AMENDED IN SENATE JULY 15, 2003

AMENDED IN SENATE JUNE 30, 2003

CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

ASSEMBLY BILL No. 1286

Introduced by Assembly Member Frommer
(Coauthors: Assembly Members Pavley and Wiggins)

February 21, 2003

An act to ~~add Sections 733 and 17500.6 to the Business and Professions Code, to~~ amend Sections 1373.65, 1373.95, 1373.96, 1392, and 1393 of, and to add Sections 1324, 1373.66, and 1373.67 to, the Health and Safety Code, and to amend Sections 10133.55 and 10133.56 of, and to add Sections 10133.57, 10133.58, and 10133.59 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1286, as amended, Frommer. Continuity of care.

(1) Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and the licensure and regulation of health insurers by the Department of Insurance. A violation of the provisions governing health care service plans is a crime.

Existing law imposes various continuity of care requirements on health care service plans and health insurers. Under these provisions, a plan is required to provide 30 days' notice to enrollees prior to termination of a contract with a medical group or individual practice association.

This bill would instead require 60 days' notice prior to termination of that contract and would extend the application of those and other related requirements to health insurers. The bill would extend the application of other continuity of care requirements to cover additional enrollees and insureds under various health conditions and circumstances. The bill would require additional disclosure to enrollees and insureds, and would require the regulating departments to develop standard notice forms in that regard. The bill would *also* enact other related changes. Because a willful violation of these and other provisions applicable to health care service plans would be a crime, the bill would impose a state-mandated local program.

(2) ~~Existing law provides for licensing and regulation of various healing arts practitioners under the Business and Professions Code or the Chiropractic or Osteopathic Initiative Acts.~~

~~This bill would require healing arts practitioners to continue to provide health care services to patients who are enrollees and insureds entitled to continuity of care coverage under provisions applicable to health care service plans and health insurers. A violation of this requirement would subject the healing arts practitioner to an administrative fine not to exceed $2,500 to be imposed by his or her regulating board or other entity.~~

~~(3) Existing law provides that it is unlawful for a person to engage in certain acts of unfair competition.~~

~~The bill would make it unlawful under these provisions for health care service plans, providers, provider organizations, or their employees to refuse to provide health care services to patients entitled to continuity of care, or to make or disseminate untrue or misleading information about a contractual relationship between a health care service plan or health insurer and a provider or provider organization. A violation of these provisions would subject these persons or entities to a civil penalty not to exceed $2,500.~~

~~(4)~~ Existing law provides for the licensing and regulation of general acute care hospitals and acute psychiatric hospitals by the State Department of Health Services.

This bill would require those hospitals to continue to provide health care services to patients entitled to continuity of care.

~~(5)~~

(3) 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.

~~(6)~~

(4) This bill would make the operation of its provisions contingent upon the enactment of SB 244.

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 733 is added to the Business and Professions Code, to read:~~

~~733. (a) A person licensed or certified under this division or the Osteopathic Initiative Act or the Chiropractic Initiative Act shall continue to provide health care services to enrollees and insureds entitled to continuity of care coverage pursuant to Section 1373.66 of the Health and Safety Code and 10133.57 of the Insurance Code.~~

~~(b) A person who violates this section may be cited and be assessed an administrative fine not exceeding two thousand five hundred dollars ($2,500).~~

~~(c) The proceedings for citation and administrative fine pursuant to subdivision (b) shall be conducted by the board that issued the license or certification in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. Each board shall have all the powers granted in that chapter.~~

~~(d) Section 2314 or any other provision providing for criminal penalties shall not apply to this section.~~

~~SEC. 2. Section 17500.6 is added to the Business and Professions Code, to read:~~

~~17500.6. (a) It is unlawful for a health care service plan, provider, or provider organization, or any employee thereof, to refuse to provide health care services as required by Section 1373.66 of the Health and Safety Code and Section 10133.57 of the Insurance Code, or to refuse to comply with the notification provisions of Section 1373.65 of the Health and Safety Code or Section 10133.59 of the Insurance Code.~~

~~(b) It is unlawful for a plan, provider, or provider organization, or any employee thereof, to make or disseminate or cause to be made or disseminated before the public in this state, or to make or disseminate or cause to be made or disseminated from this state before the public in any state, in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means, including over the Internet, any statement related to the contractual relationship between a plan or a health insurer, and a provider or provider organization, that is untrue or misleading, and that is known, or that by the exercise of reasonable care should be known to be untrue or misleading.~~

~~(c) A violation of this section is punishable by a civil penalty not exceeding two thousand five hundred dollars ($2,500). Section 17534 shall not apply to this section.~~

~~(d) The following definitions apply for purposes of this section:~~

~~(1) "Health insurer" has the same meaning as defined in Section 106 of the Insurance Code.~~

~~(2) "Hospital" means a general acute care hospital or an acute psychiatric hospital.~~

~~(3) "Provider" means any professional person, organization, health facility or other person or institution licensed by the state to deliver or furnish health care services.~~

~~(4) "Provider organization" means a provider group, hospital, hospital system that includes two or more hospitals, or health system that includes two or more acute care hospitals and a provider group.~~

~~(5) "Provider group" means a medical group, individual practice association, or any other similar group of providers.~~

~~(e) The remedies of this section are in addition to any other remedies available under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).~~

~~SEC. 3.~~

SECTION 1. Section 1324 is added to the Health and Safety Code, to read:

1324. A general acute care hospital and an acute psychiatric hospital licensed pursuant to this chapter shall continue to provide health care services to enrollees and insureds entitled to continuity

of care coverage pursuant to Section 1373.66 and Section 10133.57 of the Insurance Code.

~~SEC. 4.~~

SEC. 2. Section 1373.65 of the Health and Safety Code is amended to read:

1373.65. (a) (1) Except as provided in subdivision (b), 60 days prior to a plan terminating, for any reason, a contract between the plan and a provider organization, specialist, or primary care provider, the plan shall provide written notice of the termination to enrollees who are at that time receiving a course of treatment from an affected provider or specialist or from a provider of that provider organization, or who are designated as having selected that provider organization, specialist, or primary care provider for their care. The notice shall include instructions on selecting a new primary care provider.

(2) If a plan, without advance notice to a provider organization, specialist, or primary care provider, terminates the provider organization, specialist, or primary care provider for endangering the health and safety of patients, committing criminal or fraudulent acts, or engaging in grossly unprofessional conduct, the notice requirement of paragraph (1) is not applicable. Instead, the plan within 30 days of having terminated the provider organization, specialist, or primary care provider shall provide written notice of the termination to the enrollees who have selected that provider organization, specialist, or primary care provider.

(3) The plan shall submit the written notice required by this section to the department at least 10 business days prior to the date on which the plan intends to send the notice to enrollees. The plan may not disseminate this notice until the department has reviewed and approved it.

