

AMENDED IN ASSEMBLY MAY 1, 2001

AMENDED IN ASSEMBLY APRIL 19, 2001

CALIFORNIA LEGISLATURE—2001–02 REGULAR SESSION

ASSEMBLY BILL

No. 938

Introduced by Assembly Member Cohn

February 23, 2001

An act to amend Section 1363 of, and to add Section 1367.26 to, the Health and Safety Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

AB 938, as amended, Cohn. Health care service plans: contracting providers: lists.

Under existing law, the Knox-Keene Health Care Service Plan Act of 1975, health care service plans are regulated by the Director of the Department of Managed Health Care. Existing law requires each plan to utilize disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract, and requires the disclosure form to include, among other things, a description of any limitations on the patient's choice of a primary care or specialty care physician, and to include general authorization requirements for referral by a primary care physician to a specialty care physician.

This bill would require the disclosure form to include any limitations on the patient's choice of a nonphysician health care practitioner, and to include any general authorization requirements for referral by a primary care physician to a nonphysician health care practitioner.

This bill would require a health care service plan to provide to enrollees, upon request, a list of contracting providers, updated on a quarterly basis, and information concerning their medical education, board certification, and subspecialty training. The bill would require a health care service plan to permit enrollees to request this information through the plan’s toll-free telephone number. The bill also would require a health care service plan to provide enrollees, upon request, information on plan providers.

A willful violation of the act is a crime. Therefore, the bill’s imposition of additional or revised requirements on health care service plans would impose a state-mandated local program by creating new crimes or changing the definition of existing crimes.

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:

- 1 SECTION 1. The Legislature finds and declares all of the
- 2 following:
- 3 (a) More than 18 million Californians are enrolled in health
- 4 care service plans in California, and this number is likely to grow
- 5 significantly.
- 6 (b) A substantial number of plans limit the choice of health care
- 7 providers that an enrollee may select.
- 8 (c) An important part of the decisionmaking process for
- 9 persons enrolling in a managed care plan is choice of primary care
- 10 physicians, specialists, and other health care providers.
- 11 (d) Enrollees rely on the health care service plan to provide
- 12 accurate and reliable information regarding availability of choice
- 13 of primary care physicians, specialists, and other health care
- 14 providers.
- 15 (e) Plans should not list health care providers in their provider
- 16 directories who are not being referred patients or who are not
- 17 accepting new patients at the time the directory is updated and



1 printed without noting that fact, and health care providers should
2 not allow themselves to be listed as taking new patients when they
3 have closed practices.

4 (f) It shall be the responsibility of the plan to publish accurate
5 provider lists and failure to do so shall subject the plan to discipline
6 under this chapter.

7 SEC. 2. Section 1363 of the Health and Safety Code is
8 amended to read:

9 1363. (a) The director shall require the use by each plan of
10 disclosure forms or materials containing information regarding
11 the benefits, services, and terms of the plan contract as the director
12 may require, so as to afford the public, subscribers, and enrollees
13 with a full and fair disclosure of the provisions of the plan in
14 readily understood language and in a clearly organized manner.
15 The director may require that the materials be presented in a
16 reasonably uniform manner so as to facilitate comparisons
17 between plan contracts of the same or other types of plans. Nothing
18 contained in this chapter shall preclude the director from
19 permitting the disclosure form to be included with the evidence of
20 coverage or plan contract.

21 The disclosure form shall provide for at least the following
22 information, in concise and specific terms, relative to the plan,
23 together with additional information as may be required by the
24 director, in connection with the plan or plan contract:

25 (1) The principal benefits and coverage of the plan, including
26 coverage for acute care and subacute care.

27 (2) The exceptions, reductions, and limitations that apply to the
28 plan.

29 (3) The full premium cost of the plan.

30 (4) Any copayment, coinsurance, or deductible requirements
31 that may be incurred by the member or the member's family in
32 obtaining coverage under the plan.

33 (5) The terms under which the plan may be renewed by the plan
34 member, including any reservation by the plan of any right to
35 change premiums.

