AB 2533 (AMMIANO) - BACKGROUND

As the Patient Protection and Affordable Care Act (ACA) reaches full implementation and more and more Californians enroll in health plans and policies as required by law, tension between efforts to contain health care costs and preserve access to quality providers is reaching new heights. To achieve cost savings goals of the ACA, health care service plans and insurers are narrowing provider networks, significantly reducing the number of providers available to provide care to enrollees and limiting patient access to care.

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 toward 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 by:

- Requiring health care service plan and insurers to arrange for care from out-of-network providers, at the same out-of-pocket costs to enrollees and as in-network providers, if enrollees are unable to obtain medically necessary covered services in a timely manner.

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 within network, and limits enrollee out-of-pocket costs to co-payments, co-insurance, and deductibles. AB 2533 would largely codify these regulations and provide more consumer protection by:

- Requiring health insurers regulated by the California Department of Insurance (CDI) to promulgate regulations to ensure consumers have the opportunity to access medically necessary services in an accessible and timely manner, and to review the regulations every three years to determine if updates are necessary.

- Requiring health care service plans and insurers to annually report denials of care and complaints regarding timely access to care to the Department of Managed Health Care (DMHC), and to the California Department of Insurance (CDI), respectively, and require both state entities to post reports on its website regarding the complaint information.

- Granting the Insurance Commissioner authority to investigate and take enforcement action against insurers regarding noncompliance with the specified access requirements, and to assess administrative penalties for violations.

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