(4) Upon approval by the department, the written notice required by this section shall be jointly signed by the plan and the affected provider organization, specialist, or primary care provider. If the plan and the affected provider organization, specialist, or primary care provider are unable to agree on a jointly signed notification statement, the parties shall use the department's notice statement template.

(5) The jointly signed notification statement shall be disseminated by the plan to affected enrollees.

(b) For enrollees under a contract that provides benefits through a preferred provider contracting arrangement, the plan shall provide notice to enrollees who have received health care services from the terminated provider organization, specialist, or primary care provider within the last 12 months or who are assigned or are required to select a primary care provider to receive services under the contract.

(c) When a plan terminates a contractual arrangement with an individual provider within a provider group, the plan may request that the provider group notify the enrollees who are patients of that provider of the termination.

(d) A plan shall disclose the reasons for the termination of a contract with a provider to the provider only when the termination occurs during the contract year.

(e) Notwithstanding subdivision (d), whenever a plan indicates that a provider's contract is being terminated for quality of care reasons, it shall state specifically what those reasons are.

(f) A plan that relies on primary care providers shall have a process in place to assure that patients who do not have a primary care provider have access to medical care, including specialists.

(g) If an enrollee has not been notified pursuant to subdivision (a) that his or her primary care provider has ceased to be affiliated with the enrollee's plan, the enrollee is not required to have the approval of a primary care provider to authorize a referral within the plan. All self-referrals within the plan shall be approved for a period of 60 days from the date of the termination of the enrollee's primary care provider or until a primary care provider is assigned or chosen, whichever is earlier.

This subdivision does not apply if the enrollee's plan utilizes a process for automatically assigning enrollees a primary care provider, or if the enrollee otherwise has direct access to a primary care provider.

A plan may not retroactively assign an enrollee to a new primary care provider to avoid financial responsibility for any enrollee self-referrals due to a failure to notify the enrollee pursuant to subdivision (a).

(h) All notifications required by this section shall be by United States mail. If the notice to the enrollee is returned as undeliverable, the plan shall make a good faith effort to notify the enrollee at the first appropriate contact with the plan.

(i) Every contract with a provider shall do all of the following:

(1) Include a provision requiring the plan and the provider organization, specialist, or primary care provider to agree to jointly sign the notification statement required to be provided to enrollees pursuant to subdivision (a).

(2) Include a provision requiring the parties to use the department's joint notification statement template if the plan and the provider organization, specialist, or primary care provider cannot agree on a joint notification statement.

(j) The department shall adopt a joint notification statement for use by plans and provider organizations, specialists, and primary care providers as soon as possible after January 1, 2004.

(k) The following definitions apply for purposes of this section:

(1) ''Hospital'' means a general acute care hospital or an acute psychiatric hospital.

(2) ''Primary care provider'' means a primary care physician, as defined in Section 14254 of the Welfare and Institutions Code, who provides care for the majority of an enrollee's health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues. If a specialist meets these criteria, he or she may be a primary care provider for an enrollee.

(3) ''Provider group'' means a medical group or independent practice association, or any other similar group of providers.

(4) ''Provider organization'' means a provider group, hospital, hospital system that includes two or more hospitals, or a health system that includes two or more hospitals and a provider group.

(5) ''Termination'' means the severance of the contractual relationship between the plan and the primary care provider, specialist, or provider organization due to nonrenewal of the contract, or closure or bankruptcy of the primary care provider, specialist, or provider organization.

(*l*) The provisions of this section related to primary care providers are not applicable to a health care service plan contract that provides benefits to enrollees through preferred provider contracting arrangements if the plan does not require the enrollee to choose a primary care provider and does not have a process for automatically assigning a primary care provider.

~~SEC. 5.~~

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

1373.66. (a) Except as provided in subdivision (e), if a health care service plan and a provider organization terminate, give notification of intent to terminate an evergreen contract, or fail to renew a contract prior to the expiration date of that contract, every enrollee of a plan affected by that contract may continue to receive health care services from the previously contracting provider organization if the enrollee continues to be enrolled in the plan and the provisions of this section are met.

(b) (1) In the case of an enrollee under a group contract, or an enrollee in the Healthy Families program, the enrollee may continue to receive health care services until the effective date of coverage after the enrollee has a chance to select a new plan, not to exceed 12 months.

(2) In the case of an enrollee under an individual contract, the enrollee may continue to receive health care services for a period of up to 180 days from the expiration or termination date as described in subdivision (a).

(3) For Medi-Cal enrollees, the enrollee may continue to receive health care services for a period of up to 180 days from the expiration or termination date as described in subdivision (a).

(c) A contract between a plan and a provider organization entered into, amended, or renewed on or after January 1, 2004, and, in any event, all contracts in effect on June 30, 2005, shall contain both of the following provisions:

(1) A requirement that, in the event the contract is not renewed or terminates, the provider organization shall nevertheless continue rendering health care services to the plan's enrollees as provided in this section. Providers shall not be required to render health care services to enrollees who were enrolled in the plan after the termination date.

(2) Specification of the reimbursement rate schedule that will automatically become effective for the transition period that commences upon the effective date of the provider organization's termination from the plan and continues until all obligations to continue to provide coverage under this section are met.

(d) A contract between a plan and a provider organization entered into, amended, or renewed on or after January 1, 2004, and, in any event, all contracts in effect on June 30, 2005, that

provide benefits to enrollees through a preferred provider arrangement shall contain a provision specifying that until the effective date of new coverage obtained by the enrollee, the amount of the enrollee's benefit level for health care services provided by a provider pursuant to this section shall be the same as for a provider that remains part of the provider organization for similar services.

(e) The provisions of this section shall not apply in any of the following circumstances:

(1) The plan terminates or does not renew a contract with a provider organization because the provider organization endangered the health and safety of the enrollee, breached the contract between the plan and the provider organization, or did not meet the plan's quality of care standards.

(2) The plan terminates or does not renew a contract with a provider organization because the provider organization committed criminal or fraudulent acts, or engaged in grossly unprofessional conduct.

(3) The plan terminates or does not renew a contract with a provider organization due to demonstrable concerns regarding the financial capacity of the provider organization to provide health care services as required by the contract.

(4) The provider organization no longer maintains offices or provides services in the geographic area of the enrollee.

(f) A contract between a plan and a provider organization shall contain provisions requiring the provider organization to include in its provider contracts provisions that do both of the following:

(1) Require the provider to continue to provide health care services to enrollees pursuant to this section.

(2) Require the provider to continue to provide health care services to enrollees who are undergoing a current episode of care under Sections 1373.95 and 1373.96 after the expiration of the coverage period pursuant to subdivision (b).