36 (6) A statement that the disclosure form is a summary only, and
37 that the plan contract itself should be consulted to determine
38 governing contractual provisions. The first page of the disclosure
39 form shall contain a notice that conforms with all of the following
40 conditions:



- 1 (A) (i) States that the evidence of coverage discloses the terms
2 and conditions of coverage.
- 3 (ii) States, with respect to individual plan contracts, small
4 group plan contracts, and any other group plan contracts for which
5 health care services are not negotiated, that the applicant has a right
6 to view the evidence of coverage prior to enrollment, and, if the
7 evidence of coverage is not combined with the disclosure form, the
8 notice shall specify where the evidence of coverage can be
9 obtained prior to enrollment.
- 10 (B) Includes a statement that the disclosure and the evidence of
11 coverage should be read completely and carefully and that
12 individuals with special health care needs should read carefully
13 those sections that apply to them.
- 14 (C) Includes the plan’s telephone number or numbers that may
15 be used by an applicant to receive additional information about the
16 benefits of the plan or a statement where the telephone number or
17 numbers are located in the disclosure form.
- 18 (D) For individual contracts, and small group plan contracts as
19 defined in Article 3.1 (commencing with Section 1357), the
20 disclosure form shall state where the health plan benefits and
21 coverage matrix is located.
- 22 (E) Is printed in type no smaller than that used for the
23 remainder of the disclosure form and is displayed prominently on
24 the page.
- 25 (7) A statement as to when benefits shall cease in the event of
26 nonpayment of the prepaid or periodic charge and the effect of
27 nonpayment upon an enrollee who is hospitalized or undergoing
28 treatment for an ongoing condition.
- 29 (8) To the extent that the plan permits a free choice of provider
30 to its subscribers and enrollees, the statement shall disclose the
31 nature and extent of choice permitted and the financial liability that
32 is, or may be, incurred by the subscriber, enrollee, or a third party
33 by reason of the exercise of that choice.
- 34 (9) A summary of the provisions required by subdivision (g) of
35 Section 1373, if applicable.
- 36 (10) If the plan utilizes arbitration to settle disputes, a statement
37 of that fact.
- 38 (11) A summary of, and a notice of the availability of, the
39 process the plan uses to authorize, modify, or deny health care



1 services under the benefits provided by the plan, pursuant to
2 Sections 1363.5 and 1367.01.

3 (12) A description of any limitations on the patient's choice of
4 primary care physician, specialty care physician, or nonphysician
5 health care practitioner, based on service area and limitations on
6 the patient's choice of acute care hospital care, subacute or
7 transitional inpatient care, or skilled nursing facility.

8 (13) General authorization requirements for referral by a
9 primary care physician to a specialty care physician or a
10 nonphysician health care practitioner.

11 (14) Conditions and procedures for disenrollment.

12 (15) A description as to how an enrollee may request continuity
13 of care as required by Section 1373.96 and request a second
14 opinion pursuant to Section 1383.15.

15 (16) Information concerning the right of an enrollee to request
16 an independent review in accordance with Article 5.55
17 (commencing with Section 1374.30).

18 (17) A notice as required by Section 1364.5.

19 (b) (1) As of July 1, 1999, the director shall require each plan
20 offering a contract to an individual or small group to provide with
21 the disclosure form for individual and small group plan contracts
22 a uniform health plan benefits and coverage matrix containing the
23 plan's major provisions in order to facilitate comparisons between
24 plan contracts. The uniform matrix shall include the following
25 category descriptions together with the corresponding copayments
26 and limitations in the following sequence:

27 (A) Deductibles.

28 (B) Lifetime maximums.

29 (C) Professional services.

30 (D) Outpatient services.

31 (E) Hospitalization services.

32 (F) Emergency health coverage.

33 (G) Ambulance services.

34 (H) Prescription drug coverage.

35 (I) Durable medical equipment.

36 (J) Mental health services.

37 (K) Chemical dependency services.

38 (L) Home health services.

39 (M) Other.



1 (2) The following statement shall be placed at the top of the
2 matrix in all capital letters in at least 10-point boldface type:

3
4 THIS MATRIX IS INTENDED TO BE USED TO HELP YOU
5 COMPARE COVERAGE BENEFITS AND IS A SUMMARY
6 ONLY. THE EVIDENCE OF COVERAGE AND PLAN
7 CONTRACT SHOULD BE CONSULTED FOR A DETAILED
8 DESCRIPTION OF COVERAGE BENEFITS AND
9 LIMITATIONS.

