to take any action to enforce this section.

(m) This section does not affect a contracted payment rate for a provider who is not financially interested.

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.