(g) If a plan notifies enrollees in accordance with Section 1373.65 of a contract termination or nonrenewal and then following notification subsequently reaches an agreement with the terminated provider or provider organization to renew or not to terminate the contract or for a new contract, the plan shall not reassign the affected enrollees back to the original provider or provider organization but rather shall offer the affected enrollees

the opportunity at their sole discretion to choose to return to the original assigned provider.

(h) The plan may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.

(i) For purposes of this section, the following definitions apply:

(1) ''Evergreen contract'' means a contract for services between the provider organization and the plan that automatically renews on its own terms unless otherwise terminated by either party pursuant to the terms of the contract.

(2) ''Hospital'' means a general acute care hospital or an acute psychiatric hospital.

(3) ''Provider group'' means a medical group, individual practice association, or any other similar group of providers.

(4) ''Provider organization'' means a provider group, a hospital, a hospital system that includes two or more hospitals, or a health system that includes two or more hospitals and a provider group.

(j) Nothing in this section shall require a plan to provide benefits that are not otherwise covered under the terms and conditions of the plan contract.

(k) The department shall review all communications from a plan to an enrollee that concerns continuity of care provided by the terminated provider organization.

~~SEC. 6.~~

SEC. 4. Section 1373.67 is added to the Health and Safety Code, to read:

1373.67. (a) (1) A health care service plan shall annually file with the department, as part of its annual transition plan, a transition plan outlining the steps the plan will take to ensure the safe and appropriate transfer of medical records of its current enrollees from a terminated provider to a new provider. The transition plan shall require the transfer of the medical records within a reasonable period not to exceed 45 days of the date on which the contractual relationship between the plan and the

terminated provider was severed, as described in paragraph (5) of subdivision (i).

(2) The transition plan described in paragraph (1) shall be filed with the department as a material modification.

(b) (1) Upon the severing of the contractual relationship between a plan and a provider or provider organization, as described in paragraph (5) of subdivision (i), the plan shall directly or indirectly ensure that a copy of the medical records of the enrollee maintained by the terminated provider is provided to the enrollee or to the enrollee's new designated provider.

(2) Upon the severing of the contractual relationship between a plan and a provider organization, other than a closure or bankruptcy, the plan shall provide an enrollee with the option of requesting that medical records be duplicated and transferred to the network provider of his or her choice rather than the network provider designated by the plan.

(c) (1) A contract between a plan and an individual provider or provider organization shall include a provision that requires the parties to share equally in the costs of duplicating and transferring the medical records of an enrollee if the contract terminates for any reason other than the closure or bankruptcy of the individual provider or provider organization.

(2) The plan shall pay all of the costs in paragraph (1) if the contract terminates because of the closure or bankruptcy of the individual provider or the provider organization. Nothing in this section shall preclude a plan from seeking remedies in bankruptcy court.

(3) The plan, within five business days of the filing of a petition for bankruptcy by the individual provider or the provider organization, shall file an intervening petition in those proceedings on behalf of its enrollees to secure access, duplication, and transfer of the medical records ~~to~~ *of* the enrollees to the new designated provider. If the plan does not intervene within this time period, the director may intervene in the bankruptcy proceedings.

(d) The provisions of subdivisions (b) and (c) shall only apply if the individual provider or provider organization ceases to provide health care services to the plan's enrollee.

(e) The provisions of subdivision (d) shall only apply upon the severing of the contractual relationship between a plan and a

hospital when an enrollee seeks care at a new hospital pursuant to a new contract.

(f) For plans that provide benefits to enrollees through a preferred provider contracting arrangement, the provisions of subdivisions (b) and (c) shall only apply to the medical records of enrollees who have received health care services from the terminated primary care provider, provider organization, or specialist within the last 12 months or who are assigned or required to select a primary care provider to receive services under the contract.

(g) If the provider or provider organization's contract is severed as described in paragraph (5) of subdivision (i), the enrollee shall not incur any costs for the duplicating and transferring of his or her medical records pursuant to this section.

(h) Nothing in this section is intended to limit a plan's duty to comply with applicable state and federal laws and regulations related to the privacy and protection of the confidentiality of medical records.

(i) The following definitions apply for purposes of this section:

(1) ''Designated provider'' means the health care provider either assigned by the plan as the enrollee's primary care physician or a provider designated by the enrollee.

(2) ''Hospital'' means a general acute care hospital or an acute psychiatric hospital.

(3) ''Provider group'' means a medical group, independent practice association, or any other similar group of providers.

(4) ''Provider organization'' means a provider group, a hospital, a hospital system that includes two or more hospitals, or health system that includes two or more acute care hospitals and a provider group.

(5) ''Terminated provider'' means individual provider or provider organization whose contractual relationship with the plan has been terminated, severed due to the nonrenewal of the contract, closure, bankruptcy, or the termination of the individual provider or provider organization due to criminal or fraudulent acts, or reasons relating to a medical disciplinary cause or reason as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code.

~~SEC. 7.~~

SEC. 5. Section 1373.95 of the Health and Safety Code is amended to read:

1373.95. (a) (1) Except as provided in paragraph (3), every health care service plan shall file with the department, on or before July 1, 2004, a written policy describing how the plan shall facilitate the continuity of care for all of the following:

(A) New enrollees receiving services during a current episode of care from a nonparticipating provider for an acute condition, a serious chronic condition, a terminal illness or disease, or a pregnancy.

(B) New enrollees from birth to three years of age.

(C) New enrollees who were scheduled for nonelective surgery or procedure at the time of the termination of the contract between the plan and the provider and which surgery or procedure is scheduled to occur within 180 days of the termination.

(2) The written policy shall describe the process used to facilitate continuity of care, including the assumption of care by a participating provider.

(3) On or before July 1, 2004, a plan that provides coverage or offers professional mental health services shall file with the department as part of its written policy a description of how the plan facilitates the continuity of care for new enrollees who have been receiving services for an acute, serious, or chronic mental health condition from a nonparticipating mental health provider when the enrollee's employer has changed plans. Every written policy shall allow the new enrollee a reasonable transition period to continue his or her course of treatment with the nonparticipating mental health provider prior to transferring to another participating provider and shall include the provision of mental health services on a timely, appropriate, and medically necessary basis from the nonparticipating provider. The policy may provide that the length of the transition period take into account the severity of the enrollee's condition and the amount of time reasonably necessary to effect a safe transfer on a case-by-case basis. Nothing in this paragraph shall be construed to require the plan to accept a nonparticipating mental health provider onto its panel for treatment of other enrollees. For purposes of the continuing treatment of the transferring enrollee, the plan may require the nonparticipating mental health provider, as a condition

of the right conferred under this section, to enter into the standard mental health provider contract.

