AMENDED IN SENATE JUNE 23, 2010

AMENDED IN ASSEMBLY MAY 6, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 2533

Introduced by Assembly Member Fuentes

February 19, 2010

An act to amend Section 1367.02 of the Health and Safety Code, and to amend Section 10123.36 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2533, as amended, Fuentes. Health care coverage: quality rating.

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 makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.

Existing law requires every health care service plan and certain health insurers, on or before July 1, 1999, to file with the respective departments a description of policies and procedures related to economic profiling, as defined, utilized by the plan or insurer and its medical groups and individual practice associations and requires the Director of the Department of Managed Health Care and the Insurance Commissioner to make these filings available to the public upon request with certain exceptions. Existing law requires each plan or health insurer using economic profiling to provide, upon request, a copy of economic profiling information to the profiled individual, group, or association. Existing law also requires each plan or insurer, as a contract condition,

to require its contracting medical groups and individual practice associations that maintain economic profiles of individual providers to provide, upon request, a copy to the profiled individual providers.

This bill would *expand these provisions to apply to quality rating, as defined, utilized by the plan or insurer with respect to a particular physician, provider, medical group, or individual practice association. The bill would also* require ~~those~~ *the department* filings to be made ~~with the respective departments annually~~ *immediately upon adoption of the policies and procedures and within 30 days of making any changes to the policies and procedures. The bill would modify the required content of the filings, as specified, and would require a plan or insurer that submitted a filing prior to January 1, 2011, to update the filing by March 31, 2011, to comply with the bill's requirements and to reflect the plan's or insurer's current policies and procedures*. ~~The bill would also expand these provisions to apply to quality rating, as defined, utilized by the plan or insurer with respect to a particular physician, provider, medical group, or individual practice association.~~

Because a willful violation of the bill's requirements with respect to health care service plans would be a crime, it 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:

SECTION 1. Section 1367.02 of the Health and Safety Code is amended to read:

1367.02. (a) *(1)* For purposes of public disclosure, every health care service plan shall ~~annually~~ file with the department a description of any policies and procedures related to economic profiling or quality rating utilized by the plan and its medical groups and individual practice associations. ~~The~~ *A plan shall file this description immediately upon adoption of the policies and procedures and within 30 days of adopting any changes to the policies and procedures. A plan that filed a description pursuant*

to this section prior to January 1, 2011, shall update that filing by March 31, 2011, in order to meet the requirements of this section and to reflect its current policies and procedures.

(2) The filing shall describe how these policies and procedures are used in utilization review, peer review, incentive and penalty programs, ~~network modification, and patient steering,~~ and in provider retention and termination decisions, *as well as how they are used to designate or rate a particular physician, provider, medical group, or individual practice association within the plan's existing network and to encourage patients to see only designated or rated physicians, providers, medical groups, or individual practice associations within the plan's existing network. The filing shall include a description of the manner and methodology used to share results from economic profiling and quality rating with patients*. The filing shall also indicate in what manner the economic profiling or quality rating system being used takes into consideration risk adjustments that reflect case mix, accuracy and reliability of data relied upon, type and severity of patient illness, age of patients, patient compliance with a recommended procedure, and other enrollee characteristics that may account for higher or lower than expected quality, costs, or utilization of services. The filing shall also indicate how the economic profiling or quality rating activities avoid being in conflict with subdivision (g) of Section 1367, which requires each plan to demonstrate that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. Nothing in this section shall be construed to restrict or impair the department, in its discretion, from utilizing the information filed pursuant to this section for purposes of ensuring compliance with this chapter.

(b) The director shall make each plan's filing available to the public upon request. The director shall not publicly disclose any information submitted pursuant to this section that is determined by the director to be confidential pursuant to state law.

