AB-577 Health care coverage: maternal mental health. (2019-2020)

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Assembly Bill No. 577

CHAPTER 776

An act to amend Section 1373.96 of the Health and Safety Code, and to amend Section 10133.56 of the Insurance Code, relating to maternal health.

[Approved by Governor October 12, 2019. Filed with Secretary of State October 12, 2019.]

LEGISLATIVE COUNSEL'S DIGEST

AB 577, Eggman. Health care coverage: maternal mental health.

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 provides for the regulation of health insurers by the Department of Insurance.

Existing law requires a health care service plan and a health insurer, at the request of an enrollee or insured, to provide for the completion of services by a terminated or nonparticipating provider if the enrollee or insured is undergoing a course of treatment for one of specified conditions, including a serious chronic condition, at the time of the contract or policy termination or the time the coverage became effective.

This bill would, for purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition, as defined, from the individual's treating health care provider, require completion of covered services for that condition, not exceeding 12 months, as specified. By expanding the duties of health care service plans, the bill would expand the scope of an existing crime, thereby imposing 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 1373.96 of the Health and Safety Code is amended to read:

1373.96. (a) A health care service plan shall, at the request of an enrollee, provide for the completion of covered services as set forth in this section by a terminated provider or by a nonparticipating provider.

(b) (1) The completion of covered services shall be provided by a terminated provider to an enrollee who, at the time of the contract's termination, was receiving services from that provider for one of the conditions described in subdivision (c).

(2) The completion of covered services shall be provided by a nonparticipating provider to a newly covered enrollee who, at the time the enrollee's coverage became effective, was receiving services from that provider for one of the conditions described in subdivision (c).

(c) The health care service plan shall provide for the completion of covered services for the following conditions:

(1) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(2) (A) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice.

(B) Completion of covered services under subparagraph (A) shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(3) (A) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

(B) For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

(4) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

(5) The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(6) Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

(d) (1) The plan may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider before termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services beyond the contract termination date.

(2) Unless otherwise agreed upon by the terminated provider and the plan or by the individual provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider. Neither the plan nor the provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.

(e) (1) The plan may require a nonparticipating provider whose services are continued pursuant to this section for a newly covered enrollee to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services.

(2) Unless otherwise agreed upon by the nonparticipating provider and the plan or by the nonparticipating provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar

to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider. Neither the plan nor the provider group is required to continue the services of a nonparticipating provider if the provider does not accept the payment rates provided for in this paragraph.

(f) The amount of, and the requirement for payment of, copayments, deductibles, or other cost-sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same as would be paid by the enrollee if receiving care from a provider currently contracting with or employed by the plan.

(g) If a plan delegates the responsibility of complying with this section to a provider group, the plan shall ensure that the requirements of this section are met.

(h) This section does not require a plan to provide for completion of covered services by a provider whose contract with the plan or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code, or fraud or other criminal activity.

(i) This section does not require a plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract. Except as provided in subdivision (l), this section does not apply to a newly covered enrollee covered under an individual subscriber agreement who is undergoing a course of treatment on the effective date of their coverage for a condition described in subdivision (c).

(j) Except as provided in subdivision (l), this section does not apply to a newly covered enrollee who is offered an out-of-network option or to a newly covered enrollee who had the option to continue with their previous health plan or provider and instead voluntarily chose to change health plans.

(k) The provisions contained in this section are in addition to any other responsibilities of a health care service plan to provide continuity of care pursuant to this chapter. This section does not preclude a plan from providing continuity of care beyond the requirements of this section.

(l) (1) A health care service plan shall, at the request of a newly covered enrollee under an individual health care service plan contract, arrange for the completion of covered services as set forth in this section by a nonparticipating provider for one of the conditions described in subdivision (c) if the newly covered enrollee meets both of the following:

(A) The newly covered enrollee's prior coverage was terminated under paragraph (5) or (6) of subdivision (a) of Section 1365 or subdivision (d) or (e) of Section 10273.6 of the Insurance Code, which includes circumstances when a health benefit plan is withdrawn from any portion of a market.

(B) At the time the enrollee's coverage became effective, the newly covered enrollee was receiving services from that provider for one of the conditions described in subdivision (c).

(2) The completion of covered services required to be provided under this subdivision apply to services rendered to the newly covered enrollee on and after the effective date of their new coverage.

(3) A violation of this subdivision does not constitute a crime under Section 1390.

(m) Notice as to the process by which an enrollee may request completion of covered services pursuant to this section shall be provided in every disclosure form as required under Section 1363 and in any evidence of coverage issued after January 1, 2018. A plan shall provide a written copy of this information to its contracting providers and provider groups. A plan shall also provide a copy to its enrollees upon request. Notice as to the availability of the right to request completion of covered services shall be part of, accompany, or be sent simultaneously with any termination of coverage notice sent in the circumstances described in subdivision (l).

(n) The following definitions apply for the purposes of this section:

(1) "Individual provider" means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

(2) "Maternal mental health condition" means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

(3) "Nonparticipating provider" means a provider who is not contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.

(4) "Provider" shall have the same meaning as set forth in subdivision (i) of Section 1345.

(5) “Provider group” means a medical group, independent practice association, or any other similar organization.