(b) Notice of the policy and information regarding how enrollees may request a review under the policy shall be provided to all new enrollees, except those enrollees who are not eligible as described in subdivision (e). A copy of the written policy shall be provided to eligible enrollees upon request. The written policy required to be filed under subdivision (a) shall describe how requests to continue services with an existing provider are reviewed by the plan. The policy shall ensure that reasonable consideration is given to the potential clinical effect that a change of provider would have on the enrollee's treatment for the condition.

(c) A plan may require any nonparticipating provider or nonparticipating mental health provider whose services are continued pursuant to the written policy to agree in writing to meet the same contractual terms and conditions that are imposed upon the plan's participating providers, including location within the plan's service area, reimbursement methodologies, and rates of payment. If the plan determines that a patient's health care treatment should temporarily continue with the patient's existing provider, nonparticipating provider, or nonparticipating mental health provider, the plan shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provision of services by the existing provider, nonparticipating provider, or nonparticipating mental health provider.

(d) Nothing in this section shall require a plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.

(e) The written policy shall not apply to any enrollee who is offered an out-of-network option, or who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change plans.

(f) This section shall not apply to plan contracts that include out-of-network coverage under which the enrollee is able to obtain services from the enrollee's existing provider, nonparticipating provider, or nonparticipating mental health provider.

(g) The department shall review all communications from a plan or a terminated provider to an enrollee that concerns continuity of care provided by the terminated provider.

(h) (1) For purposes of this section, ''provider'' refers to a person who is described in subdivision (f) of Section 900 of the Business and Professions Code.

(2) For purposes of this section, ''nonparticipating mental health provider'' refers to a psychiatrist, licensed psychologist, licensed marriage and family therapist, or licensed social worker who is not part of the plan.

(3) For the purposes of this section, ''nonparticipating provider'' means a provider who is not part of the plan.

(4) For the purposes of this section, ''terminal illness or disease'' means a medical condition for which the life expectancy prognosis is one year or less, if the illness or disease follows its natural course.

~~SEC. 8.~~

SEC. 6. Section 1373.96 of the Health and Safety Code is amended to read:

1373.96. (a) Every health care service plan shall, at the request of an enrollee, arrange for the continuation of covered services rendered by a terminated provider, subject to the provisions of this section, to an enrollee who at the time of the contract termination meets one of the following criteria:

(1) Is between birth and three years of age.

(2) Is undergoing a course of treatment from a terminated provider for an acute condition, serious chronic condition, terminal illness or disease, or a pregnancy.

(3) Is scheduled for a nonelective surgery or other procedure that is scheduled to occur within 180 days of the date of contract termination.

(b) Subject to subdivisions (c) and (d), the plan shall, at the request of an enrollee who meets one of the criteria in subdivision (a), provide for continuity of care for the enrollee by a terminated provider who has been providing care as ~~provided in this subdivision. In~~ *follows:*

(1) In the case of an enrollee undergoing a course of treatment for an acute condition or a serious chronic condition, the plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider for up to 90 days

or a longer period if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice. ~~In~~

(2) In the case of an enrollee undergoing a course of treatment for an acute, serious, or chronic mental health condition, the plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider for up to 90 days or a longer period if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice. ~~In~~

(3) In the case of an enrollee who is between birth and three years of age, the plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider for 90 days. ~~In~~

(4) In the case of an enrollee who was scheduled for nonelective surgery or procedure, the plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider for the period necessary for a safe transfer to another provider, as determined by the plan in consultation with the terminated provider. ~~In~~

(5) In the case of a pregnancy, the plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider until postpartum services related to the delivery are completed or for a longer period if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice. ~~In~~

(6) In the case of an enrollee receiving health care services from a terminated provider for a terminal illness or disease, the plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider until the enrollee's death.

(c) The plan may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual

terms and conditions, there shall be no obligation on the part of the plan to continue the provider's services beyond the contract termination date. Further, if the terminated provider or provider group voluntarily leaves the plan, there shall be no obligation on the part of the provider or the plan to continue the provider's services beyond the contract termination date.

(d) Unless otherwise agreed upon between the terminated provider and the plan or between the provider and the provider group, the agreement shall be construed to require a rate and method of payment to the terminated provider, for the services rendered pursuant to this section, similar to rates and methods of payment used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider. The plan or the provider group shall not be obligated to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this section.

(e) A description as to how an enrollee may request continuity of care pursuant to this section shall be provided in the plan's evidence of coverage and disclosure form. A plan shall provide a written copy of this information to its contracting providers and provider groups. A plan shall also provide a copy to its enrollees upon request.

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

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

(h) For the purposes of this section:

(1) ''Provider'' means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

(2) ''Terminated provider'' means a provider whose contract to provide services to plan enrollees is terminated or not renewed by

the plan or one of the plan's contracting provider groups. A terminated provider is not a provider who voluntarily leaves the plan or contracting provider group.

(3) ''Provider group'' includes a medical group, independent practice association, or any other similar group of providers.

(4) ''Acute condition'' means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

(5) ''Serious chronic condition'' means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following:

(A) Persists without full cure or worsens over an extended period of time.

(B) Requires ongoing treatment to maintain remission or prevent deterioration.

(6) ''Terminal illness or disease'' means a medical condition for which the expectancy prognosis is one year or less~~,~~ if the illness or disease follows its natural course.

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

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

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

~~SEC. 9.~~

SEC. 7. Section 1392 of the Health and Safety Code is amended to read:

1392. (a) (1) Whenever it appears to the director that any person has engaged, or is about to engage, in any act or practice constituting a violation of any provision of this chapter, any rule

adopted pursuant to this chapter, or any order issued pursuant to this chapter, the director may bring an action in superior court, or the director may request the Attorney General to bring an action to enjoin these acts or practices or to enforce compliance with this chapter, any rule or regulation adopted by the director pursuant to this chapter, or any order issued by the director pursuant to this chapter, or to obtain any other equitable relief.

(2) If the director determines that it is in the public interest, the director may include in any action authorized by paragraph (1) a claim for any ancillary or equitable relief and the court shall have jurisdiction to award this additional relief.

(3) Upon a proper showing, a permanent or preliminary injunction, restraining order, writ of mandate, or other relief shall be granted~~,~~ and a receiver, monitor, conservator, or other designated fiduciary or officer of the court may be appointed for the defendant or the defendant's assets. The director may also seek an order from the superior court to enjoin or stay any applicable entities from proceeding with any of the following actions against the defendant health care service plan or the defendant's assets:

(A) Terminating contractual relationships on the grounds of breach of contract due to nonpayment of claims, insolvency, and filing for bankruptcy relief.

(B) Commencing or continuing a judicial, administrative, or other action or proceeding against the defendant.

(C) Enforcing a judgment obtained before the conservatorship.

(D) Taking any action to create, perfect, or enforce any lien against the defendant.

