

**Assembly Bill No. 1553**

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Passed the Assembly    September 11, 1997

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*Chief Clerk of the Assembly*

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Passed the Senate    September 9, 1997

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*Secretary of the Senate*

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This bill was received by the Governor this \_\_\_\_ day  
of \_\_\_\_\_, 1997, at \_\_\_\_ o'clock \_\_M.

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*Private Secretary of the Governor*



## CHAPTER \_\_\_\_

An act to amend Section 1367.62 of the Health and Safety Code, and to amend Sections 510 and 10123.87 of, and to add Section 12995 to, the Insurance Code, relating to insurance, and declaring the urgency thereof, to take effect immediately.

## LEGISLATIVE COUNSEL'S DIGEST

AB 1553, Committee on Insurance. Insurance: late fees: disclosures.

(1) Existing law provides for the licensure and regulation of health care service plans administered by the Commissioner of Corporations and for the regulation of policies of disability insurance administered by the Insurance Commissioner. Under existing law, a willful violation of any of the provisions governing health care service plans is punishable as either a felony or a misdemeanor. Existing law also requires health care service plans and certain disability insurance policies that provide maternity coverage to provide specified minimum levels of coverage for postdelivery inpatient hospital care and to provide notice thereof in the plan's or the insurer's evidence of coverage for evidence of coverage issued on or after January 1, 1998, and to provide additional written notice of this coverage during the course of an enrollee's or insured's prenatal care.

This bill would require health care service plans that issue contracts that provide for coverage of the type commonly referred to as "preferred provider organizations," and certain disability insurers, to provide additional written notice of this postdelivery inpatient hospital care coverage to all females between the ages of 10 and 50 who are covered by these contracts and policies.

Because a willful violation of the provisions applicable to health care service plans is a crime, this bill would impose a state-mandated local program.

(2) Existing law provides that whenever a policy of insurance, a policy of life insurance, a policy of disability



insurance, or a certificate of coverage, as specified, is first issued to or delivered to a new insured or a new policyholder in this state, the insurer shall include a written disclosure printed in large, boldface type containing certain information.

This bill would require an insurer to also include in the written disclosure, at the insurer's discretion, either the address and the telephone number of the insurer or the address and telephone number of the agent or broker of record, or both of those addresses and telephone numbers. The bill would also provide that if the policy or certificate was issued or delivered by an agent or broker, the disclosure shall specifically advise the insured to contact his or her agent or broker for assistance.

(3) Existing law sets forth various fees that may be charged by the Department of Insurance relative to the performance of various services by the department.

This bill would provide that certain uncontested departmental billings for authorized services or assessments that are not paid to the department within 45 days of the invoice date shall be subject to a late charge. The bill would provide a procedure for an insurer to contest a billing under which late charges for the portion of the billing that is contested would be tolled.

(4) 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.

(5) This bill would declare that it is to take effect immediately as an urgency statute, and would provide for delayed operation of certain provisions of the bill, as specified.

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

SECTION 1. Section 1367.62 of the Health and Safety Code, as added by Chapter 389 of the Statutes of 1997, is amended to read:



1367.62. (a) No health care service plan contract that is issued, amended, renewed, or delivered on or after the effective date of the act adding this section, that provides maternity coverage, shall do any of the following:

(1) Restrict benefits for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following a delivery by caesarean section. However, coverage for inpatient hospital care may be for a time period less than 48 or 96 hours if both of the following conditions are met:

(A) The decision to discharge the mother and newborn before the 48- or 96-hour time period is made by the treating physicians in consultation with the mother.

(B) The contract covers a postdischarge followup visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician. The visit shall be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit shall include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician shall disclose to the mother the availability of a postdischarge visit, including an in-home visit, physician office visit, or plan facility visit. The treating physician, in consultation with the mother, shall determine whether the postdischarge visit shall occur at home, the plan's facility, or the treating physician's office after assessment of certain factors. These factors shall include, but not be limited to, the transportation needs of the family, and environmental and social risks.

