AMENDED IN SENATE AUGUST 24, 2012

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AMENDED IN ASSEMBLY APRIL 17, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 2152

Introduced by Assembly Member Eng
(Principal coauthor: Assembly Member Huffman)

February 23, 2012

An act to amend, repeal, and add Section 1373.65 of, and to add Section 1373.66 to, the Health and Safety Code, and to amend Sections ~~10123.12,10192.17~~ *10123.12, 10192.17*, and 10601 of, to amend, repeal, and add ~~Section10604~~ *Section 10604* of, and to add Section 10133.57 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2152, as amended, Eng. Health care coverage.

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 requires a health care service plan to submit a block transfer filing to the department at least 75 days prior to the termination of its contract with a provider group or a general acute care hospital and to provide 60 days' notice of the contract's termination to enrollees assigned to the terminated provider. Existing law specifies that a health care service plan is not required to send this

notice to enrollees of a preferred provider organization unless the terminated provider is a general acute care hospital.

This bill would, commencing July 1, 2013, make these provisions inapplicable with respect to a contract between a plan and a provider that provides benefits to enrollees and subscribers through a preferred provider arrangement. The bill would instead require the plan under those contracts to notify the department at least 30 days prior to terminating a contract with a provider group or general acute care hospital~~, and where~~ *where the termination would affect 800 or more covered lives who have obtained services from the provider group or hospital within the preceding 6 months. Where* the termination would affect 2,000 or more covered lives who have obtained services from the provider group or hospital within the preceding 6 months, *the bill* would require the plan to send a written notice at least 10 days prior to the termination date to all of those covered lives, as specified.

Because a willful violation of these requirements would be a crime, the bill would impose a state-mandated local program.

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, commencing July 1, 2013, require a health insurer to notify the department at least 30 days prior to terminating a contract with a provider group or general acute care hospital to provide services at alternative rates of payment *if the termination would affect 800 or more covered lives who have obtained services from the provider group or hospital within the preceding 6 months*. Where that termination would affect 2,000 or more covered lives who have obtained services from the provider group or hospital within the preceding 6 months, the bill would, commencing July 1, 2013, require the insurer to send a written notice to all of those covered lives at least 10 days prior to the termination date, 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 cancellation, rescission, or nonrenewal, a description of the limitations on the insured's choice of provider, and, with respect to insurers that contract for alternate rates of payment, a statement describing the basic method of reimbursement made to its participating providers, as specified. The bill would also require the first page of the disclosure form for health insurance policies to include other specified information. The bill would require a health insurer, medical group, or participating provider that uses or receives financial bonuses or other incentives to provide a written summary of specified information to any requesting person. The bill would make these provisions operative on July 1, 2013.

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 1373.65 of the Health and Safety Code is amended to read:

1373.65. (a) At least 75 days prior to the termination date of its contract with a provider group or a general acute care hospital, the health care service plan shall submit an enrollee block transfer filing to the department that includes the written notice the plan proposes to send to affected enrollees. The plan may not send this notice to enrollees 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 health care service plan and a provider group or a general acute care hospital, the plan shall send the written notice described in subdivision (a) by United States mail to enrollees who are assigned to the terminated provider group or hospital. A plan that is unable to comply with the timeframe because of exigent circumstances shall apply to the department for a waiver. The plan 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 and the plan assigns enrollees to a provider group with exclusive admitting privileges to the hospital, the plan shall send the written notice to each enrollee who is a member of the provider group and who resides within a 15-mile radius of the terminated hospital. If the plan operates as a preferred provider organization or assigns members to a provider group with admitting privileges to hospitals in the same geographic area as the terminated hospital, the plan shall send the written notice to all enrollees who reside within a 15-mile radius of the terminated hospital.

(c) The health care service plan shall send enrollees of a preferred provider organization the written notice 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 care service plan, the plan 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 care service plan reaches an agreement with a terminated provider to renew or enter into a new contract or to not terminate their contract, the plan shall offer each affected enrollee the option to return to that provider. If an affected enrollee does not exercise this option, the plan shall reassign the enrollee to another provider.

(f) A health care service plan and a provider shall include in all written, printed, or electronic communications sent to an enrollee that concern the contract termination or block transfer, 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 HMO's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov."