(E) Taking any action to collect, assess, or recover a claim against the defendant that arose before the conservatorship.

(b) A receiver, monitor, conservator, or other designated fiduciary, or officer of the court appointed by the superior court pursuant to this section may, with the approval of the court, exercise any or all of the powers of the defendant's officers, directors, partners, or trustees, or any other person who exercises similar powers and performs similar duties, including the filing of a petition for bankruptcy. No action at law or in equity may be maintained by any party against the director, or a receiver, monitor, conservator, or other designated fiduciary or officer of the court by reason of their exercising these powers or performing these duties pursuant to the order of, or with the approval of, the superior court.

~~SEC. 10.~~

SEC. 8. Section 1393 of the Health and Safety Code is amended to read:

1393. (a) The superior court of the county in which is located the principal office of the plan in this state shall, upon the filing by the director of a verified application showing any of the conditions enumerated in Section 1386 to exist, issue its order vesting title to all of the assets of the plan, wherever situated, in the director or the director's successor in office, in his or her official capacity, and direct the director to take possession of all of its books, records, property, real and personal, and assets, and to conduct, as conservator, the business or portion of the business of the person as may seem appropriate to the director, and enjoining the person and its officers, directors, agents, servants, and employees from the transaction of its business or disposition of its property until the further order of the court.

(b) Whenever it appears to the director that irreparable loss and injury to the property and business of the plan or to the plan's enrollees has occurred or may occur unless the director acts immediately, the director, without notice and before applying to the court for any order, may take possession of the property, business, books, records, and accounts of the plan, and of the offices and premises occupied by it for the transaction of its business, and retain possession until returned to the plan or until further order of the director or subject to an order of the court. Any person having possession of and refusing to deliver any of the books, records, or assets of a plan against which a seizure order has been issued by the director, shall be guilty of a misdemeanor and punishable by a fine not exceeding ten thousand dollars ($10,000) or imprisonment not exceeding one year, or both the fine and imprisonment. Whenever the director has taken possession of any plan pursuant to this subdivision, the owners, officers, and directors of the plan may apply to the superior court in the county in which the principal office of the plan is located, within 10 days after the taking, to enjoin further proceedings. The court, after citing the director to show cause why further proceedings should not be enjoined, and after a hearing and a determination of the facts upon the merits, may do any of the following:

(1) Dismiss the application after confirming the director's authority to take possession of all of the plan's books, records,

property, real and personal, and assets, and to conduct, as conservator, the business or portion of the business as the director may deem appropriate, and enjoining the owners, officers, and directors, and their agents and employees, from the transaction of plan business or disposition of plan property until the further order of the court.

(2) Enjoin the director from further proceedings and direct the director to surrender the property and business to the plan.

(3) Make any further order as may be just.

(c) If any facts occur that would entitle the director to take possession of the property, business, and assets of the plan, the director may appoint a conservator over the plan and require any bond of the conservator as the director deems proper. The conservator, under the direction of the director, shall take possession of the property, business, and assets of the plan pending further disposition of its business. The conservator shall retain possession until the property, business, and assets of the plan are returned to the plan, or until further order of the director, except that the conservator shall be able to pay necessary costs of the ongoing operation without formal order of the director. Whenever the director has taken possession of any plan pursuant to subdivision (b), the director shall, within 10 days after the taking, apply to the superior court in the county in which the principal office of the plan is located for an order confirming the director's appointment of the conservator. The order may be given after a hearing upon notice that the court prescribes. The director may also seek an order from the superior court to enjoin or stay any applicable entities from proceeding with any of the following actions against the defendant health care service plan:

(1) Terminating contractual relationships on the grounds of breach of contract due to nonpayment of claims, insolvency, and filing for bankruptcy relief.

(2) Commencing or continuing a judicial, administrative, or other action or proceeding against the defendant.

(3) Enforcing a judgment obtained before the conservatorship.

(4) Taking any action to create, perfect, or enforce any lien against the defendant.

(5) Taking any action to collect, assess, or recover a claim against the defendant that arose before the conservatorship.

(d) (1) Subject to the other provisions of this section, a conservator, while in possession of the property, business, and assets of a plan, has the same powers and rights, and is subject to the same duties and obligations, as the director under the same circumstances, and during this time, the rights of a plan and of all persons with respect to the plan are the same as if the director had taken possession of the property, business, and assets of the plan, for the purpose of carrying out the conservatorship.

(2) Subject to the other provisions of this section, a conservator, while in possession of the property, business, and assets of a plan, shall have all of the rights, powers, and privileges of the plan, and its officers and directors, for the purpose of carrying out the conservatorship. All expenses of any conservatorship shall be paid from the assets of the plan, and shall be a lien on the plan which shall be prior to any other lien.

(3) No action at law or in equity may be maintained by any party against the director or a conservator by reason of their exercising or performing the privileges, powers, rights, duties, and obligations pursuant to the order, or with the approval, of the superior court.

(e) Upon appointing a conservator, the director shall cause to be made and completed, at the earliest possible date, an examination of the affairs of the plan as shall be necessary to inform the director as to the plan's financial condition.

(f) If the director becomes satisfied that it may be done safely and in the public interest, the director may terminate the conservatorship and permit the plan for which the conservator was appointed to resume its business under the direction of its board of directors, subject to any terms, conditions, restrictions, and limitations the director prescribes.

~~SEC. 11.~~

SEC. 9. Section 10133.55 of the Insurance Code is amended to read:

10133.55. (a) (1) Except as provided in paragraph (3), every health insurer that contracts with providers for alternative rates pursuant to Section 10133 and limits payments under those policies to services secured by insureds from providers charging alternative rates pursuant to these contracts, shall file with the department, on or before January 1, 2004, a written policy

describing how the insurer shall facilitate the continuity of care for all of the following:

(A) New insureds receiving services during a current episode of care from a noncontracting provider for an acute condition, a serious chronic condition, a terminal illness or disease, or a pregnancy.

(B) New insureds from birth to three years of age.

(C) New insureds who were scheduled for nonelective surgery or procedure at the time of the termination of the contract between the insurer and the provider and which surgery or procedure is scheduled to occur within 180 days of the termination.

(2) The written policy shall describe the process used to facilitate continuity of care, including the assumption of care by a contracting provider.