10
11 (c) Nothing in this section shall prevent a plan from using
12 appropriate footnotes or disclaimers to reasonably and fairly
13 describe coverage arrangements in order to clarify any part of the
14 matrix that may be unclear.

15 (d) All plans, solicitors, and representatives of a plan shall,
16 when presenting any plan contract for examination or sale to an
17 individual prospective plan member, provide the individual with
18 a properly completed disclosure form, as prescribed by the director
19 pursuant to this section for each plan so examined or sold.

20 (e) In the case of group contracts, the completed disclosure
21 form and evidence of coverage shall be presented to the
22 contractholder upon delivery of the completed health care service
23 plan agreement.

24 (f) Group contractholders shall disseminate copies of the
25 completed disclosure form to all persons eligible to be a subscriber
26 under the group contract at the time those persons are offered the
27 plan. If the individual group members are offered a choice of plans,
28 separate disclosure forms shall be supplied for each plan available.
29 Each group contractholder shall also disseminate or cause to be
30 disseminated copies of the evidence of coverage to all applicants,
31 upon request, prior to enrollment and to all subscribers enrolled
32 under the group contract.

33 (g) In the case of conflicts between the group contract and the
34 evidence of coverage, the provisions of the evidence of coverage
35 shall be binding upon the plan notwithstanding any provisions in
36 the group contract that may be less favorable to subscribers or
37 enrollees.

38 (h) In addition to the other disclosures required by this section,
39 every health care service plan and any agent or employee of the
40 plan shall, when presenting a plan for examination or sale to any



1 individual purchaser or the representative of a group consisting of
2 25 or fewer individuals, disclose in writing the ratio of premium
3 costs to health services paid for plan contracts with individuals and
4 with groups of the same or similar size for the plan's preceding
5 fiscal year. A plan may report that information by geographic area,
6 provided the plan identifies the geographic area and reports
7 information applicable to that geographic area.

8 (i) Subdivision (b) shall not apply to any coverage provided by
9 a plan for the Medi-Cal program or the Medicare program pursuant
10 to Title XVIII and Title XIX of the Social Security Act.

11 SEC. 3. Section 1367.26 is added to the Health and Safety
12 Code, to read:

13 1367.26. (a) On or before July 1, 2002, a health care service
14 plan shall provide, upon request, a list of the following contracting
15 providers, within the enrollee's or prospective enrollee's general
16 geographic area:

17 (1) Primary care providers.

18 (2) Medical groups.

19 (3) Independent practice associations.

20 (4) Hospitals.

21 (5) All other available contracting physicians, psychologists,
22 acupuncturists, optometrists, podiatrists, and chiropractors to the
23 extent their services may be accessed and are covered through the
24 contract with the plan.

25 (b) This list shall indicate which providers have notified the
26 plan that they have closed practices or are otherwise not accepting
27 new patients at that time.

28 (c) A health care service plan shall provide this information in
29 written form to its enrollees or prospective enrollees upon request.
30 A plan may, with the permission of the enrollee, satisfy the
31 requirements of this section by directing the enrollee or
32 prospective enrollee to the plan's provider listings on its website.
33 Plans shall ensure that the information provided is updated at least
34 quarterly. *A plan may satisfy this update requirement by providing*
35 *an insert or addendum to any existing provider listing.*

36 (d) Each plan shall make information available, upon request,
37 concerning a contracting provider's professional degree, board
38 certifications and any subspecialty training a specialist may have.

39 (e) Nothing in this section shall prohibit a plan from requiring
40 its contracting providers or contracting provider groups to satisfy



1 these requirements. If a plan delegates the responsibility of
2 complying with this section to its contracting providers or
3 contracting provider groups, the plan shall ensure that the
4 requirements of this section are met.

5 (f) Every health care service plan shall allow enrollees to
6 request the information required by this section through their
7 toll-free telephone number or in writing.

8 SEC. 4. No reimbursement is required by this act pursuant to
9 Section 6 of Article XIII B of the California Constitution because
10 the only costs that may be incurred by a local agency or school
11 district will be incurred because this act creates a new crime or
12 infraction, eliminates a crime or infraction, or changes the penalty
13 for a crime or infraction, within the meaning of Section 17556 of
14 the Government Code, or changes the definition of a crime within
15 the meaning of Section 6 of Article XIII B of the California
16 Constitution.

