AMENDED IN ASSEMBLY JUNE 18, 2009

AMENDED IN SENATE APRIL 14, 2009

SENATE BILL No. 196

Introduced by Senator Corbett

February 23, 2009

~~An act to add Section 1367.49 to the Health and Safety Code, and to add Section 10117.6 to the Insurance Code, relating to health care coverage.~~ *An act to amend Sections 1255.1 and 1255.2 of the Health and Safety Code, relating to emergency medical services.*

LEGISLATIVE COUNSEL'S DIGEST

SB 196, as amended, Corbett. ~~Health care coverage: provider contracts.~~ *Emergency medical services.*

Under existing law, the State Department of Public Health administers provisions governing the licensure and regulation of health facilities, including hospitals. A violation of these provisions is a crime. Existing law requires any hospital that provides emergency medical services to provide notice of any intended elimination or reduction of emergency services as soon as possible, but not later than 90 days prior to a planned elimination or reduction in services to the department, the local government agency in charge of health services, and specified entities under contract with the hospital to provide the services. In addition, existing law requires a health facility that implements a downgrade or closure to make reasonable efforts to ensure that the community served by the facility is informed.

This bill would, instead, require the notice to be provided 180 days prior to the planned reduction or elimination of the level of emergency medical services, and would require the notice to also be provided to all employees of the hospital. It would also require that the hospital

provide public notice of, and hold a minimum of 3 public meetings on, the intended change in a manner that is likely to reach a significant number of residents of the community served by the facility.

The bill would also require that any health facility implementing a downgrade or change hold a minimum of 3 public meetings to inform and ensure that the community served by its facility is informed of the downgrade or closure.

Because the bill creates a new 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.

~~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 provides for the regulation of health insurers by the Department of Insurance.~~

~~This bill would prohibit a contract between a health care provider and a health care service plan or a health insurer from containing a provision that restricts the ability of the plan or insurer to furnish information on the cost of procedures, as specified, or information on health care quality to subscribers, enrollees, policyholders, or insureds. If the health care quality information is quality of care data compiled by the plan or insurer, the bill would require plans and insurers to involve health care providers in the development of the information and to provide affected health care providers an opportunity to review the information prior to furnishing it to subscribers, enrollees, policyholders, or insureds, as specified, and would also require that information to be based on specified guidelines and to be updated at appropriate intervals. The bill would also prohibit a health care service plan or health care provider from disclosing negotiated capitation rates or other prepaid arrangements to enrollees or subscribers.~~

~~Because a willful violation of the bill's provisions relating to health care service plans would be 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:

SECTION 1. Section 1255.1 of the Health and Safety Code is amended to read:

1255.1. (a) Any hospital that provides emergency medical services under Section 1255 shall, as soon as possible, but not later than ~~90~~ *180* days prior to a planned reduction or elimination of the level of emergency medical services, provide notice of the intended change to the ~~state~~ department, the local government entity in charge of the provision of health services, *all employees of the hospital,* and all health care service plans or other entities under contract with the hospital to provide services to enrollees of the plan or other entity.

(b) In addition to the notice required by subdivision (a), the hospital shall, within the time limits specified in subdivision (a), provide public notice of *and hold public meetings in accordance with Section 1255.2 on* the intended change in a manner that is likely to reach a significant number of residents of the community serviced by that facility.

(c) A hospital shall not be subject to this section or Section 1255.2 if the state department does either of the following:

(1) Determines that the use of resources to keep the emergency center open substantially threatens the stability of the hospital as a whole.

(2) Cites the emergency center for unsafe staffing practices.

SEC. 2. Section 1255.2 of the Health and Safety Code is amended to read:

1255.2. A health facility implementing a downgrade or change shall ~~make reasonable efforts to~~ *hold a minimum of three public meetings to inform and* ensure that the community served by its facility is informed of the downgrade or closure. ~~Reasonable~~ *In addition to public meetings, the facility implementing a downgrade*

or change shall make reasonable efforts *that* may include, but not be limited to, advertising the change in terms likely to be understood by a layperson, soliciting media coverage regarding the change, informing patients of the facility of the impending change, and notifying contracting health care service plans as required in Section 1255.1.

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.

