

AMENDED IN ASSEMBLY JULY 5, 2001

AMENDED IN SENATE MAY 2, 2001

AMENDED IN SENATE APRIL 4, 2001

AMENDED IN SENATE MARCH 19, 2001

SENATE BILL

No. 103

Introduced by Senator Speier

(Coauthor: Senator Kuehl)

(Coauthors: Assembly Members Chan, Pavley, and Richman)

January 22, 2001

An act to amend Section 1373.96 of the Health and Safety Code, and to amend Section 10133.56 of the Insurance Code, relating to health coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 103, as amended, Speier. Health 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 the willful violation of any of its provisions a crime. Existing law also provides for the regulation of disability insurers by the Department of Insurance.

Existing law requires a health care service plan and a disability insurer to provide at the request of the enrollee or insured continuity of care coverage by a terminated provider for up to 90 days or for a longer period if necessary for a safe transfer of care to another provider if the enrollee or insured is being treated for an acute or serious chronic condition or a pregnancy. Under existing law, a plan and insurer are excused from this requirement if the terminated provider does not agree

to continue to be subject to the terms and conditions of the contract or does not accept specified rate provisions.

This bill would instead require a health care service plan and a disability insurer to provide continuity of care from a terminated provider to an enrollee or insured for any condition, *including a pregnancy*, and would extend that period of coverage for a specified period of time. The bill would delete the conditions described under existing law that excuse the plan or insurer from providing continuity of care coverage and would, instead, require a contract between a provider and a plan or insurer to ~~specify~~ *provide* reimbursement rates payable in those circumstances, *as specified*.

Because this bill would impose additional requirements on health care service plans, the willful violation of which would constitute a criminal offense, it would expand the scope of an existing crime, thereby creating 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:

1 SECTION 1. Section 1373.96 of the Health and Safety Code
 2 is amended to read:
 3 1373.96. (a) Every health care service plan shall ensure the
 4 continuation of covered services to an enrollee by a terminated
 5 provider. *In the case of an evergreen contract, every health care*
 6 *service plan shall ensure the continuation of covered services to an*
 7 *enrollee when a provider has notified the plan of its intention to*
 8 *terminate a contract.*
 9 (b) The plan shall furnish the enrollee with health care services
 10 on a timely and appropriate basis from the terminated provider
 11 until the ~~commencement date of the enrollee's next open~~
 12 ~~enrollment period~~ *effective date of new plan coverage selected by*
 13 *the enrollee during his or her next open enrollment.* The plan is not
 14 required to furnish these services for more than 180 days after the



1 termination date of its contract with the provider. If the ~~enrollee's~~
2 ~~next open enrollment period~~ *effective date of new plan coverage*
3 *selected by the enrollee during his or her next open enrollment*
4 does not commence within this 180-day period, the enrollee shall
5 be allowed to enroll in any health care service plan that was
6 available to the enrollee at the time of his or her prior open
7 enrollment period. Notwithstanding the provisions of this
8 subdivision, a plan shall be required to furnish the enrollee with
9 health care services from a terminated provider for a period longer
10 than 180 days if necessary for a safe transfer to another provider
11 as determined by the plan in consultation with the terminated
12 provider, consistent with good professional practice. *In the case*
13 *of a pregnancy, the plan shall furnish the enrollee with health care*
14 *services on a timely and appropriate basis from the terminated*
15 *provider until postpartum services related to the delivery are*
16 *completed or for a longer period if necessary for a safe transfer to*
17 *another provider as determined by the plan in consultation with the*
18 *terminated provider, consistent with good professional practice.*

19 (c) A contract between a plan and a provider shall describe the
20 provider's obligation under this section to provide continuity of
21 care upon the contract's termination. The contract between a plan
22 and a provider shall also include the terms and conditions
23 including the rate and method of payment to the provider for
24 services provided pursuant to this section after the contract's
25 termination.

26 (1) *For contracts in effect prior to December 31, 2001, the*
27 *payment to the provider for services provided pursuant to this*
28 *section after the contract's termination shall increase by 10*
29 *percent. For multiyear contracts, the 10-percent payment increase*
30 *shall be multiplied by the number of years since the last payment*
31 *increase.*

32 (2) *For contracts agreed to after January 1, 2002, the payment*
33 *for services provided pursuant to this section after the contract's*
34 *termination date shall increase by at least the current all health*
35 *care inflation rate for California, or, if not available, for the west*
36 *region, or by an amount mutually agreed upon by both parties. The*
37 *department shall provide the designated current all health care*
38 *inflation rate.*



1 (d) The Department of Managed Health Care shall review all
2 communication from a plan or a terminated provider to an enrollee
3 that concerns the continuity of care by the terminated provider.

