AMENDED IN ASSEMBLY APRIL 28, 2010

AMENDED IN ASSEMBLY APRIL 20, 2010

AMENDED IN ASSEMBLY APRIL 5, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 2586

Introduced by Assembly Member Chesbro

February 19, 2010

An act to amend Sections 1367.26 and 1380 of, and to add Section 1373.68 to, the Health and Safety Code, and to add Sections 10133.35 and 10133.4 to, and to repeal Section 10133.1 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2586, as amended, Chesbro. Health care coverage: network modification: contracting providers.

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 and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a plan to obtain department approval prior to a material modification of its plan or operations and requires a plan to take specified actions prior to terminating a contract with a provider group or a general acute care hospital. Existing law imposes specified requirements with respect to the accessibility of services provided by both plans and insurers.

This bill would require a plan or an insurer that contracts with providers to obtain approval from its regulating department prior to implementing a network modification, as defined, and would require

the plan or insurer, in order to obtain approval, to demonstrate that the modified network would meet certain access requirements. The bill would require plans and insurers to notify affected providers and enrollees or insureds of the modification, as specified.

Existing law requires a health care service plan or a health insurer to include in its disclosure form and evidence of coverage a statement describing how participation in the plan or policy may affect the choice of provider, among other things. Existing law requires a health care service plan to, upon request, provide an enrollee or prospective enrollee with a list of certain contracting providers within his or her general geographic area.

This bill would require the list to include additional information regarding hospital-based physicians. ~~The bill would also require a plan to reimburse a contracting provider or provider group to which the plan delegates the responsibilities of complying with the provider listing requirements.~~

Existing law requires health insurers that contract with providers to provide group policyholders with a current roster of contracting providers and to make this list available for public inspection, as specified.

This bill would instead require those health insurers to provide a list of certain contracting providers to insureds and prospective insureds upon request and would require that the list be updated, as specified. The bill would also require these health insurers to make information available, upon request, concerning a contracting provider's degree, certifications, or subspecialty qualifications.

The bill would prohibit both plans and health insurers that contract with providers from including out-of-network or ~~noncontracted~~ *noncontracting* providers in their lists ~~and would make a plan or insurer who violates this prohibition subject to specified disciplinary and civil action~~. The bill would require those plans and insurers to provide a mechanism enabling enrollees, insureds, and providers to easily report provider directory errors to the plan or insurer and would require plans and insurers to correct confirmed errors within a specified period of time.

The bill would enact other related provisions.

Existing law requires the Department of Managed Health Care, as often as the director of the department deems necessary, but not less frequently than once every 3 years, to conduct an onsite medical survey of the health delivery system of each plan to ensure protection of

subscribers and enrollees, as specified. Existing law requires that the survey include a review of, among other things, the procedures for obtaining health services, the procedures for regulating utilization, and the internal procedures for assuring quality of care.

This bill would require the survey to also include a review of the plan's compliance with certain accessibility standards and with the contracting provider listing requirements described above.

Because a willful violation of the bill's requirements by a health care service plan would be a crime, the 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:

SECTION 1. Section 1367.26 of the Health and Safety Code is amended to read:

1367.26. (a) A health care service plan shall provide, upon request, a list of the following contracting providers, within the enrollee's or prospective enrollee's general geographic area:

(1) Primary care providers.

(2) Medical groups.

(3) Independent practice associations.

(4) Hospitals.

(5) Hospital-based physicians. The list shall also include the specialty of each of these physicians and the name of the hospital where the physician is contracted to provide services.

(6) All other available contracting physicians, listed by specialty or subspecialty, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, and nurse midwives to the extent their services may be accessed and are covered through the contract with the plan.

(b) The list shall indicate which *contracting* providers have notified the plan that they have closed practices or are otherwise not accepting new patients at that time.

(c) The list shall indicate that it may be subject to change without notice and shall provide a telephone number that enrollees can contact to obtain information regarding a particular provider. This information shall include whether or not that provider has indicated that he or she is accepting new patients.

(d) The list shall not include ~~contracted~~ *contracting* providers who are deceased, retired, or who are otherwise not actually practicing in the service area.

(e) The list shall not include out-of-network or ~~noncontracted providers. For each violation of this subdivision the department may assess additional fines and penalties up to, and including, suspension and revocation of the health care service plan's license. A provider shall be entitled to recover, in a civil action, damages arising from a health care service plan's violation of this subdivision and may exercise any other remedies available under law.~~ *noncontracting providers.*

(f) A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee or prospective enrollee, satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan's provider listings on its Internet Web site.