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

(h) This section shall become inoperative on July 1, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that is enacted on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 1373.65 is added to the Health and Safety Code, to read:

1373.65. (a) At least 75 days prior to the termination date of its contract with a provider group or a general acute care hospital, the health care service plan shall submit an enrollee block transfer filing to the department that includes the written notice the plan proposes to send to affected enrollees. The plan may not send this notice to enrollees 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 health care service plan and a provider group or a general acute care hospital, the plan shall send the written notice described in subdivision (a) by United States mail to enrollees who are assigned to the terminated provider group or hospital. A plan that is unable to comply with the timeframe because of exigent circumstances shall apply to the department for a waiver. The plan 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 and the plan assigns enrollees to a provider group with exclusive admitting privileges to the hospital, the plan shall send the written notice to each enrollee who is a member of the provider group and who resides within a 15-mile radius of the terminated hospital. If the plan assigns members to a provider group with admitting privileges

to hospitals in the same geographic area as the terminated hospital, the plan shall send the written notice to all enrollees who reside within a 15-mile radius of the terminated hospital.

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

(d) If, after sending the notice required by subdivision (b), a health care service plan reaches an agreement with a terminated provider to renew or enter into a new contract or to not terminate their contract, the plan shall offer each affected enrollee the option to return to that provider. If an affected enrollee does not exercise this option, the plan shall reassign the enrollee to another provider.

(e) A health care service plan and a provider shall include in all written, printed, or electronic communications sent to an enrollee that concern the contract termination or block transfer 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 HMO's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov."

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

(g) This section shall not apply with respect to a contract between a plan and a provider that provides benefits to enrollees and subscribers through a preferred provider arrangement.

(h) This section shall become operative on July 1, 2013.

SEC. 3. Section 1373.66 is added to the Health and Safety Code, to read:

1373.66. (a) This section shall apply only with respect to a contract between a health care service plan and a provider that provides benefits to enrollees and subscribers through a preferred provider arrangement.

(b) At least 30 days prior to the termination date of a contract between a health care service plan and a provider group or a general

acute care hospital, the health care service plan shall submit a written notice notifying the department of the termination *if the termination would affect 800 or more covered lives who have obtained services from the provider group or general acute care hospital within the preceding six months* and shall include with that notice the written notice the plan proposes to send to affected enrollees pursuant to subdivision (c)~~, if applicable~~.

(c) Where the termination of a contract between a health care service plan and a provider group or a general acute care hospital would affect 2,000 or more covered lives who have obtained services from the provider group or general acute care hospital within the preceding six months, unless the department establishes a higher threshold by regulation, the health care service plan shall send the written notice described in subdivision (b) by United States mail to all of those affected covered lives at least 10 days prior to the contract termination date. A health care service plan that is unable to comply with the timeframe because of exigent circumstances shall apply to the department for a waiver. The health care service plan 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.

(d) If an individual provider terminates his or her contract or employment with a provider group that contracts with a health care service plan and that termination would affect 2,000 or more covered lives who have obtained services from the provider within the preceding six months, unless the department establishes a higher threshold by regulation, the plan may require that the provider group send the notice required by subdivision (c).

(e) If, after sending the notice required by subdivision (c), a health care service plan reaches an agreement with a terminated provider group or general acute care hospital to renew or enter into a new contract or to not terminate their contract, the plan shall send a written notice notifying the affected covered lives that the provider group or hospital remains in their plan network.

(f) A health care service plan or a provider group shall include in the written notice sent pursuant to subdivision (c) or (d) the following information in not less than 12-point type:

(1) The name of the terminated provider group or general acute care hospital, or in the case of a notice sent pursuant to subdivision (d), the name of the terminated individual provider.

(2) The date of the pending contract termination.

(3) A brief explanation of the termination of the contract between the plan and the terminated provider group or general acute care hospital, or, in the case of a notice sent pursuant to subdivision (d), a brief explanation of the termination of the contract between the individual provider and the provider group.

(4) A description explaining how to access a list of contracted providers in the enrollee's plan network.

(5) A statement that the enrollee may contact the plan's customer service department to request completion of care for an ongoing course of treatment from a terminated provider and a telephone number for further explanation.

(6) A statement informing the enrollee that he or she may be required to pay a larger portion of costs if the enrollee continues to use the terminated provider.

(7) The following statement:

"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 plan's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov."

(g) For purposes of this section, "provider group" means a group of 20 or more physicians and surgeons who are employees, partners, or shareholders of the group and who practice substantially full time as part of the group.