4 (e) A description as to how an enrollee may request continuity
5 of care pursuant to this section shall be provided in any plan
6 evidence of coverage and disclosure form issued after July 1, 1999.
7 A plan shall provide a written copy of this information to its
8 contracting providers and provider groups. A plan shall also
9 provide a copy to its enrollees upon request.

10 (f) The payment of copayments, deductibles, or other cost
11 sharing components by the enrollee during the period of
12 continuation of care with a terminated provider shall be the same
13 copayments, deductibles, or other cost sharing components that
14 would be paid by the enrollee when receiving care from a provider
15 currently contracting with or employed by the plan.

16 (g) If a plan delegates the responsibility of complying with this
17 section to its contracting providers or contracting provider groups,
18 the plan shall ensure that the requirements of this section are met.

19 (h) For the purposes of this section:

20 (1) “Provider” means a person who is a licentiate, as defined
21 in Section 805 of the Business and Professions Code ~~or~~, a person
22 licensed under Chapter 2 (commencing with Section 1000) of
23 Division 2 of the Business and Professions Code, *or a provider*
24 *group*.

25 (2) “Terminated provider” means a provider whose contract to
26 provide services to plan enrollees is terminated or not renewed by
27 the plan or one of the plan’s contracting provider groups. A
28 terminated provider is not a provider who voluntarily leaves the
29 plan or contracting provider group.

30 (3) “Provider group” includes a medical group, independent
31 practice association, *health system*, or any other similar group of
32 providers.

33 (4) “*Evergreen contract*” means a contract for services
34 between a provider and a health care service plan that
35 automatically renews on its own terms unless otherwise terminated
36 by either party pursuant to the terms of the contract.

37 (i) This section shall not require a plan or provider group to
38 provide for continuity of care by a provider whose contract with
39 the plan or group has been terminated or not renewed for reasons
40 relating to a medical disciplinary cause or reason, as defined in



1 paragraph (6) of subdivision (a) of Section 805 of the Business and
2 Professions Code, or fraud or other criminal activity.

3 (j) This section shall not require a plan to cover services or
4 provide benefits that are not otherwise covered under the terms and
5 conditions of the plan contract.

6 (k) The provisions contained in this section are in addition to
7 any other responsibilities of health care service plans to provide
8 continuity of care pursuant to this chapter. Nothing in this section
9 shall preclude a plan from providing continuity of care beyond the
10 requirements of this section.

11 SEC. 2. Section 10133.56 of the Insurance Code is amended
12 to read:

13 10133.56. (a) Disability insurers who provide hospital,
14 medical, or surgical coverage and that negotiate and enter into
15 contracts with professional or institutional providers to provide
16 services at alternative rates of payment pursuant to Section 10133,
17 shall ensure the continuation of covered services rendered to an
18 insured by a terminated provider. *In the case of an evergreen*
19 *contract, every disability insurer shall ensure the continuation of*
20 *covered services to an insured when a provider has notified the*
21 *disability insurer of its intention to terminate a contract.*

22 (b) The insurer shall provide for continuity of care for the
23 insured by a terminated provider until the ~~commencement date of~~
24 ~~the insured's next open enrollment period~~ *effective date of new*
25 *policy coverage selected by the insured during his or her next open*
26 *enrollment.* The insurer is not required to provide these services for
27 more than 180 days after the termination date of its contract with
28 the provider. If the ~~insured's next open enrollment period~~ *effective*
29 *date of new policy coverage selected by the insured during his or*
30 *her next open enrollment* does not commence within this 180-day
31 period, the insured shall not be excluded as a late enrollee from any
32 health benefit plan that was available to the insured at the time of
33 his or her prior open enrollment period. Notwithstanding the
34 provisions of this subdivision, an insurer shall be required to
35 provide the insured with health care services from a terminated
36 provider for a period longer than 180 days if necessary to ensure
37 a safe transfer to another provider, as determined by the insurer, in
38 consultation with the terminated provider, consistent with good
39 professional practice. *In the case of a pregnancy, the disability*
40 *insurer shall furnish the insured with health care services on a*



1 *timely and appropriate basis from the terminated provider until*
2 *postpartum services related to the delivery are completed or for a*
3 *longer period if necessary for a safe transfer to another provider*
4 *as determined by the plan in consultation with the terminated*
5 *provider, consistent with good professional practice. After the*
6 *required period of continuity of care has expired pursuant to this*
7 *section, coverage shall be provided pursuant to the general terms*
8 *and conditions of the insured's policy.*