(c) Each plan that uses economic profiling or quality rating shall, upon request, provide a copy of economic profiling or quality rating information related to an individual provider, contracting medical group, or individual practice association to the profiled or rated individual, group, or association. In addition, each plan shall require as a condition of contract that its medical groups and individual practice associations that maintain economic profiles

or quality ratings of individual providers shall, upon request, provide a copy of individual economic profiling or quality rating information to the individual providers who are profiled or rated. The economic profiling or quality rating information provided pursuant to this section shall be provided upon request until 60 days after the date upon which the contract between the plan and the individual provider, medical group, or individual practice association terminates, or until 60 days after the date the contract between the medical group or individual practice association and the individual provider terminates, whichever is applicable.

(d) For the purposes of this section, "economic profiling" shall mean any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.

(e) For the purposes of this section, "quality rating" shall mean any efforts by a health care service plan or by an entity contracted by a health care service plan to develop, evaluate, rate, or designate a particular physician, provider, medical group, or individual practice association based in whole or in part on quality measures and claims data.

SEC. 2. Section 10123.36 of the Insurance Code is amended to read:

10123.36. (a) *(1)* For purposes of public disclosure, every health insurer that authorizes insureds to select providers who have contracted with the insurer for alternative rates of payment as described in Section 10133, and the health insurer or any of its contracting providers or provider groups utilize economic profiling or quality rating related to services provided to insureds, shall ~~annually~~ file with the department a description of any policies and procedures related to economic profiling or quality rating utilized by the insurer and any of its contracting providers and provider groups. ~~The~~ *A health insurer shall file this description immediately upon adoption of the policies and procedures and within 30 days of adopting any changes to the policies and procedures. A health insurer that filed a description pursuant to this section prior to January 1, 2011, shall update that filing by March 31, 2011, in order to meet the requirements of this section and to reflect its current policies and procedures.*

(2) The filing shall describe how these policies and procedures are used in utilization review, peer review, incentive and penalty programs, ~~network modification, and patient steering,~~ and in provider retention and termination decisions*, as well as how they are used to designate or rate a particular physician, provider, medical group, or individual practice association within the insurer's existing network and to encourage patients to see only designated or rated physicians, providers, medical groups, or individual practice associations within the insurer's existing network. The filing shall include a description of the manner and methodology used to share results from economic profiling and quality rating with patients*. The filing shall also indicate in what manner the economic profiling or quality rating system being used takes into consideration risk adjustments that reflect case mix, accuracy and reliability of data relied upon, type and severity of patient illness, age of patients, patient compliance with a recommended procedure, and other policyholder characteristics that may account for higher or lower than expected quality, costs, or utilization of services. Nothing in this section shall be construed to restrict or impair the department, in its discretion, from utilizing the information filed pursuant to this section for purposes of ensuring compliance with this chapter.

(b) The commissioner shall make each health insurer filing available to the public upon request. The commissioner shall not publicly disclose any information submitted pursuant to this section that is determined by the commissioner to be confidential pursuant to state law.

(c) Each health insurer that uses economic profiling or quality rating shall, upon request, provide a copy of economic profiling or quality rating information related to a contracting provider or provider group to the profiled or rated provider or group. In addition, each health insurer shall require as a condition of contract that its contracting provider groups that maintain economic profiles or quality ratings of individual providers who may be selected by insureds shall, upon request, provide a copy of individual economic profiling or quality rating information to individual providers who are profiled. The economic profiling or quality rating information provided pursuant to this section shall be provided upon request until 60 days after the date upon which the contract between the insurer and the individual provider or provider group terminates,

or until 60 days after the date the contract between the provider group and the individual provider terminates, whichever is applicable.

(d) For the purposes of this section, "economic profiling" shall mean any evaluation of a particular physician, provider, or provider group based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, or provider group.

(e) For the purposes of this section, "quality rating" shall mean any efforts by a health insurer or by an entity contracted by a health insurer to develop, evaluate, rate, or designate a particular physician, provider, medical group, or individual practice association based in whole or in part on quality measures and claims data.

SEC. 3. 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.

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