ASSEMBLY BILL No. 2152

Introduced by Assembly Member Eng

February 23, 2012

An act to amend Sections 10123.12, 10601, and 10604 of, and to add Section 10133.57 to, the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 2152, as introduced, Eng. Disability insurance.

Existing law provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health insurer may contract with providers for alternative rates of payment. Existing law requires those insurers to file a policy with the department describing how the insurer facilitates the continuity of care for new insureds under group policies receiving services for an acute condition from a noncontracting provider. Existing law also requires those health insurers to, at the request of an insured, arrange for the completion of covered services by a terminated provider if the insured is undergoing treatment for certain conditions, as specified.

This bill would require a health insurer to submit a transition plan to the department at least 75 days prior to terminating a contract with a provider to provide services at alternative rates of payment and would require the insurer to send a written notice within a specified time period to all insureds who have obtained services from that provider within the last six months, as specified.

Existing law requires disability insurance policies to include a disclosure form that contains specified information, including the principal benefits and coverage of the policy, the exceptions, reductions, and limitations that apply to the policy, and a statement, with respect

to health insurance policies, describing how participation in the policy may affect the choice of physician, hospital, or health care providers, and describing the extent of financial liability that may be incurred if care is furnished by a nonparticipating provider.

With respect to health insurance policies, this bill would require the disclosure form to include additional information, including conditions and procedures for disenrollment, a description of the limitations on the insured's choice of provider, and a statement describing the basic method of reimbursement made to its participating providers, as specified. The bill would also require the front page of the disclosure form for health insurance policies to include specified information. The bill would require a health insurer, medical group, independent practice association, or participating provider that uses or receives financial bonuses or other incentives to provide a written summary of specified information to any requesting person.

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

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

SECTION 1. Section 10123.12 of the Insurance Code is amended to read:

10123.12. *(a)* Every health insurer, including those insurers that contract for alternative rates of payment pursuant to Section 10133, and every self-insured employee welfare benefit plan that will affect the choice of physician, hospital, or other health care providers shall include within its disclosure form and within its evidence or certificate of coverage a statement clearly describing how participation in the policy or plan may affect the choice of physician, hospital, or other health care providers, and describing the nature and extent of the financial liability that is, or that may be, incurred by the insured, enrollee, or covered dependents if care is furnished by a provider that does not have a contract with the insurer or plan to provide service at alternative rates of payment pursuant to Section 10133. The form shall clearly inform prospective insureds or plan enrollees that participation in the policy or plan will affect the person's choice in this regard by placing the following statement in a conspicuous place on all material required to be given to prospective insureds or plan

enrollees including promotional and descriptive material, disclosure forms, and certificates and evidences of coverage:

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

It is not the intent of this section to require that the names of individual health care providers be enumerated to prospective insureds or enrollees.

If a health insurer providing coverage for hospital, medical, or surgical expenses provides a list of *providers or* facilities to patients or contracting providers, the insurer shall include within the ~~provider~~ listing a notification that insureds or enrollees may contact the insurer in order to obtain a list of the facilities with which the health insurer is contracting for subacute care and/or transitional inpatient care.

(b) Every health insurer, including those insurers that contract for alternative rates of payment pursuant to Section 10133, shall include within its disclosure form a statement clearly describing the basic method of reimbursement, including the scope and general methods of payment, made to its contracting providers of health care services, and whether financial bonuses or any other incentives are used. The disclosure form shall indicate that if an insured wishes to know more about these issues, the insured may request additional information from the insurer, the insured's provider, or the provider's medical group or independent practice association regarding the information required pursuant to subdivision (c).

(c) If a health insurer, medical group, independent practice association, or participating health care provider uses or receives financial bonuses or any other incentives, the insurer, medical group, independent practice association, or health care provider shall provide a written summary to any person who requests it that includes both of the following:

(1) A general description of the bonus and any other incentive arrangements used in its compensation agreements. Nothing in this paragraph shall be construed to require disclosure of trade secrets or commercial or financial information that is privileged

or confidential, such as payment rates, as determined by the commissioner, pursuant to state law.

(2) A description regarding whether, and in what manner, the bonuses and any other incentives are related to a provider's use of referral services.

