

AMENDED IN SENATE JUNE 13, 1995
AMENDED IN ASSEMBLY APRIL 17, 1995

CALIFORNIA LEGISLATURE—1995–96 REGULAR SESSION

ASSEMBLY BILL

No. 1266

Introduced by Assembly Member Goldsmith

February 23, 1995

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

LEGISLATIVE COUNSEL'S DIGEST

AB 1266, as amended, Goldsmith. Health care service plans: preexisting conditions: required disclosures.

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 Commissioner of Corporations. Under existing law, willful violation of the act is a misdemeanor.

Existing law requires the commissioner to require the use by plans of certain disclosure forms containing specified information.

This bill would add additional information required to be disclosed by plans.

By changing the definition of 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. State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1363 of the Health and Safety
2 Code is amended to read:

3 1363. (a) The commissioner shall require the use by
4 each plan of disclosure forms or materials containing
5 information regarding the benefits, services, and terms of
6 the plan contract as the commissioner may require, so as
7 to afford the public, subscribers, and enrollees with a full
8 and fair disclosure of the provisions of the plan in readily
9 understood language and in a clearly organized manner.
10 The commissioner may require that the materials be
11 presented in a reasonably uniform manner so as to
12 facilitate comparisons between plan contracts of the same
13 or other types of plans. Nothing contained in this chapter
14 shall preclude the commissioner from permitting the
15 disclosure form to be included with the evidence of
16 coverage or plan contract.

17 The disclosure form shall provide for at least the
18 following information, in concise and specific terms,
19 relative to the plan, together with additional information
20 as may be required by the commissioner, in connection
21 with the plan or plan contract:

- 22 (1) The principal benefits and coverage of the plan.
- 23 (2) The exceptions, reductions, and limitations that
24 apply to the plan.
- 25 (3) The full premium cost of the plan.
- 26 (4) Any copayment, coinsurance, or deductible
27 requirements that may be incurred by the member or the
28 member’s family in obtaining coverage under the plan.
- 29 (5) The terms under which the plan may be renewed
30 by the plan member, including any reservation by the
31 plan of any right to change premiums.



1 (6) A statement that the disclosure form is a summary
2 only, and that the plan contract itself should be consulted
3 to determine governing contractual provisions.

4 (7) A statement as to when benefits shall cease in the
5 event of nonpayment of the prepaid or periodic charge
6 and the effect of nonpayment upon an enrollee who is
7 hospitalized or undergoing treatment for an ongoing
8 condition.

9 (8) To the extent that the plan permits a free choice
10 of provider to its subscribers and enrollees, the statement
11 shall disclose the nature and extent of choice permitted
12 and the financial liability which is, or may be, incurred by
13 the subscriber, enrollee, or a third party by reason of the
14 exercise of that choice.

15 (9) A summary of the provisions required by
16 subdivision (g) of Section 1373, if applicable.

17 (10) If the plan utilizes arbitration to settle disputes, a
18 statement of that fact.

19 (11) A summary of, and a notice of the availability of,
20 the process the plan uses to authorize or deny health care
21 services under the benefits provided by the plan,
22 pursuant to Section 1363.5.

23 (12) A ~~statement~~ *description* of any limitations on
24 ~~access to~~ the patient's choice of *primary care or specialty*
25 *care* physician based on ~~the geographic location of the~~
26 ~~patient and the physician.~~ *service area.*

27 (13) ~~Authorization~~ *General authorization*
28 requirements for referral by a primary care physician to
29 a specialty care physician.

30 (14) Conditions and procedures for disenrollment.

31 (b) All plans, solicitors, and representatives of a plan
32 shall, when presenting any plan contract for examination
33 or sale to an individual prospective plan member, provide
34 the individual with a properly completed disclosure form,
35 as prescribed by the commissioner pursuant to this
36 section for each plan so examined or sold.

37 (c) In the case of group contracts, the completed
38 disclosure form and evidence of coverage shall be
39 presented to the contractholder upon delivery of the
40 completed health care service plan agreement.



1 (d) Group contractholders shall disseminate copies of
2 the completed disclosure form to all persons eligible to be
3 a subscriber under the group contract at the time those
4 persons are offered the plan. Where the individual group
5 members are offered a choice of plans, separate
6 disclosure forms shall be supplied for each plan available.
7 Each group contractholder shall also disseminate or cause
8 to be disseminated copies of the evidence of coverage to
9 all subscribers enrolled under the group contract.

10 (e) In the case of conflicts between the group contract
11 and the evidence of coverage, the provisions of the
12 evidence of coverage shall be binding upon the plan
13 notwithstanding any provisions in the group contract
14 which may be less favorable to subscribers or enrollees.

15 (f) In addition to the other disclosures required by this
16 section, every health care service plan and any agent or
17 employee of the plan shall, when presenting a plan for
18 examination or sale to any individual purchaser or the
19 representative of a group consisting of 25 or fewer
20 individuals, disclose in writing the ratio of premium costs
21 to health services paid for plan contracts with individuals
22 and with groups of the same or similar size for the plan's
23 preceding fiscal year. A plan may report that information
24 by geographic area, provided the plan identifies the
25 geographic area and reports information applicable to
26 that geographic area.

27 ~~SEC. 3.—~~

28 *SEC. 2.* The amendments made to Section 1357.51 of
29 the Health and Safety Code by the act adding this section
30 shall apply to plan contracts issued, amended, delivered,
31 or renewed in this state on or after January 1, 1996.

32 ~~SEC. 4.—~~

33 *SEC. 3.* No reimbursement is required by this act
34 pursuant to Section 6 of Article XIII B of the California
35 Constitution because the only costs that may be incurred
36 by a local agency or school district will be incurred
37 because this act creates a new crime or infraction,
38 eliminates a crime or infraction, or changes the penalty
39 for a crime or infraction, within the meaning of Section
40 17556 of the Government Code, or changes the definition



1 of a crime within the meaning of Section 6 of Article
2 XIII B of the California Constitution.
3 Notwithstanding Section 17580 of the Government
4 Code, unless otherwise specified, the provisions of this act
5 shall become operative on the same date that the act
6 takes effect pursuant to the California Constitution.

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