SEC. 2. Section 10133.56 of the Insurance Code is amended to read:

10133.56. (a) (1) A health insurer that enters into a contract with a professional or institutional provider to provide services at alternative rates of payment pursuant to Section 10133 shall, at the request of an insured, arrange for the completion of covered services by a terminated provider, if the insured is undergoing a course of treatment for any of the following conditions:

(A) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(B) (i) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health insurer in consultation with the insured and the terminated provider and consistent with good professional practice.

(ii) Completion of covered services under clause (i) shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered insured.

(C) (i) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

(ii) For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual’s treating health care provider, completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

(D) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new insured.

(E) The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered insured.

(F) Performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract’s termination date or within 180 days of the effective date of coverage for a newly covered insured.

(2) The insurer may require the terminated provider whose services are continued beyond the contract termination date pursuant to this subdivision, to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the insurer is not required to continue the provider’s services beyond the contract termination date.

(3) Unless otherwise agreed upon between the terminated provider and the insurer or between the terminated provider and the provider group, the agreement shall be construed to require a rate and method of payment to the terminated provider, for the services rendered pursuant to this subdivision, that are the same as the rate and method of payment for the same services while under contract with the insurer and at the time of termination. The provider shall accept the reimbursement as payment in full and shall not bill the insured for any amount in excess of the reimbursement rate, with the exception of copayments and deductibles pursuant to subdivision (c).

(b) Notice as to the process by which an insured may request completion of covered services pursuant to this section shall be provided in any insurer evidence of coverage and disclosure form issued after March 31, 2004. An insurer shall provide a written copy of this information to its contracting providers and provider groups. An insurer shall also provide a copy to its insureds upon request. Notice as to the availability of the right to request completion of covered services shall be part of, accompany, or be sent simultaneously with any termination of coverage notice sent in the circumstances described in subdivision (i).

(c) The payment of copayments, deductibles, or other cost-sharing components by the insured during the period of completion of covered services with a terminated provider pursuant to subdivision (a) or a nonparticipating provider pursuant to subdivision (i)

shall be the same copayments, deductibles, or other cost-sharing components that would be paid by the insured when receiving care from a provider currently contracting with the insurer.

(d) If an insurer delegates the responsibility of complying with this section to its contracting entities, the insurer shall ensure that the requirements of this section are met.

(e) For the purposes of this section, the following terms have the following meanings:

(1) “Provider” means a person who is a licentiate as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

(2) “Provider group” includes a medical group, independent practice association, or any other similar organization.

(3) “Nonparticipating provider” means a provider who is not contracted with the insured’s health insurer to provide services under the insured’s policy. A nonparticipating provider does not include a terminated provider.

(4) “Terminated provider” means a provider whose contract to provide services to insureds is terminated or not renewed by the insurer or one of the insurer’s contracting provider groups. A terminated provider is not a provider who voluntarily leaves the insurer or contracting provider group.

(5) “Maternal mental health condition” means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

(f) This section does not require an insurer or provider group to provide for the completion of covered services by a provider whose contract with the insurer or provider group has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code, or fraud or other criminal activity.

(g) This section does not require an insurer to cover services or provide benefits that are not otherwise covered under the terms and conditions of the insurer contract.

(h) The provisions contained in this section are in addition to any other responsibilities of insurers to provide continuity of care pursuant to this chapter. This section does not preclude an insurer from providing continuity of care beyond the requirements of this section.

(i) (1) A health insurer shall, at the request of a newly covered insured under an individual insurance policy, arrange for the completion of covered services as set forth in this section by a nonparticipating provider for one of the conditions described in subdivision (a) if the newly covered insured meets both of the following:

(A) The newly covered insured’s prior coverage was terminated under subdivision (d) or (e) of Section 10273.6 or paragraph (5) or (6) of subdivision (a) of Section 1365 of the Health and Safety Code, which includes circumstances when a health benefit plan is withdrawn from any portion of a market.

(B) At the time the insured’s coverage became effective, the newly covered insured was receiving services from that provider for one of the conditions described in subdivision (a).

(2) The completion of covered services required to be provided under this subdivision shall apply to services rendered to the newly covered insured on and after the effective date of their new coverage.

(3) (A) The insurer may require a nonparticipating provider whose services are continued pursuant to this subdivision for a newly covered insured to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently participating providers providing similar services who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the insurer is not required to continue the provider’s services.

(B) Unless otherwise agreed upon by the nonparticipating provider and the insurer, the services rendered pursuant to this subdivision shall be compensated at rates and methods of payment similar to those used by the insurer for currently participating providers providing similar services who are practicing in the same or a similar geographic area as the nonparticipating provider. Neither the insurer nor the provider group is required to continue the services of a nonparticipating provider if the provider does not accept the payment rates provided for in this paragraph. The provider who agrees to provide services pursuant to this subdivision shall accept the reimbursement as payment in full and shall not bill the insured for any amount in excess of the reimbursement rate, with the exception of copayments and deductibles pursuant to subdivision (c).

(C) A provider's agreement to contractual terms and conditions and acceptance of payment rates to provide the completion of covered services to an insured pursuant to this subdivision shall not be construed as an agreement to contractual terms and conditions or acceptance of payment rates for any other insureds or for any services other than covered services pursuant to this subdivision, nor shall it be construed as agreement to any other contract.

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.