(h) The director 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. The director shall coordinate with the Department of Insurance in the implementation and enforcement of this section and Section 10133.57 of the Insurance Code.

(i) This section shall become operative on July 1, 2013.

SEC. 4. Section 10192.17 of the Insurance Code is amended to read:

10192.17. (a) Medicare supplement policies and certificates shall include a renewal, continuation, or conversion provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(b) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after the date of issue or upon reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(c) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

(d) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, those limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(e) (1) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate, and of the outline of coverage, or attached thereto, in no less than 10-point uppercase type, stating in substance that the policyholder or certificate holder shall have the right to return the

policy or certificate, via regular mail, within 30 days of receiving it, and to have the full premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason. The return shall void the contract from the beginning, and the parties shall be in the same position as if no contract had been issued.

(2) For purposes of this section, a timely manner shall be no later than 30 days after the issuer receives the returned contract.

(3) If the issuer fails to refund all prepaid or periodic charges paid in a timely manner, then the applicant shall receive interest on the paid charges at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure. The interest shall be paid from the date the issuer received the returned contract.

(f) (1) Issuers of health insurance policies, certificates, or contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services and in a type size no smaller than 12-point type. Delivery of the guide shall be made whether or not the policies or certificates are advertised, solicited, or issued for delivery as Medicare supplement policies or certificates as defined in this article. Except in the case of direct response issuers, delivery of the guide shall be made to the applicant at the time of application, and acknowledgment of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request, but not later than at the time the policy is delivered.

(2) For the purposes of this section, “form” means the language, format, type size, type proportional spacing, bold character, and line spacing.

(g) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement policies or certificates in a format acceptable to the commissioner. The notice shall include both of the following:

(1) A description of revisions to the Medicare Program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate.

(2) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(h) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(i) The notices shall not contain or be accompanied by any solicitation.

(j) (1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(2) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All Medicare supplement plans authorized by federal law shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(3) The commissioner may adopt regulations to implement this article, including, but not limited to, regulations that specify the required information to be contained in the outline of coverage

provided to applicants pursuant to this section, including the format of tables, charts, and other information.

(k) (1) Any disability insurance policy or certificate, a basic, catastrophic or major medical expense policy, or single premium nonrenewal policy or certificate issued to persons eligible for Medicare, other than a Medicare supplement policy, a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.), a disability income policy, or any other policy identified in subdivision (b) of Section 10192.3, advertised, solicited, or issued for delivery in this state to persons eligible for Medicare, shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the disability insurance policies or certificates described in paragraph (1) shall disclose the extent to which the policy duplicates Medicare in a manner required by the commissioner. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

(*l*) (1) Insurers issuing Medicare supplement policies or certificates for delivery in California shall provide an outline of coverage to all applicants at the time of presentation for examination or sale as provided in Section 10605, and in no case later than at the time the application is made. Except for direct response policies, insurers shall obtain a written acknowledgment of receipt of the outline from the applicant.

Any advertisement that is not a presentation for examination or sale as defined in paragraph (5) of subdivision (a) of Section 10601 shall contain a notice in no less than 10-point uppercase type that an outline of coverage is available upon request. The insurer or agent that receives any request for an outline of coverage shall

provide an outline of coverage to the person making the request within 14 days of receipt of the request.

(2) If an outline of coverage is provided at or before the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage shall be in the language and format prescribed in this subdivision in no less than 12-point type, and shall include the following items in the order prescribed below. Titles, as set forth below in paragraphs (B) to (H), inclusive, shall be capitalized, centered, and printed in boldface type.

(A) (i) The following shall only apply to policies sold for effective dates prior to June 1, 2010:

(I) The outline of coverage shall include the items, and in the same order, specified in the chart set forth in Section 17 of the Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners in 2004.

(II) The cover page shall contain the 14-plan (A-L) charts. The plans offered by the insurer shall be clearly identified. Innovative benefits shall be explained in a manner approved by the commissioner. The text shall read:

"Medicare supplement insurance can be sold in only 12 standard plans. This chart shows the benefits included in each plan. Every insurance company must offer Plan A. Some plans may not be available.

The BASIC BENEFITS included in ALL plans are:

Hospitalization: Medicare Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical expenses: Medicare Part B coinsurance (usually 20 percent of the Medicare-approved amount).

Blood: First three pints of blood each year.

Mammogram: One annual screening to the extent not covered by Medicare.

