AMENDED IN SENATE AUGUST 2, 2010

AMENDED IN SENATE JUNE 16, 2010

AMENDED IN ASSEMBLY MAY 24, 2010

AMENDED IN ASSEMBLY MAY 20, 2010

AMENDED IN ASSEMBLY APRIL 8, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 2389

Introduced by Assembly Member Gaines

February 19, 2010

An act to add Section 1367.49 to the Health and Safety Code, and to add Section 10133.64 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2389, as amended, Gaines. Health care coverage: ~~provider contracts.~~ *health facilities: cost and quality information.*

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. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a contract between a plan or insurer and a health care provider from containing certain terms.

This bill would prohibit a contract by or on behalf of a plan or insurer and a health care facility, as defined, to provide inpatient hospital services or ambulatory care services to subscribers and enrollees of the plan or policyholders and insureds of the insurer from containing a

provision that restricts the ability of the plan or insurer to furnish information to subscribers or enrollees of the plan or policyholders or insureds of the insurer concerning the cost range of procedures at the facility or the quality of services performed by the facility. The bill would require that the cost information be *limited to certain elective, uncomplicated procedures, and be* displayed in a specified manner and would prohibit a health care service plan from disclosing negotiated capitation rates or other prepaid arrangements to enrollees or subscribers in either the cost or quality information, except as specified. The bill would require a plan or insurer that furnishes the cost or quality information to also disclose the location of its facility *cost ranges and* quality measurements to subscribers, enrollees, policyholders, and insureds, and to make specified disclosures regarding those measurements *and the cost information provided*. ~~If the quality information is quality of care data developed and compiled by the plan or insurer, the~~ *The* bill would require plans and insurers to provide affected facilities an opportunity to review the information prior to furnishing it to subscribers, enrollees, policyholders, or insureds, as specified, and would also, among other things, require, *if the information is data developed and compiled by the plan or insurer,* that the information be based on specified guidelines and be updated ~~at appropriate intervals~~ *regularly*, as specified. The bill would make a ~~contractural~~ *contractual* provision inconsistent with the bill's requirements void and unenforceable.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

SECTION 1. Section 1367.49 is added to the Health and Safety Code, to read:

1367.49. (a) A contract issued, amended, renewed, or delivered on or after January 1, 2011, by or on behalf of a health care service plan and a health care facility to provide inpatient hospital services or ambulatory care services to subscribers and enrollees of the plan shall not contain any provision that restricts the ability of the health care service plan to furnish information to subscribers or enrollees of the plan concerning the cost range of procedures at the facility or the quality of services performed by the facility.

(b) Information on the cost range of procedures ~~furnished pursuant to subdivision (a)~~ *at a health care facility furnished by a plan to enrollees or subscribers* shall be displayed as an episode of care, unless an episode of care is not applicable, and may include, but shall not be limited to, applicable diagnostic tests, prescription drugs, hospital days, and medical supplies that are associated with a typical procedure or illness. *The information shall be limited to the cost range of elective, uncomplicated procedures performed on patients without malignancy or comorbidity, with a length of stay consistent with the diagnosis-related group assignment.*

(c) A health care service plan shall not disclose negotiated capitation rates or other prepaid arrangements in the information ~~furnished to enrollees or subscribers pursuant to subdivision (a).~~ *described in subdivision (a) that is furnished to enrollees or subscribers.* However, if the health care service plan includes in that information allocated capitation payments to a health care facility for an episode of care, the plan and the facility shall consult on an appropriate and reasonable methodology formula.

(d) If the information proposed to be furnished ~~pursuant to subdivision (a)~~ *to enrollees and subscribers* on the quality of services performed by a health care facility is quality of care data that the plan has developed and compiled, all of the following requirements shall be satisfied:

(1) The information shall be based on nationally recognized ~~evidence-based~~ *evidence-* or consensus-based clinical recommendations or guidelines. When available, a plan shall use measures endorsed by the National Quality Forum or other entities ~~whose work in the area of quality performance is generally accepted in the health care industry.~~ *nationally recognized for quality or performance review.*

(2) The plan shall utilize appropriate risk adjustment factors to account for different characteristics of the population, such as case mix, severity of patient's condition, comorbidities, outlier episodes, and other factors to account for differences in the use of health care resources among health care facilities.