9 (c) A contract between an insurer and a provider shall describe
10 the provider's obligation under this section to provide continuity
11 of care upon the contract's termination. The contract between an
12 insurer and a provider shall also include the terms and conditions
13 including the rate and method of payment to the provider for
14 services provided pursuant to this section after the contract's
15 termination. The provider shall accept the reimbursement as
16 payment in full, and shall not bill the insured for any amount in
17 excess of the reimbursement rate, with the exception of
18 copayments and deductibles pursuant to subdivision (f).

19 (1) *For contracts in effect prior to December 31, 2001, the*
20 *payment to the provider for services provided pursuant to this*
21 *section after the contract's termination shall increase by 10*
22 *percent. For multiyear contracts, the 10-percent payment increase*
23 *shall be multiplied by the number of years since the last payment*
24 *increase.*

25 (2) *For contracts agreed to after January 1, 2002, the payment*
26 *for services provided pursuant to this section after the contract's*
27 *termination date shall increase by at least the current all health*
28 *care inflation rate for California, or, if not available, for the west*
29 *region, or by an amount mutually agreed upon by both parties. The*
30 *department shall provide the designated current all health care*
31 *inflation rate.*

32 (d) The Department of Insurance shall review all
33 communication from an insurer or terminated provider to an
34 insured that concerns the continuity of care by the terminated
35 provider.

36 (e) Notice as to how an insured may request continuity of care
37 pursuant to this section shall be provided in any insurer evidence
38 of coverage and disclosure form issued after July 1, 1999. An
39 insurer shall provide a written copy of this information to its



1 contracting providers and provider groups. An insurer shall also
2 provide a copy to its insureds upon request.

3 (f) The payment of copayments, deductibles, or other cost
4 sharing components by the insured during the period of
5 continuation of care with a terminated provider shall be the same
6 copayments, deductibles, or other cost sharing components that
7 would be paid by the insured when receiving care from a provider
8 currently contracting with the insurer.

9 (g) If an insurer delegates the responsibility of complying with
10 this section to its contracting entities, the insurer shall ensure that
11 the requirements of this section are met.

12 (h) For the purposes of this section:

13 (1) “Provider” means a person who is a licentiate as defined
14 in Section 805 of the Business and Professions Code ~~or~~, a person
15 licensed under Chapter 2 (commencing with Section 1000) of
16 Division 2 of the Business and Professions Code, *or a provider*
17 *group*.

18 (2) “Terminated provider” means a provider whose contract to
19 provide services to insureds is terminated or not renewed by the
20 insurer or one of the insurer’s contracting provider groups. A
21 terminated provider is not a provider who voluntarily leaves the
22 insurer or contracting provider group.

23 (3) “Provider group” includes a medical group, independent
24 practice association, *health system*, or any other similar group of
25 providers.

26 (4) “*Evergreen contract*” means a contract for services
27 between a disability insurer and a provider that automatically
28 renews on its own terms unless otherwise terminated by either
29 party pursuant to the terms of the contract.

30 (i) This section shall not require an insurer or provider group
31 to provide for continuity of care by a provider whose contract with
32 the insurer or group has been terminated or not renewed for
33 reasons relating to medical disciplinary cause or reason, as defined
34 in paragraph (6) of subdivision (a) of Section 805 of the Business
35 and Professions Code, or fraud or other criminal activity.

36 (j) This section shall not require an insurer to cover services or
37 provide benefits that are not otherwise covered under the terms and
38 conditions of the insurer contract.

39 (k) The provisions contained in this section are in addition to
40 any other responsibilities of insurers to provide continuity of care



1 pursuant to this chapter. Nothing in this section shall preclude an
2 insurer from providing continuity of care beyond the requirements
3 of this section.

4 SEC. 3. No reimbursement is required by this act pursuant to
5 Section 6 of Article XIII B of the California Constitution because
6 the only costs that may be incurred by a local agency or school
7 district will be incurred because this act creates a new crime or
8 infraction, eliminates a crime or infraction, or changes the penalty
9 for a crime or infraction, within the meaning of Section 17556 of
10 the Government Code, or changes the definition of a crime within
11 the meaning of Section 6 of Article XIII B of the California
12 Constitution.

13 _____
14 CORRECTIONS
15 Text — Pages 3, 4 and 6.
16 _____
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