Cervical cancer test: One annual screening."

[Reference to the mammogram and cervical cancer screening test shall not be included so long as California is required to disallow them for Medicare beneficiaries by the Centers for Medicare and Medicaid Services or other agent of the federal government under 42 U.S.C. Sec. 1395ss.]

(ii) The following shall only apply to policies sold for effective dates on or after June 1, 2010:

(I) The outline of coverage shall include the items, and in the same order specified in the chart set forth in Section 17 of the Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners in 2008.

(II) The cover page shall contain all Medicare supplement benefit plan charts A to D, inclusive, F, high deductible F, G, and K to N, inclusive. The plans offered by the insurer shall be clearly identified. Innovative benefits shall be explained in a manner approved by the commissioner. The text shall read:

"Medicare supplement insurance can be sold in only standard plans. This chart shows the benefits included in each plan. Every insurance company must offer Plan A. Some plans may not be available. Plans E, H, I and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

The BASIC BENEFITS included in ALL plans are:

Hospitalization: Medicare Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical expenses: Medicare Part B coinsurance (usually 20 percent of the Medicare-approved amount) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

Mammogram: One annual screening to the extent not covered by Medicare.

Cervical cancer test: One annual screening."

[Reference to the mammogram and cervical cancer screening test shall not be included so long as California is required to disallow them for Medicare beneficiaries by the Centers for Medicare and Medicaid Services or other agent of the federal government under 42 U.S.C. Sec. 1395ss.]

(B) PREMIUM INFORMATION. Premium information for plans that are offered by the insurer shall be shown on, or immediately following, the cover page and shall be clearly and prominently displayed. The premium and mode shall be stated for all offered plans. All possible premiums for the prospective applicant shall be illustrated in writing. If the premium is based on the increasing age of the insured, information specifying when and how premiums will change shall be clearly illustrated in writing. The text shall state: "We [the insurer's name] can only raise your premium if we raise the premium for all policies like yours in California."

(C) The text shall state: "Use this outline to compare benefits and premiums among policies."

(D) READ YOUR POLICY VERY CAREFULLY. The text shall state: "This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company."

(E) THIRTY-DAY RIGHT TO RETURN THIS POLICY. The text shall state: "If you find that you are not satisfied with your policy, you may return it to [insert the insurer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it has never been issued and return all of your payments."

(F) POLICY REPLACEMENT. The text shall read: "If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it."

(G) DISCLOSURES. The text shall read: "This policy may not fully cover all of your medical costs." "Neither this company nor any of its agents are connected with Medicare." "This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult 'The Medicare Handbook' for more details." "For additional information concerning policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, 1-800-434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California."

For policies effective on dates on or after June 1, 2010, the following language shall be required until June 1, 2011, "This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale."

(H) [For policies that are not guaranteed issue] COMPLETE ANSWERS ARE IMPORTANT. The text shall read: "When you fill out the application for a new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may have the right to cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded."

(I) One chart for each benefit plan offered by the insurer showing the services, Medicare payments, payments under the policy and payments expected from the insured, using the same uniform format and language. No more than four plans may be shown on one page. Include an explanation of any innovative benefits in a manner approved by the commissioner.

(m) An issuer shall comply with all notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Public Law 108-173).

SEC. 5. 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 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 that contracts 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 regarding the information required pursuant to subdivision (c).

(c) If a health insurer, medical group, or participating health care provider uses or receives financial bonuses or any other incentives, the insurer, medical group, 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.

(e) Subdivisions (b), (c), and (d) shall become operative on July 1, 2013.

SEC. 6. Section 10133.57 is added to the Insurance Code, to read:

10133.57. (a) At least 30 days prior to the termination date of a contract between a health insurer and a provider group or a general acute care hospital to provide services at alternative rates of payment pursuant to Section 10133, the health insurer shall submit a written notice notifying the department of the termination *if the termination would affect 800 or more covered lives who have obtained services from the provider group or general acute care hospital within the preceding six months* and shall include with that notice the written notice the insurer proposes to send to affected insureds pursuant to subdivision (b)~~, if applicable~~.

(b) Where the termination of a contract between a health insurer and a provider group or a general acute care hospital to provide services at alternative rates of payment pursuant to Section 10133 would affect 2,000 or more covered lives who have obtained services from the provider group or general acute care hospital within the preceding six months, unless the department establishes a higher threshold by regulation, the health insurer shall send the written notice described in subdivision (a) by United States mail to all of those affected covered lives at least 10 days prior to the contract termination date. 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.