(3) The information, and the data used as the basis for that ~~information, shall be updated at appropriate intervals, but not less~~ *information, shall be updated regularly, and no less* than annually.

(4) If the health care service plan is evaluating quality measurements for which it is also furnishing the cost range of procedures to its enrollees or subscribers, it shall link the two together for comparison purposes when appropriate.

~~(5) The~~

(e) A health care service plan shall, prior to furnishing the information *described in subdivision (a)* to its enrollees or subscribers, provide all of the following to the affected health care facility:

~~(A)~~

(1) At least 45-days written notice to review the information.

~~(B) The criteria used in the development and evaluation of quality measurements and reasonable access to these criteria. The criteria shall be sufficiently detailed and reasonably understandable to allow the facility to verify the data against its records.~~

(2) A summary of the criteria and methodology used in the development and evaluation of cost range and quality measurements. This summary shall be sufficiently detailed and reasonably understandable to allow the facility to verify the data against its own records.

~~(C)~~

(3) An explanation to the facility that it has the right to correct errors and seek review of the data used to measure the quality of services provided at the facility *and to provide supplemental information to the plan if the facility finds discrepancies in the data or cost range criteria used by the plan*.

~~(D)~~

(4) A reasonable, prompt, and transparent appeal process. If the facility makes an appeal prior to the expiration of the time period provided under ~~subparagraph (A)~~ *paragraph (1)*, the health care service plan shall make no *material* changes to its current information about the facility until the appeal is completed.

(5) Notice of, and an annual update of, the information furnished to enrollees or subscribers on the cost range of procedures at the facility. A plan may satisfy this requirement by providing an electronic copy to the facility or by providing the facility with access to the plan's cost information through an Internet Web site or electronic portal made available by the plan.

~~(e)~~

(f) A health care service plan that furnishes information concerning the cost range of procedures at a health care facility or the quality of services provided by the facility to its subscribers or enrollees ~~pursuant to subdivision (a)~~ shall also disclose the following to its subscribers or enrollees:

(1) Where the plan's facility *cost ranges and* quality measurements can be found.

(2) That facility *cost ranges and* quality measurements provided by the plan are only a guide to choosing a facility, that enrollees or subscribers should confer with their existing facility before making a decision, and that these *ranges and* measurements have a risk of error and should not be the sole basis for selecting a facility.

(3) Information explaining the facility quality measurement process, including the basis upon which quality is measured and any limitation of the data used.

(4) Reasonable details on the factors and criteria used by the facility quality measurement system, including whether severity cost adjustments have been utilized.

(5) How an enrollee or subscriber may register a complaint ~~about the plan's facility quality measurements or provide feedback on the quality measurement system.~~ *about, or provide feedback on, the quality measurement system or the cost range information provided by the plan.*

~~(f) Any contractural~~

(g) Any contractural provision inconsistent with this section shall be void and unenforceable.

~~(g) For purposes of this section, the following definitions apply:~~

~~(1) "Health care facility" means a licensed hospital or any other licensed health care facility owned by a licensed hospital.~~

~~(2) "Licensed hospital" has the same meaning as set forth in Section 4028 of the Business and Professions Code.~~

~~(3) "Licensed health care facility" means any institution or health facility, other than a long-term health care facility as defined pursuant to Section 1418, licensed by the State Department of Public Health to deliver or furnish health care services.~~

(h) For purposes of this section, "health care facility" means a health facility defined in subdivision (a), (b), or (f) of Section 1250.

~~(h)~~

(i) Section 1390 shall not apply for purposes of this section.

SEC. 2. Section 10133.64 is added to the Insurance Code, to read:

10133.64. (a) A contract issued, amended, renewed, or delivered on or after January 1, 2011, by or on behalf of a health insurer and a health care facility to provide inpatient hospital services or ambulatory care services to policyholders and insureds of the insurer shall not contain any provision that restricts the ability of the health insurer to furnish information to policyholders or insureds concerning the cost range of procedures at the health care facility or the quality of services provided by the facility.