(d) The statements and written information provided pursuant to subdivisions (b) and (c) shall be communicated in clear and simple language that enables consumers to evaluate and compare health insurance policies.

SEC. 2. Section 10133.57 is added to the Insurance Code, to read:

10133.57. (a) At least 75 days prior to the termination date of its contract with a professional or institutional provider to provide services at alternative rates of payment pursuant to Section 10133, a health insurer shall submit a transition plan to the department that includes the written notice the insurer proposes to send to affected insureds if the termination of the contract results in a material change to the insurer's provider network, as defined by the department by regulation. The insurer shall not send this notice to insureds until the department has reviewed and approved its content. If the department does not respond within seven days of the date of its receipt of the filing, the notice shall be deemed approved.

(b) At least 60 days prior to the termination date of a contract between a professional or institutional provider to provide services at alternative rates of payment pursuant to Section 10133, the health insurer shall send the written notice described in subdivision (a) by United States mail to all insureds who have obtained services from the professional or institutional provider within the preceding six months if the termination of the contract results in a material change to the insurer's provider network, as defined by the department by regulation. A health insurer that is unable to comply with the timeframe because of exigent circumstances shall apply to the department for a waiver. The health insurer is excused from complying with this requirement only if its waiver application is granted by the department or the department does not respond within seven days of the date of its receipt of the waiver application. If the terminated provider is a hospital, the health insurer shall send the written notice to all insureds who reside within a 15-mile radius of the terminated hospital.

(c) The health insurer shall send the written notice regarding termination of a provider contract with a hospital required by subdivision (b) only if the terminated provider is a general acute care hospital.

(d) If an individual provider terminates his or her contract or employment with a provider group that contracts with a health insurer, the insurer may require that the provider group send the notice required by subdivision (b).

(e) If, after sending the notice required by subdivision (b), a health insurer reaches an agreement with a terminated provider to renew or enter into a new contract or to not terminate their contract, the insurer shall offer each affected insured the option to return to that provider.

(f) A health insurer and a provider shall include in all written, printed, or electronic communications sent to an insured that concern the contract termination or transition plan, the following statement in not less than 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, and if you have further questions, you are encouraged to contact the Department of Insurance, which protects insurance consumers, by telephone at its toll-free number, 800-927-HELP (4357), or at a TDD number for the hearing impaired at 800-482-4833, or online at www.insurance.ca.gov."

(g) For purposes of this section, "provider group" means a medical group, independent practice association, or any other similar organization.

(h) The commissioner may adopt regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) that are necessary to implement the provisions of this section.

SEC. 3. Section 10601 of the Insurance Code is amended to read:

10601. As used in this chapter:

(a) "Benefits and coverage" means the accident, sickness or disability indemnity available under a policy of disability insurance.

(b) "Exception" means any provision in a policy whereby coverage for a specified hazard or condition is entirely eliminated.

(c) "Reduction" means any provision in a policy which reduces the amount of a policy benefit to some amount or period less than would be otherwise payable for medically authorized expenses or services had such a reduction not been used.

(d) "Limitation" means any provision other than an exception or a reduction which restricts coverage under the policy.

(e) "Presenting for examination or sale" means either (1) publication and dissemination of any brochure, mailer, advertisement, or form which constitutes a presentation of the provisions of the policy and which provides a policy enrollment or application form, or (2) consultations or discussions between prospective beneficiaries or their contract agents and employees or agents of disability insurers, when such consultations or discussions include presentation of formal, organized information about the policy which is intended to influence or inform the prospective insured or beneficiary, such as brochures, summaries, charts, slides, or other modes of information in lieu of or in addition to the policy itself.

(f) "Disability insurance" means every policy of disability insurance, self-insured employee welfare benefit plan, and nonprofit hospital service plan issued, delivered, or entered into pursuant to or described in Chapter 1 (commencing with Section 10110), Chapter 4 (commencing with Section 10270), or Chapter 11A (commencing with Section 11491) of this part.

(g) "Insurer" means every insurer transacting disability insurance, every self-insured employee welfare plan, and every nonprofit hospital service plan specified in subdivision (e).