(g) A plan shall ensure that the list required under this section, including the information provided on the plan's Internet Web site pursuant to subdivision (f), is updated at least quarterly. With respect to written provider lists, a plan may satisfy this update requirement by providing an insert or addendum to the list. This update requirement shall not mandate a complete republishing of a plan's provider directory.

(h) Each plan shall make information available, upon request, concerning a contracting provider's professional degree, board certifications, and any recognized subspeciality qualifications a specialist may have.

(i) Nothing in this section shall prohibit a plan from requiring its contracting providers, contracting provider groups, or contracting specialized health care service plans to satisfy these requirements. If a plan delegates the responsibility of complying

with this section to its contracting providers, contracting provider groups, or contracting specialized health care service plans, the plan shall ensure that the requirements of this section are met ~~and shall reimburse the contracting provider or contracting provider group for any costs incurred to comply with this section.~~.

(j) A health care service plan shall allow enrollees to request the information required by this section through its toll-free telephone number or in writing.

(k) A health care service plan shall provide a mechanism enabling enrollees and providers to easily report provider directory errors to the plan, such as through the plan's Internet Web site or through its toll-free telephone number. All errors reported and subsequently confirmed by the plan shall be corrected within 30 days.

(*l*) Information requested of health care service plans by the department to ascertain compliance with this section shall be provided in a uniform format approved by the department.

SEC. 2. Section 1373.68 is added to the Health and Safety Code, to read:

1373.68. (a) A health care service plan shall obtain approval from the department prior to implementing a network modification, as defined in subdivision (e). In order to obtain approval from the department, a health care service plan shall demonstrate to the department that the modified network would meet the network adequacy, geographic access, and timely access standards set forth in this chapter and in Title 28 of the California Code of Regulations.

(b) At least 45 days prior to seeking approval of a network modification pursuant to subdivision (a), a plan shall notify affected health care providers of the plan's intent to undertake a network modification.

(c) After a network modification has been approved by the department pursuant to subdivision (a), a plan shall, at least 60 days prior to implementing the modification, notify affected enrollees in writing of the modification. The notice shall include the statement identified in subdivision (f) of Section 1373.65 in no less than 8-point type and shall be provided in a manner consistent with Section 1373.65, if applicable.

(d) The department may request from a health care service plan any information it deems necessary to review a proposed network

modification under subdivision (a) and to ascertain whether a plan has complied with this section. This information shall be in a uniform format approved by the department.

(e) For purposes of this section, "network modification" means a change to a network of contracted health care providers where the change would affect more than 2,000 enrollees by reducing the number of contracted physicians in a service area, or by terminating, renegotiating, or otherwise impacting a provider contract in the network.

(f) This section shall not apply to a health care service plan that exclusively contracts with a single medical group in a specific geographic area to provide or arrange for professional medical services for the enrollees of the plan.

SEC. 3. Section 1380 of the Health and Safety Code is amended to read:

1380. (a) The department shall conduct periodically an onsite medical survey of the health delivery system of each plan. The survey shall include a review of the procedures for obtaining health services, the procedures for regulating utilization, peer review mechanisms, internal procedures for ensuring quality of care, and the overall performance of the plan in providing health care benefits and meeting the health needs of the subscribers and enrollees. In order to ensure enrollee access to health care services, the survey shall also include, but not be limited to, a review of the plan's compliance with Section 1367.26, with Item H of Section 1300.51 of Title 28 of the California Code of Regulations, and with Sections 1300.67.2 and 1300.67.2.1 of Title 28 of the California Code of Regulations.

(b) The survey shall be conducted by a panel of qualified health professionals experienced in evaluating the delivery of prepaid health care. The department shall be authorized to contract with professional organizations or outside personnel to conduct medical surveys and these contracts shall be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. These organizations or personnel shall have demonstrated the ability to objectively evaluate the delivery of health care by plans or health maintenance organizations.

(c) Surveys performed pursuant to this section shall be conducted as often as deemed necessary by the director to ensure

the protection of subscribers and enrollees, but not less frequently than once every three years. Nothing in this section shall be construed to require the survey team to visit each clinic, hospital office, or facility of the plan. To avoid duplication, the director shall employ, but is not bound by, the following:

(1) For hospital-based health care service plans, to the extent necessary to satisfy the requirements of this section, the findings of inspections conducted pursuant to Section 1279.

(2) For health care service plans contracting with the State Department of Health Care Services pursuant to the Waxman-Duffy Prepaid Health Plan Act, the findings of reviews conducted pursuant to Section 14456 of the Welfare and Institutions Code.

(3) To the extent feasible, reviews of providers conducted by professional standards review organizations, and surveys and audits conducted by other governmental entities.