(3) On or before July 1, 2004, a health insurer that contracts with providers for alternative rates pursuant to Section 10133 and limits payments under those policies to services secured by insureds from providers charging alternative rates pursuant to these contracts, shall file with the department as part of its written policy a description of how the insurer shall facilitate the continuity of care for new insureds who have been receiving services for an acute, serious, or chronic mental health condition from a nonparticipating mental health provider when the insured's employer has changed policies. Every written policy shall allow the new insured a reasonable transition period to continue his or her course of treatment with the nonparticipating mental health provider prior to transferring to another participating provider and shall include the provision of mental health services on a timely, appropriate, and medically necessary basis from the nonparticipating provider. The policy may provide that the length of the transition period take into account the severity of the insured's condition and the amount of time reasonably necessary to effect a safe transfer on a case-by-case basis. Nothing in this paragraph shall be construed to require the insurer to accept a nonparticipating mental health provider onto its panel for treatment of other insureds. For purposes of the continuing treatment of the transferring insured, the insurer may require the nonparticipating mental health provider, as a condition of the right conferred under this section, to enter into the standard mental health provider contract.

(b) Notice of the policy and information regarding how insureds may request a review under the policy shall be provided to all new insureds, except those insureds who are not eligible as described in subdivision (e). A copy of the written policy shall be provided to eligible insureds upon request. The written policy required to be filed under subdivision (a) shall describe how requests to continue services with an existing noncontracting provider are reviewed by the insurer. The policy shall ensure that reasonable consideration is given to the potential clinical effect that a change of provider would have on the insured's treatment for the acute condition.

(c) An insurer may require any nonparticipating provider or nonparticipating mental health provider whose services are continued pursuant to the written policy to agree in writing to meet the same contractual terms and conditions that are imposed upon the insurer's participating providers, including location within the service area, reimbursement methodologies, and rates of payment. If the insurer determines that a patient's health care treatment should temporarily continue with the patient's existing provider, nonparticipating provider, or nonparticipating mental health provider, the insurer shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provision of services by the existing provider, nonparticipating provider, or nonparticipating mental health provider.

(d) Nothing in this section shall require an insurer to cover services or provide benefits that are not otherwise covered under the terms and conditions of the policy contract.

(e) The written policy shall not apply to any insured who is offered an out-of-network option, or who had the option to continue with his or her previous health benefits carrier or provider and instead voluntarily chose to change policies.

(f) This section shall not apply to insurer contracts that include out-of-network coverage under which the insured is able to obtain services from the insured's existing provider, nonparticipating provider, or nonparticipating mental health provider.

(g) The department shall review all communications from an insurer or a terminated provider to an insured that concerns continuity of care provided by the terminated provider.

(h) (1) For purposes of this section, ‘‘provider’’ refers to a person who is described in subdivision (f) of Section 900 of the Business and Professions Code.

(2) For purposes of this section, ‘‘nonparticipating mental health provider’’ refers to a psychiatrist, licensed psychologist, licensed marriage and family therapist, or licensed social worker who is not part of the insurer’s contracted provider network.

(3) For purposes of this section, ‘‘nonparticipating provider’’ means a provider who has not contracted with the insurer.

(4) For purposes of this section, ‘‘terminal illness or disease’’ means a medical condition for which the life expectancy prognosis is one year or less, if the disease follows its natural course.

~~SEC. 12.~~

SEC. 10. Section 10133.56 of the Insurance Code is amended to read:

10133.56. (a) Health insurers that negotiate and enter into contracts with professional or institutional providers to provide services at alternative rates of payment pursuant to Section 10133, shall, at the request of an insured, arrange for the continuation of covered services rendered by a terminated provider to an insured who, at the time of the contract termination, subject to the provisions of this section, meets one of the following criteria:

(1) Is between birth and three years of age.

(2) Is undergoing a course of treatment from a terminated provider for an acute condition, a serious chronic condition, a terminal illness or disease, or a pregnancy.

(3) Is scheduled for a nonelective surgery or other procedure that is scheduled to occur within 180 days of the date of contract termination.

(b) Subject to subdivisions (c) and (d), the insurer shall, at the request of an insured who meets one of the criteria in subdivision (a), provide for continuity of care as ~~provided in this subdivision. In~~ *follows:*

(1) In a case involving an insured undergoing a course of treatment for an acute condition or a serious chronic condition, the insurer shall furnish the insured with health care services on a timely and appropriate basis from the terminated provider for up to 90 days or a longer period if necessary for a safe transfer to another provider as determined by the insurer in consultation with

the terminated provider, consistent with good professional practice. ~~In~~

(2) In a case involving an insured undergoing a course of treatment for an acute or serious chronic mental health condition, the insurer shall furnish the insured with health care services for up to 90 days or a longer period if necessary to ensure a safe transfer to another provider, as determined by the insurer, in consultation with the terminated provider, consistent with good professional practice. ~~In~~

(3) In the case of an insured who is between birth and three years of age, the plan shall furnish the insured with health care services on a timely and appropriate basis from the terminated provider for 90 days. ~~In~~

(4) In the case of an insured who was scheduled for nonelective surgery or procedure, the plan shall furnish the insured with health care services on a timely and appropriate basis from the terminated provider for the period necessary for a safe transfer to another provider, as determined by the insurer in consultation with the terminated provider. ~~In~~

(5) In the case of a pregnancy, the insurer shall furnish the insured with health care services on a timely and appropriate basis from the terminated provider until postpartum services related to the delivery are completed or for a longer period if necessary for a safe transfer to another provider as determined by the insurer in consultation with the terminated provider, consistent with good professional practice. ~~In~~

(6) In the case of an insured receiving health care services from a terminated provider for a terminal illness or disease, the insurer shall furnish the insured with health care services on a timely and appropriate basis from the terminated provider until the insured's death. ~~After~~

After the required period of continuity of care has expired pursuant to this section, coverage shall be provided pursuant to the general terms and conditions of the insured's policy.

(c) The insurer may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review,

and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, there shall be no obligation on the part of the insurer to continue the provider's services beyond the contract termination date. Further, if the terminated individual provider voluntarily cancels the contract with the insurer, there shall be no obligation on the part of the provider or the insurer to continue the individual provider's services beyond the contract termination date.

(d) Unless otherwise agreed upon between the terminated provider and the insurer or between the terminated provider and the provider group, the agreement shall be construed to require a rate and method of payment to the terminated provider, for the services rendered pursuant to this section, that is the same as the rates and method of payment for the same services while under contract with the insurer and at the time of termination. The provider shall accept the reimbursement as payment in full, and shall not bill the insured for any amount in excess of the reimbursement rate, with the exception of copayments and deductibles pursuant to subdivision (f). The insurer or provider group shall not be obligated to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this section.

(e) Notice as to how an insured may request continuity of care pursuant to this section shall be provided in the insurer's evidence of coverage and disclosure form. An insurer shall provide a written copy of this information to its contracting providers and provider groups. An insurer shall also provide a copy to its insureds upon request.

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

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

(h) For the purposes of this section:

(1) ‘‘Provider’’ means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

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

(3) ‘‘Provider group’’ includes a medical group, independent practice association, or any other similar group of providers.

(4) ‘‘Acute condition’’ means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention, and has a limited duration.