(2) Reduce or limit the reimbursement of the attending provider for providing care to an individual enrollee in accordance with the coverage requirements.

(3) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual enrollee in a manner inconsistent with the coverage requirements.



(4) Deny a mother or her newborn eligibility, or continued eligibility, to enroll or to renew coverage solely to avoid the coverage requirements.

(5) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum coverage requirements.

(6) Restrict inpatient benefits for the second day of hospital care in a manner that is less than favorable to the mother or her newborn than those provided during the preceding portion of the hospital stay.

(7) Require the treating physician to obtain authorization from the health care service plan prior to prescribing any services covered by this section.

(b) (1) Every health care service plan shall include notice of the coverage specified in subdivision (a) in the plan's evidence of coverage for evidences of coverage issued on or after January 1, 1998, and except as specified in paragraph (2), shall provide additional written notice of this coverage during the course of the enrollee's prenatal care. The contract may require the treating physician or the enrollee's medical group to provide this additional written notice of coverage during the course of the enrollee's prenatal care.

(2) Health care service plans that issue contracts that provide for coverage of the type commonly referred to as "preferred provider organizations" shall provide additional written notice to all females between the ages of 10 and 50 who are covered by those contracts of the coverage under subdivision (a) within 60 days of the effective date of this act. The plan shall provide additional written notice of the coverage specified in subdivision (a) during the course of prenatal care if both of the following conditions are met:

(A) The plan previously notified subscribers that hospital stays for delivery would be inconsistent with the requirement in subparagraph (A) of paragraph (1) of subdivision (a).

(B) The plan received notice, whether by receipt of a claim, a request for preauthorization for



pregnancy-related services, or other actual notice that the enrollee is pregnant.

(c) Nothing in this section shall be construed to prohibit a plan from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

SEC. 2. Section 510 of the Insurance Code is amended to read:

510. Whenever a policy of insurance specified in Section 660 or 675, a policy of life insurance as defined in Section 101, a policy of disability insurance as defined in Section 106, or a certificate of coverage as defined in Section 10270.6, is first issued to or delivered to a new insured or a new policyholder in this state, the insurer shall include a written disclosure containing the name, address, and toll-free telephone number of the unit within the Department of Insurance that deals with consumer affairs. The telephone number shall be the same as that provided to consumers under Section 12921.1. The disclosure shall be printed in large, boldface type.

The disclosure shall contain, at the discretion of the insurer, either the address and telephone number of the insurer or the address and telephone number of the agent or broker of record, or both of those addresses and telephone numbers. The disclosure shall also contain a statement that the Department of Insurance should be contacted only after discussions with the insurer, or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem. If the policy or certificate was issued or delivered by an agent or broker, the disclosure shall specifically advise the insured to contact his or her agent or broker for assistance.

SEC. 3. Section 10123.87 of the Insurance Code, as added by Chapter 389 of the Statutes of 1997, is amended to read:

10123.87. (a) No individual or group policy of disability insurance that provides coverage for hospital, medical, and surgical benefits that is issued, amended,



renewed, or delivered on or after the effective date of the act adding this section, that provides maternity coverage, shall do any of the following:

(1) Restrict benefits for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following a delivery by caesarean section. However, coverage for inpatient hospital care may be for a time period less than 48 or 96 hours if both of the following conditions are met:

(A) The decision to discharge the mother and newborn before the 48- or 96-hour time period is made by the treating physicians in consultation with the mother.

(B) The policy covers a postdischarge followup visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician. The visit shall be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit shall include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician shall disclose to the mother the availability of a postdischarge visit, including an in-home visit, physician office visit, or a visit to a facility under contract with the insurer. The treating physician, in consultation with the mother, shall determine whether the postdischarge visit shall occur at home, the contracted facility, or the treating physician's office after assessment of certain factors. These factors shall include, but not be limited to, the transportation needs of the family, and environmental and social risks.

(2) Reduce or limit the reimbursement of the attending provider for providing care to an individual insured in accordance with the coverage requirements.