(d) Nothing in this section shall be construed to require the medical survey team to review peer review proceedings and records conducted and compiled under Section 1370 or medical records. However, the director shall be authorized to require onsite review of these peer review proceedings and records or medical records where necessary to determine that quality health care is being delivered to subscribers and enrollees. Where medical record review is authorized, the survey team shall ensure that the confidentiality of physician-patient relationship is safeguarded in accordance with existing law and neither the survey team nor the director or the director's staff may be compelled to disclose this information except in accordance with the physician-patient relationship. The director shall ensure that the confidentiality of the peer review proceedings and records is maintained. The disclosure of the peer review proceedings and records to the director or the medical survey team shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to Sections 1370 and 1370.1.

(e) The procedures and standards utilized by the survey team shall be made available to the plans prior to the conducting of medical surveys.

(f) During the survey the members of the survey team shall examine the complaint files kept by the plan pursuant to Section 1368. The survey report issued pursuant to subdivision (h) shall include a discussion of the plan's record for handling complaints.

(g) During the survey the members of the survey team shall offer such advice and assistance to the plan as deemed appropriate.

(h) (1) Survey results shall be publicly reported by the director as quickly as possible but no later than 180 days following the completion of the survey unless the director determines, in his or her discretion, that additional time is reasonably necessary to fully and fairly report the survey results. The director shall provide the plan with an overview of survey findings and notify the plan of deficiencies found by the survey team at least 90 days prior to the release of the public report.

(2) Reports on all surveys, deficiencies, and correction plans shall be open to public inspection, except that no surveys, deficiencies, or correction plans shall be made public unless the plan has had an opportunity to review the report and file a response within 45 days of the date that the department provided the report to the plan. After reviewing the plan's response, the director shall issue a final report that excludes any survey information and legal findings and conclusions determined by the director to be in error, describes compliance efforts, identifies deficiencies that have been corrected by the plan by the time of the director's receipt of the plan's 45-day response, and describes remedial actions for deficiencies requiring longer periods to the remedy required by the director or proposed by the plan.

(3) The final report shall not include a description of "acceptable" or of "compliance" for any uncorrected deficiency.

(4) Upon making the final report available to the public, a single copy of a summary of the final report's findings shall be made available free of charge by the department to members of the public, upon request. Additional copies of the summary may be provided at the department's cost. The summary shall include a discussion of compliance efforts, corrected deficiencies, and proposed remedial actions.

(5) If requested by the plan, the director shall append the plan's response to the final report issued pursuant to paragraph (2), and shall append to the summary issued pursuant to paragraph (4) a brief statement provided by the plan summarizing its response to the report. The plan may modify its response or statement at any time and provide modified copies to the department for public distribution no later than 10 days from the date of notification from the department that the final report will be made available to the

public. The plan may file an addendum to its response or statement at any time after the final report has been made available to the public. The addendum to the response or statement shall also be made available to the public.

(6) Any information determined by the director to be confidential pursuant to statutes relating to the disclosure of records, including the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), shall not be made public.

(i) (1) The director shall give the plan a reasonable time to correct deficiencies. Failure on the part of the plan to comply to the director's satisfaction shall constitute cause for disciplinary action against the plan.

(2) No later than 18 months following release of the final report required by subdivision (h), the department shall conduct a followup review to determine and report on the status of the plan's efforts to correct deficiencies. The department's followup report shall identify any deficiencies reported pursuant to subdivision (h) that have not been corrected to the satisfaction of the director.

(3) If requested by the plan, the director shall append the plan's response to the followup report issued pursuant to paragraph (2). The plan may modify its response at any time and provide modified copies to the department for public distribution no later than 10 days from the date of notification from the department that the followup report will be made available to the public. The plan may file an addendum to its response at any time after the followup report has been made available to the public. The addendum to the response or statement shall also be made available to the public.

(j) The director shall provide to the plan and to the executive officer of the Dental Board of California a copy of information relating to the quality of care of any licensed dental provider contained in any report described in subdivisions (h) and (i) that, in the judgment of the director, indicates clearly excessive treatment, incompetent treatment, grossly negligent treatment, repeated negligent acts, or unnecessary treatment. Any confidential information provided by the director shall not be made public pursuant to this subdivision. Notwithstanding any other provision of law, the disclosure of this information to the plan and to the executive officer shall not operate as a waiver of confidentiality. There shall be no liability on the part of, and no cause of action of

any nature shall arise against, the State of California, the Department of Managed Health Care, the Director of the Department of Managed Health Care, the Dental Board of California, or any officer, agent, employee, consultant, or contractor of the state or the department or the board for the release of any false or unauthorized information pursuant to this section, unless the release of that information is made with knowledge and malice.