(c) If an individual provider terminates his or her contract or employment with a provider group that contracts with a health insurer and that termination would affect 2,000 or more covered lives who have obtained services from the provider within the preceding six months, unless the department establishes a higher threshold by regulation, the insurer may require that the provider group send the notice required by subdivision (b).

(d) If, after sending the notice required by subdivision (b), a health insurer reaches an agreement with a terminated provider group or general acute care hospital to renew or enter into a new contract or to not terminate their contract, the insurer shall send a written notice notifying the affected covered lives that the provider group or hospital remains in their provider network.

(e) A health insurer or a provider group shall include in the written notice sent pursuant to subdivision (b) or (c) the following information in not less than 12-point type:

(1) The name of the terminated provider group or general acute care hospital, or in the case of a notice sent pursuant to subdivision (c), the name of the terminated individual provider.

(2) The date of the pending contract termination.

(3) A brief explanation of the termination of the contract between the insurer and the terminated provider group or general acute care hospital, or, in the case of a notice sent pursuant to subdivision (c), a brief explanation of the termination of the contract between the individual provider and the provider group.

(4) A description explaining how to access a list of contracted providers in the insured's provider network.

(5) A statement that the insured may contact the insurer's customer service department to request completion of care for an ongoing course of treatment from a terminated provider and a telephone number for further explanation.

(6) A statement informing the insured that he or she may be required to pay a larger portion of costs if the insured continues to use the terminated provider.

(7) The following statement:

"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."

(f) For purposes of this section, "provider group" means a group of 20 or more physicians and surgeons who are employees, partners, or shareholders of the group and who practice substantially full time as part of the group.

(g) 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. The commissioner shall coordinate with the Department of Managed Health Care in the implementation and enforcement of this section and Section 1373.66 of the Health and Safety Code.

(h) This section shall become operative on July 1, 2013.

SEC. 7. Section 10601 of the Insurance Code is amended to read:

10601. (a) As used in this chapter:

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

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

(3) "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.

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

(5) "Presenting for examination or sale" means either (A) 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 (B) 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.

(6) "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.

(7) "Insurer" means every insurer transacting disability insurance, every self-insured employee welfare plan, and every nonprofit hospital service plan specified in paragraph (6).

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

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

(b) Paragraph (9) of subdivision (a) shall become operative on July 1, 2013.

SEC. 8. Section 10604 of the Insurance Code is amended to read:

10604. (a) The disclosure form shall include the following information, in concise and specific terms, relative to the disability insurance policy:

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

(A) Basic hospital expense coverage.

(B) Basic medical-surgical expense coverage.

(C) Hospital confinement indemnity coverage.

(D) Major medical expense coverage.

(E) Disability income protection coverage.

(F) Accident only coverage.

(G) Specified disease or specified accident coverage.

(H) Such other categories as the commissioner may prescribe.

(2) The principal benefits and coverage of the disability insurance policy.

(3) The exceptions, reductions, and limitations that apply to such policy.

(4) A summary, including a citation of the relevant contractual provisions, of the process used to authorize 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 paragraph shall only

apply to policies of disability insurance that cover hospital, medical, or surgical expenses.

(5) The full premium cost of such policy.

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

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

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

(b) This section shall become inoperative on July 1, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that is enacted on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 9. Section 10604 is added to the Insurance Code, to read:

10604. (a) 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:

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

(A) Basic hospital expense coverage.

(B) Basic medical-surgical expense coverage.

(C) Hospital confinement indemnity coverage.

(D) Major medical expense coverage.

(E) Disability income protection coverage.

(F) Accident only coverage.

(G) Specified disease or specified accident coverage.

(H) Such other categories as the commissioner may prescribe.

(2) 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.

(3) The exceptions, reductions, and limitations that apply to the policy.

(4) 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 paragraph shall only apply to health insurance policies, as defined in Section 106.

(5) The full premium cost of the policy.

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

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

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

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

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

(i) (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, 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.

(ii) 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.

(iii) 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

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

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

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

(C) 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.

(D) 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.

(E) 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.

(F) 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.

(G) Conditions and procedures for cancellation, rescission, or nonrenewal.

(H) 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.

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

(J) A notice as required by Section 791.04.

(b) This section shall become operative on July 1, 2013.

SEC. 10. 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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