(3) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual insured in a manner inconsistent with the coverage requirements.



(4) Deny a mother or her newborn eligibility, or continued eligibility, to enroll or to renew coverage solely to avoid the coverage requirements.

(5) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum coverage requirements.

(6) Restrict inpatient benefits for the second day of hospital care in a manner that is less than favorable to the mother or her newborn than those provided during the preceding portion of the hospital stay.

(7) Require the treating physician to obtain authorization from the insurer prior to prescribing any services covered by this section.

(b) (1) Every individual or group policy of disability insurance that provides coverage for hospital, medical, and surgical benefits shall include notice of the coverage specified in subdivision (a) in the insurer's evidence of coverage or certificate of insurance for evidences of coverage or certificates of insurance issued on or after January 1, 1998.

(2) Every insurer that issues a policy of disability insurance under paragraph (1) shall provide additional written notice to all females between the ages of 10 and 50 who are covered under those policies of the coverage under subdivision (a) within 60 days of the effective date of this act. The insurer shall provide additional written notice of the coverage specified in subdivision (a) during the course of prenatal care if both of the following conditions are met:

(A) The insurer previously notified policyholders that hospital stays for delivery would be inconsistent with the requirement in subparagraph (A) of paragraph (1) of subdivision (a).

(B) The insurer received notice, whether by receipt of a claim, a request for preauthorization for pregnancy-related services, or other actual notice that the insured is pregnant.

(c) Nothing in this section shall be construed to prohibit an insurer from negotiating the level and type of



reimbursement with a provider for care provided in accordance with this section.

SEC. 4. Section 12995 is added to the Insurance Code, to read:

12995. (a) Notwithstanding any other provision of this code, all uncontested departmental billings for services or assessments authorized herein, which are not paid within 45 days of the invoice date, shall be subject to a late charge, unless waived or modified by the department. The late charge shall be 1<sup>1</sup>/<sub>2</sub> percent per month of the balance due. This late charge shall be compounded monthly.

(b) Billings from the department shall be postmarked within five working days of the invoice date. If the billing is postmarked more than five working days after the invoice date, the insurer shall be given 45 days from the date of the postmark to pay the amount due. In those instances where a billing is postmarked more than five working days after the invoice date, the insurer is required to submit the postmarked envelope with payment to avoid a late charge.

(c) Payments shall be postmarked by the due date to avoid a late charge. Except as provided in subdivision (d), contested billings for which the original amount is paid to the department after the 45 day period shall be subject to the late charge, unless waived or modified by the department. The insurer shall provide written notice of the contested billing and shall set forth the basis for the contestability in writing to the department prior to the due date.

(d) Late charges shall be tolled for the portion of the billing that is contested by an insurer. The commissioner shall consider the material submitted by the insurer and reach a decision on the contested billing within 30 days of receiving written notification that a billing is being contested. The commissioner's written decision on contested amounts shall be final and written notification, including a revised amount, if any, shall be provided indicating the basis for the decision. This written notification shall also include an invoice date from which



an insurer shall be given 30 days to remit payment. This section shall not preclude an insurer from filing a petition for writ of mandate in accordance with the provisions of the Code of Civil Procedure.

(e) All late charges collected pursuant to this section shall be deposited into the General Fund.

(f) This section shall not apply to the Insurance Department Schedule of Fees and Charges pursuant to Section 12978.

SEC. 5. In order to prevent any unnecessary waste of resources that might result from insurers' efforts to comply with Section 510 of the Insurance Code as amended by this act, an insurer may continue to use disclosure forms specified in Section 510 of the Insurance Code that were produced or printed prior to January 1, 1998, until current supplies are depleted or until December 31, 1998, whichever comes first.

SEC. 6. 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.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

SEC. 7. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to protect the health of mothers and their newborns at the earliest possible time, it is necessary that this act take effect immediately.



SEC. 8. Notwithstanding Section 7 of this act, Sections 2, 4, and 5 shall not become operative until January 1, 1998.



Approved \_\_\_\_\_, 1997

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*Governor*