(k) Nothing in this section shall be construed as affecting the director's authority pursuant to Article 7 (commencing with Section 1386) or Article 8 (commencing with Section 1390) of this chapter.

SEC. 4. Section 10133.1 of the Insurance Code is repealed.

SEC. 5. Section 10133.35 is added to the Insurance Code, to read:

10133.35. (a) For purposes of this section, "health insurer" means a health insurer that contracts with providers for alternate rates pursuant to Section 10133.

(b) A health insurer shall provide to an insured or prospective insured, upon request, a list of the following contracting providers, within the insured's or prospective insured's general geographic area:

(1) Primary care providers.

(2) Medical groups.

(3) Independent practice associations.

(4) Hospitals.

(5) Hospital-based physicians. The list shall also include the specialty of each of these physicians and the name of the hospital where the physician is contracted to provide services.

(6) All other available contracting physicians, listed by specialty or subspecialty, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, and nurse midwives to the extent their services may be accessed and are covered through the policy with the insurer.

(c) The list shall indicate which *contracting* providers have notified the insurer that they have closed practices or are otherwise not accepting new patients at that time.

(d) The list shall indicate that it may be subject to change without notice and shall provide a telephone number that insureds can contact to obtain information regarding a particular provider.

This information shall include whether or not that provider has indicated that he or she is accepting new patients.

(e) The list shall not include ~~contracted~~ *contracting* providers who are deceased, retired, or who are otherwise not actually practicing in the service area.

(f) The list shall not include out-of-network or ~~noncontracted~~ *noncontracting* providers. ~~For each violation of this subdivision the department may assess additional fines and penalties up to, and including, suspension and revocation of the health insurer's certificate of authority. A provider shall be entitled to recover, in a civil action, damages arising from a health insurer's violation of this subdivision and may exercise any other remedies available under the law.~~

(g) A health insurer shall provide this information in written form to its insureds or prospective insureds upon request. An insurer may, with the permission of the insured or prospective insured, satisfy the requirements of this section by directing the insured or prospective insured to the insurer's provider listings on its Internet Web site.

(h) A health insurer shall ensure that the list required under this section, including the information provided on its Internet Web site pursuant to subdivision (g), is updated at least quarterly. With respect to written provider lists, an insurer may satisfy this update requirement by providing an insert or addendum to the list. This update requirement shall not mandate a complete republishing of an insurer's provider directory.

(i) Each health insurer shall make information available, upon request, concerning a contracting provider's professional degree, board certifications, and any recognized subspeciality qualifications a specialist may have.

(j) Nothing in this section shall prohibit an insurer from requiring its contracting providers, contracting provider groups, or contracting specialized health insurers to satisfy these requirements. If an insurer delegates the responsibility of complying with this section to its contracting providers, contracting provider groups, or contracting specialized health insurers, the insurer shall ensure that the requirements of this section are met ~~and shall reimburse the contracting provider or contracting provider group for any costs incurred to comply with this section.~~.

(k) A health insurer shall allow insureds to request the information required by this section through its toll-free telephone number or in writing.

(*l*) A health insurer shall provide a mechanism enabling insureds and providers to easily report provider directory errors to the insurer, such as through the insurer's Internet Web site or through its toll-free telephone number. All errors reported and subsequently confirmed by the insurer shall be corrected within 30 days.

(m) Information requested of health insurers by the department to ascertain compliance with this section shall be provided in a uniform format approved by the department.

SEC. 6. Section 10133.4 is added to the Insurance Code, to read:

10133.4. (a) A health insurer that contracts with providers for alternate rates pursuant to Section 10133 shall obtain approval from the department prior to implementing a network modification, as defined in subdivision (e). In order to obtain approval from the department, a health insurer shall demonstrate to the department that the modified network would meet the network access standards set forth in Article 6 (commencing with Section 2240) of Subchapter 2 of Chapter 5 of Title 10 of the California Code of Regulations.

(b) At least 45 days prior to seeking approval of a network modification pursuant to subdivision (a), an insurer shall notify affected health care providers of its intent to undertake a network modification.

(c) After a network modification has been approved by the department pursuant to subdivision (a), an insurer shall, at least 60 days prior to implementing the modification, notify affected insureds of the modification in writing. The notice shall include the following statement in at least 8-point type:

"If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact your insurer's customer service department."

(d) The department may request from a health insurer any information it deems necessary to review a proposed network modification under subdivision (a) and to ascertain whether an

insurer has complied with this section. This information shall be in a uniform format approved by the department.

(e) For purposes of this section, "network modification" means a change to a network of contracted health care providers where the change would affect more than 2,000 insureds by reducing the number of contracted physicians in a service area, or by terminating, renegotiating, or otherwise impacting a provider contract in the network.

SEC. 7. 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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