(5) ‘‘Serious chronic condition’’ means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following:

(A) Persists without full cure or worsens over an extended period of time.

(B) Requires ongoing treatment to maintain remission or prevent deterioration.

(6) ‘‘Terminal illness or disease’’ means a medical condition for which the life expectancy prognosis is one year or less~~,~~ if the disease or illness follows its natural course.

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

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

(k) The provisions contained in this section are in addition to any other responsibilities of insurers to provide continuity of care pursuant to this chapter. Nothing in this section shall preclude an insurer from providing continuity of care beyond the requirements of this section.

~~SEC. 13.~~

SEC. 11. Section 10133.57 is added to the Insurance Code, to read:

10133.57. (a) Except as provided in subdivision (e), if a health insurer and a provider organization terminate, give notification of intent to terminate an evergreen contract, or ~~fails~~ *fail* to renew a contract prior to the expiration date of that contract, every insured affected by that contract may continue to receive health care services from the previously contracting provider organization if the insured continues to be insured by the insurer and the provisions of this section are met.

(b) (1) In the case of an insured under a group contract, or enrolled in the Healthy Families Program, the insured may continue to receive health care services until the effective date of coverage after the insured has a chance to select a new insurer, not to exceed 12 months.

(2) In the case of an insured under an individual contract, the insured may continue to receive health care services for a period of up to 180 days from the expiration or termination date as described in subdivision (a).

(3) For Medi-Cal enrollees, the insured may continue to receive health care services for a period of up to 180 days from the expiration or termination date as described in subdivision (a).

(c) A contract between an insurer and a provider organization entered into, amended, or renewed on or after January 1, 2004, and, in any event, all contracts in effect on June 30, 2005, shall contain both of the following provisions:

(1) A requirement that, in the event the contract is not renewed or has terminated, the provider organization shall nevertheless continue rendering health care services to the insureds as provided in this section. Providers shall not be required to render health care services to insureds who commenced their coverage by the insurer after the termination date.

(2) Specification of the reimbursement rate schedule that will automatically become effective for the transition period that commences upon the effective date of the provider organization's termination of its contract with the insurer and continues until all obligations to continue to provide coverage under this section are met.

(d) A contract between a provider organization and an insurer that provides benefits to insureds through a preferred provider arrangement pursuant to Section 10133 shall contain a provision specifying that until the effective date of new coverage obtained by the insured, the amount of the insured's benefit level for health care services provided by a provider pursuant to this section shall be the same as for a provider that contracts with the insurer for similar services.

(e) The provisions of this section shall not apply in any of the following circumstances:

(1) The insurer terminates or does not renew a contract with a provider organization because the provider organization endangered the health and safety of the insured, breached the contract between the insurer and the provider organization, or did not meet the insurer's quality of care standards.

(2) The insurer terminates or does not renew a contract with a provider organization because the provider organization committed criminal or fraudulent acts, or engaged in grossly unprofessional conduct.

(3) The insurer terminates or does not renew a contract with a provider organization due to demonstrable concerns regarding the financial capacity of the provider organization to provide health care services as required by the contract.

(4) The provider organization no longer maintains offices or provides services in the geographic area of the insured.

(f) A contract between an insurer and a provider organization shall contain provisions requiring the provider organization to include in its provider contracts provisions that do both of the following:

(1) Require the provider to continue to provide health care services to insureds pursuant to this section.

(2) Require the provider to continue to provide health care services to insureds who are undergoing a current episode of care under Section 10133.55 or 10133.56 after the expiration of the coverage period pursuant to subdivision (b).

(g) If an insurer notifies insureds in accordance with Section 10133.59 of a contract termination or nonrenewal and then following notification subsequently reaches an agreement with the terminated provider or provider organization to renew or not to terminate the contract or for a new contract, the insurer shall not

reassign the affected insureds back to the original provider or provider organization but rather shall offer the affected insureds the opportunity at their sole discretion to choose to return to the original assigned provider.

(h) The insurer may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.

(i) For purposes of this section, the following definitions apply:

(1) ''Evergreen contract'' means a contract for services between the provider organization and the insurer that automatically renews on its own terms unless otherwise terminated by either party pursuant to the terms of the contract.

(2) ''Hospital'' means a general acute care hospital or an acute psychiatric hospital.

(3) ''Provider group'' means a medical group, individual practice association, or any other similar group of providers.

(4) ''Provider organization'' means a provider group, a hospital, or a hospital system that includes two or more hospitals, or a health system that includes two or more hospitals and a provider group.

(j) Nothing in this section shall require an insurer to provide benefits that are not otherwise covered under the terms and conditions of the insurance contract.

(k) The department shall review all communications from an insurer to an insured that concerns continuity of care provided by the terminated provider organization.

~~SEC. 14.~~

SEC. 12. Section 10133.58 is added to the Insurance Code, to read:

10133.58. (a) A health insurer shall annually file with the department, as part of its annual transition plan, a transition plan outlining the steps the insurer will take to ensure the safe and appropriate transfer of medical records of its current insureds from a terminated provider to the new provider. The transition plan shall require the transfer of the medical records within a reasonable period not to exceed 45 days of the date on which the contractual

relationship between the insurer and the terminated provider was severed, as described in paragraph (5) of subdivision (i).

(b) (1) Upon the severing of the contractual relationship between an insurer and a provider or provider organization, as described in paragraph (5) of subdivision (i), the insurer shall directly or indirectly ensure that a copy of the medical records of the insured maintained by the terminated provider is provided to the insured or to the insured's new designated provider.

(2) Upon the severing of the contractual relationship between an insurer and a provider organization, other than a bankruptcy, the insurer shall provide an insured with the option of requesting that medical records be duplicated and transferred to the network provider of his or her choice rather than the network provider designated by the insurer.

(c) (1) A contract between an insurer and an individual provider or provider organization shall include a provision that requires the parties to share equally in the costs of duplicating and transferring the medical records of an insured if the contract terminates for any reason other than the closure or bankruptcy of the individual provider or provider organization.

(2) The insurer shall pay all of the costs in paragraph (1) if the contract terminates because of the closure or bankruptcy of the individual provider or the provider organization. Nothing in this section shall preclude an insurer from seeking remedies in bankruptcy court.

(3) The insurer, within five business days of the filing of a petition for bankruptcy by the individual provider or the provider organization, shall file an intervening petition in those proceedings on behalf of its insureds to secure access, duplication, and transfer of the medical records to the insureds or to the new designated provider. If the insurer does not intervene within this time period, the commissioner may intervene in the bankruptcy proceedings.

(d) The provisions of subdivisions (b) and (c) shall only apply if the individual provider or provider organization ceases to provide health care services to the insureds.