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

~~1367.49. (a) A contract between a health care service plan and a health care provider that is issued, amended, renewed, or delivered on or after January 1, 2010, shall not contain any provision that restricts the ability of the health care service plan to furnish information on the cost of procedures or information about health care quality to subscribers or enrollees of the plan.~~

~~(b) If the health care quality information that the health care service plan proposes to disclose pursuant to subdivision (a) is quality of care data that the health care service plan has compiled, all of the following requirements shall be satisfied:~~

~~(1) The information shall be based on nationally recognized evidence-based 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. A plan shall utilize risk adjustment factors, with appropriate and transparent statistical techniques, to account for differences in the use of health care resources among individual health care providers.~~

~~(2) The information shall be updated at appropriate intervals.~~

~~(3) The health care service plan shall, prior to furnishing the information to its enrollees or subscribers, do both of the following:~~

~~(A) Involve health care providers in the development of the information.~~

~~(B) Provide all of the following to any affected health care provider:~~

~~(i) At least 45 days written notice to review the information.~~

~~(ii) The criteria used in the development and evaluation of quality measurements. The criteria shall be sufficiently detailed and reasonably understandable to allow the provider to verify the data against his or her records.~~

~~(iii) An explanation to the provider that he or she has the right to correct errors and seek review of the data and that he or she may submit any additional information for consideration. The health care service plan shall provide a reasonable, prompt, and transparent appeal process. If a provider makes a timely appeal, the plan shall make no changes to its current information about the provider until the appeal is completed.~~

~~(c) A health care service plan or health care provider shall not disclose negotiated capitation rates or other prepaid arrangements to subscribers or enrollees of the plan.~~

~~(d) Nothing in this section shall apply to specialized health care service plans covering dental benefits.~~

~~(e) Any contractual provision inconsistent with this section shall be void and unenforceable.~~

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

~~(1) "Information on the cost of procedures" means information that an enrollee or subscriber of a health care service plan may use to make comparisons among individual health care providers or health care facilities concerning the cost to the enrollee or subscriber of health care treatment options. Information on the cost of procedures shall be displayed as an episode of care, unless an episode of care is not applicable, and shall include, but not be limited to, applicable diagnostic tests, prescription drugs, hospital days, and physician fees that are associated with a typical procedure or illness.~~

~~(2) "Health care provider" means any professional person, medical group, independent practice association, organization, health facility, other than a long-term health care facility as defined in Section 1418, or other person or institution licensed or authorized by the state to deliver or furnish health care services.~~

~~SEC. 2. Section 10117.6 is added to the Insurance Code, to read:~~

~~10117.6. (a) A contract between a health insurer and a health care provider that is issued, amended, renewed, or delivered on or after January 1, 2010, shall not contain any provision that restricts the ability of the health insurer to furnish information on the cost of procedures or information about health care quality to policyholders or insureds of the insurer.~~

~~(b) If the health care quality information that the health insurer proposes to disclose pursuant to subdivision (a) is quality of care data that the health insurer has compiled, all of the following requirements shall be satisfied:~~

~~(1) The information shall be based on nationally recognized evidence-based 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. An insurer shall utilize risk adjustment factors, with appropriate and transparent statistical techniques, to account for differences in the use of health care resources among individual health care providers.~~

~~(2) The information shall be updated at appropriate intervals.~~

~~(3) The health insurer shall, prior to furnishing the information to its policyholders or insureds, do both of the following:~~

~~(A) Involve health care providers in the development of the information.~~

~~(B) Provide all of the following to any affected health care provider:~~

~~(i) At least 45 days written notice to review the information.~~

~~(ii) The criteria used in the development and evaluation of quality measurements. The criteria shall be sufficiently detailed and reasonably understandable to allow the provider to verify the data against his or her records.~~

~~(iii) An explanation to the provider that he or she has the right to correct errors and seek review of the data and that he or she may submit any additional information for consideration. The health insurer shall provide a reasonable, prompt, and transparent appeal process. If a provider makes a timely appeal, the insurer shall make no changes to its current information about the provider until the appeal is completed.~~

~~(c) Nothing in this section shall apply to dental insurers.~~

~~(d) Any contractual provision inconsistent with this section shall be void and unenforceable.~~

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

~~(1) "Information on the cost of procedures" means information that a policyholder or insured of a health insurer may use to make comparisons among individual health care providers or health care facilities concerning the cost to the policyholder or insured of health care treatment options. Information on the cost of procedures shall be displayed as an episode of care, unless an episode of care is not applicable, and shall include, but not be limited to, applicable diagnostic tests, prescription drugs, hospital days, and physician fees that are associated with a typical procedure or illness.~~

~~(2) "Health care provider" means any professional person, medical group, independent practice association, organization, health facility, other than a long-term health care facility as defined in Section 1418 of the Health and Safety Code, or other person or institution licensed or authorized by the state to deliver or furnish health care services.~~

~~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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