(b) Information on the cost range of procedures ~~furnished pursuant to subdivision (a)~~ *at a health care facility furnished by an insurer to policyholders or insureds* shall be displayed as an episode of care, unless an episode of care is not applicable, and may include, but shall not be limited to, applicable diagnostic tests, prescription drugs, hospital days, and medical supplies that are associated with a typical procedure or illness. *The information shall be limited to the cost range of elective, uncomplicated procedures performed on patients without malignancy or comorbidity, with a length of stay consistent with the diagnosis-related group assignment.*

(c) If the information proposed to be furnished ~~pursuant to subdivision (a)~~ *to policyholders or insureds* on the quality of services performed by a health care facility is quality of care data that the insurer has developed and compiled, all of the following requirements shall be satisfied:

(1) The information shall be based on nationally recognized ~~evidence-based~~ *evidence-* or consensus-based clinical recommendations or guidelines. When available, an insurer shall use measures endorsed by the National Quality Forum or other entities ~~whose work in the area of quality performance is generally accepted in the health care industry.~~ *nationally recognized for quality or performance review.*

(2) The insurer shall utilize appropriate risk adjustment factors to account for different characteristics of the population, such as case mix, severity of patient's condition, comorbidities, outlier episodes, and other factors to account for differences in the use of health care resources among health care facilities.

(3) The information, and the data used as the basis for that ~~information, shall be updated at appropriate intervals, but not less~~ *information, shall be updated regularly, but no less* than annually.

(4) If the health insurer is evaluating quality measurements for which it is also furnishing the cost range of procedures to its policyholders or insureds, it shall link the two together for comparison purposes when appropriate.

~~(5) The~~

(d) A health insurer shall, prior to furnishing the information *described in subdivision (a)* to its policyholders or insureds, provide all of the following to the affected health care facility:

~~(A)~~

(1) At least 45-days written notice to review the information.

~~(B) The criteria used in the development and evaluation of quality measurements and reasonable access to these criteria. The criteria shall be sufficiently detailed and reasonably understandable to allow the facility to verify the data against its records.~~

(2) A summary of the criteria and methodology used in the development and evaluation of cost range and quality measurements. This summary shall be sufficiently detailed and reasonably understandable to allow the facility to verify the data against its own records.

~~(C)~~

(3) An explanation to the facility that it has the right to correct errors and seek review of the data used to measure the quality of services provided at the facility *and to provide supplemental information to the insurer if the facility finds discrepancies in the data or cost range criteria used by the insurer*.

~~(D)~~

(4) A reasonable, prompt, and transparent appeal process. If the facility makes an appeal prior to the expiration of the time period provided under ~~subparagraph (A)~~ *paragraph (1)*, the health insurer shall make no *material* changes to its current information about the facility until the appeal is completed.

(5) Notice of, and an annual update of, the information furnished to policyholders or insureds on the cost range of procedures at the facility. A health insurer may satisfy this requirement by providing an electronic copy to the facility or by providing the facility with access to the insurer's cost information through an

Internet Web site or electronic portal made available by the insurer.

~~(d)~~

(e) A health insurer that furnishes information concerning the cost range of procedures at a health care facility or the quality of services provided by the facility to its policyholders or insureds ~~pursuant to subdivision (a)~~ shall also disclose the following to its policyholders or insureds:

(1) Where the insurer's facility *cost ranges and* quality measurements can be found.

(2) That facility *cost ranges and* quality measurements provided by the insurer are only a guide to choosing a facility, that policyholders or insureds should confer with their existing facility before making a decision, and that these *ranges and* measurements have a risk of error and should not be the sole basis for selecting a facility.

(3) Information explaining the facility quality measurement process, including the basis upon which quality is measured and any limitation of the data used.

(4) Reasonable details on the factors and criteria used by the facility quality measurement system, including whether severity cost adjustments have been utilized.

(5) How a policyholder or insured may register a complaint ~~about the insurer's facility quality measurements or provide feedback on the quality measurement system.~~ *about, or provide feedback on, the quality measurement system or the cost range information provided by the insurer.*

~~(e) Any contractural~~

(f) Any contractural provision inconsistent with this section shall be void and unenforceable.

~~(f) For purposes of this section, the following definitions apply:~~

~~(1) "Health care facility" means a licensed hospital or any other licensed health care facility owned by a licensed hospital.~~

~~(2) "Licensed hospital" has the same meaning as set forth in Section 4028 of the Business and Professions Code.~~

~~(3) "Licensed health care facility" means any institution or health facility, other than a long-term health care facility as defined pursuant to Section 1418 of the Health and Safety Code, licensed by the State Department of Public Health to deliver or furnish health care services.~~

(g) For purposes of this section, "health care facility" means a health facility defined in subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code.

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