(e) The provisions of subdivision (d) shall only apply upon the severing of the contractual relationship between an insurer and a hospital when an insured seeks care at a new hospital pursuant to a new contract.

(f) For insurers that provide benefits to insureds through a preferred provider contracting arrangement, the provisions of subdivisions (b) and (c) shall only apply to the medical records of insureds who have received health care services from the terminated primary care provider, provider organization, or specialist within the last 12 months or who are assigned or required to select a primary care provider to receive services under the contract.

(g) If the provider or provider organization's contract is severed as described in paragraph (5) of subdivision (i), the insured shall not incur any costs for the duplicating and transferring of his or her medical records pursuant to this section.

(h) Nothing in this section is intended to limit an insurer's duty to comply with applicable state and federal laws and regulations related to the privacy and protection of the confidentiality of medical records.

(i) The following definitions apply for purposes of this section:

(1) ''Designated provider'' means the health care provider either assigned by the insurer as the insured's primary care physician or a provider designated by the insured.

(2) ''Hospital'' means a general acute care hospital or an acute psychiatric hospital.

(3) ''Provider group'' means a medical group, independent practice association, or any other similar group of providers.

(4) ''Provider organization'' means a provider group, a hospital, a hospital system that includes two or more hospitals, or health system that includes two or more acute care hospitals and a provider group.

(5) ''Terminated provider'' means individual provider or provider organization whose contractual relationship with the insurer has been terminated, severed due to the nonrenewal of the contract, closure, bankruptcy, or the termination of the individual provider or provider organization due to criminal or fraudulent acts, or reasons relating to a medical disciplinary cause or reason as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code.

~~SEC. 15.~~

SEC. 13. Section 10133.59 is added to the Insurance Code, to read:

10133.59. (a) (1) Except as provided in subdivision (b), 60 days prior to a termination, for any reason, of a contract between a health insurer and a provider organization, specialist, or primary care provider, the insurer shall provide written notice of the termination to insureds who are at that time receiving a course of treatment from an affected provider or specialist or from a provider of that provider organization or who are designated as having selected that provider organization, specialist, or primary care provider for their care. The notice shall include instructions on selecting a new primary care provider.

(2) If an insurer, without advance notice to a provider organization, specialist, or primary care provider, terminates the provider organization, specialist or primary care provider for endangering the health and safety of patients, committing criminal or fraudulent acts, or engaging in grossly unprofessional conduct, the notice requirement of paragraph (1) is not applicable. Instead, the insurer within 30 days of having terminated the provider organization, specialist, or primary care provider shall provide written notice of the termination to the insureds who have selected that provider organization, specialist, or primary care provider.

(3) The insurer shall submit the written notice required by this section to the department at least 10 business days prior to the date on which the insurer intends to send the notice to insureds. The insurer may not disseminate this notice until the department has reviewed and approved it.

(4) Upon approval by the department, the written notice required by this section shall be jointly signed by the insurer and the affected provider organization, specialist, or primary care provider. If the insurer and affected provider organization, specialist, or primary care provider are unable to agree on a jointly signed notification statement, the parties shall utilize the department's notice statement template.

(5) The jointly signed notification statement shall be disseminated by the insurer to affected insureds.

(b) For insureds under a contract that provides benefits through a preferred provider contracting arrangement, the insurer shall provide notice to insureds who have received health care services from the terminated provider organization, specialist or primary care provider within the last 12 months or who are assigned or

required to select a primary care provider to receive services under the contract.

(c) When an insurer terminates a contractual arrangement with an individual provider within a provider group, the insurer may request that the provider group notify the insureds who are patients of that provider of the termination.

(d) An insurer shall disclose the reasons for the termination of a contract with a provider to the provider only when the termination occurs during the contract year.

(e) Notwithstanding subdivision (d), whenever an insurer indicates that a provider's contract is being terminated for quality of care reasons, it shall state specifically what those reasons are.

(f) An insurer that relies on primary care providers shall have a process in place to assure that patients who do not have a primary care provider have access to medical care, including specialists.

(g) If an insured has not been notified pursuant to subdivision (a) that his or her primary care provider has ceased to be affiliated with the insured's insurer, the insured is not required to have the approval of a primary care provider to authorize a referral within the insurer. All self-referrals within the insurer's network shall be approved for a period of 60 days from the date of the termination of the insured's primary care provider or until a primary care provider is assigned or chosen, whichever is earlier.

This subdivision does not apply if the insurer utilizes a process for automatically assigning insureds a primary care provider, or if the insured otherwise has direct access to a primary care provider.

An insurer may not retroactively assign an insured to a new primary care provider to avoid financial responsibility for any insured self-referrals due to a failure to notify the insured pursuant to subdivision (a).

(h) All notifications required by this section shall be by United States mail. If the notice to the insured is returned as undeliverable, the insurer shall make a good faith effort to notify the insured at the first appropriate contact with the insurer.

(i) Every contract with a provider shall do the following:

(1) Include a provision requiring the insurer and the provider organization, specialist, or primary care provider to agree to jointly sign the notification statement provided to insureds required pursuant to subdivision (a).

(2) Include a provision requiring the parties to use the department's joint notification statement template if the insurer and the provider organization, specialist or primary care provider cannot agree on a joint notification statement.

(j) The department shall adopt a joint notification statement template for use by insurers and provider organizations, specialists, and primary care providers as soon as possible after January 1, 2004.

(k) The following definitions apply for purposes of this section:

(1) ''Hospital'' means a general acute care hospital or an acute psychiatric hospital.

(2) ''Primary care provider'' means a primary care physician, as defined in Section 14254 of the Welfare and Institutions Code, who provides care for the majority of an insured's health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues. For purposes of this section, if a specialist meets the above criteria of paragraph (1), he or she may be a primary care provider for an insured.

(3) ''Provider group'' means a medical group or independent practice association, or any other similar group of providers.

(4) ''Provider organization'' means a provider group, a hospital, a hospital system that includes two or more hospitals, or a health system that includes two or more hospitals and a provider group.

(5) ''Termination'' means the contractual relationship between the insurer and the primary care provider, specialist or provider organization has been severed due to the nonrenewal of the contract, closure, or bankruptcy of the primary care provider, specialist or the provider organization.

(*l*) The provisions of this section related to primary care providers are not applicable to an insurer contract that provides benefits to insureds through preferred provider contracting arrangements if the insurer does not require the insured to choose a primary care provider and does not have a process for automatically assigning a primary care provider.

~~SEC. 16.~~

SEC. 14. 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.

~~SEC. 17.~~

SEC. 15. This act shall become operative only if Senate Bill 244 of the 2003–04 Regular Session is enacted and becomes effective, and shall become operative on the date on which Senate Bill 244 of the 2003–04 Regular Session is enacted and becomes effective.

CORRECTIONS

Text — Pages 15, 25, and 26.

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