(h) "Disclosure form" means the standard supplemental disclosure form required pursuant to Section 10603.

(i) "Small group health insurance policy" means a group health insurance policy issued to a small employer, as defined in Section 10700.

SEC. 4. Section 10604 of the Insurance Code is amended to read:

10604. The disclosure form shall include *at least* the following information, in concise and specific terms, relative to the disability insurance policy, *together with additional information as the commissioner may require in connection with the policy*:

(a) The applicable category or categories of coverage provided by the policy, from among the following:

(1) Basic hospital expense coverage.
(2) Basic medical-surgical expense coverage.
(3) Hospital confinement indemnity coverage.
(4) Major medical expense coverage.
(5) Disability income protection coverage.
(6) Accident only coverage.
(7) Specified disease or specified accident coverage.
(8) Such other categories as the commissioner may prescribe.

(b) The principal benefits and coverage of the disability insurance policy, *including coverage for acute care and subacute care if the policy is a health insurance policy, as defined in Section 106*.

(c) The exceptions, reductions, and limitations that apply to ~~such~~ *the* policy.

(d) A summary, including a citation of the relevant contractual provisions, of the process used to authorize, *modify, delay,* or deny payments for services under the coverage provided by the policy including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. This subdivision shall only apply to *health insurance* policies ~~of disability insurance that cover hospital, medical, or surgical expenses~~, *as defined in Section 106*.

(e) The full premium cost of ~~such~~ *the* policy.

(f) Any copayment, coinsurance, or deductible requirements that may be incurred by the insured or his family in obtaining coverage under the policy.

(g) The terms under which the policy may be renewed by the insured, including any reservation by the insurer of any right to change premiums.

(h) A statement that the disclosure form is a summary only, and that the policy itself should be consulted to determine governing contractual provisions.

(i) For a health insurance policy, as defined in Section 106, all of the following:

(1) A notice on the first page of the disclosure form that conforms with all of the following conditions:

(A) (i) States that the form discloses the terms and conditions of coverage.

(ii) States, with respect to individual health insurance policies, small group health insurance policies, and any group health

insurance policies for which health care services are not negotiated, that the applicant has a right to view the disclosure form and policy prior to beginning coverage under the policy, and, if the policy does not accompany the disclosure form, the notice shall specify where the policy can be obtained prior to beginning coverage.

(B) Includes a statement that the disclosure and the policy should be read completely and carefully and that individuals with special health care needs should read carefully those sections that apply to them.

(C) Includes the insurer's telephone number or numbers that may be used by an applicant to receive additional information about the benefits of the policy, or states where those telephone number or numbers are located in the disclosure form.

(D) For individual health insurance policies, and small group health insurance policies, states where a health policy benefits and coverage matrix is located.

(E) Is printed in type no smaller than that used for the remainder of the disclosure form and is displayed prominently on the page.

(2) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an insured who is hospitalized or undergoing treatment for an ongoing condition.

(3) To the extent that the policy or insurer permits a free choice of provider to its insureds, the statement shall disclose, consistent with Section 10123.12, the nature and extent of choice permitted and the financial liability that is, or may be, incurred by the insured, covered dependents, or a third party by reason of the exercise of that choice.

(4) For group health insurance policies, including small group health insurance policies, a summary of the terms and conditions under which insureds may remain in the policy in the event the group ceases to exist, the group policy is terminated, or an individual insured leaves the group, or the insureds' eligibility status changes.

(5) If the policy utilizes arbitration to settle disputes, a statement of that fact. If the policy requires binding arbitration, a disclosure pursuant to Section 10123.19.

(6) A description of any limitations on the insured's choice of primary care physician, specialty care physician, or nonphysician

health care practitioner, based on service area and limitations on the insured's choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

(7) General authorization requirements for referral by a primary care physician to a specialty care physician or a nonphysician health care practitioner.

(8) Conditions and procedures for disenrollment.

(9) A description as to how an insured may request continuity of care as required by Sections 10133.55 and 10133.56, and request a second opinion pursuant to Section 10123.68.

(10) Information concerning the right of an insured to request an independent review in accordance with Article 3.5 (commencing with Section 10169) of Chapter 1.

(11) A notice as required by Section 791.04.

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