

AMENDED IN ASSEMBLY JANUARY 4, 2006

CALIFORNIA LEGISLATURE—2005—06 REGULAR SESSION

ASSEMBLY BILL

No. 1744

Introduced by Committee on Health (Chan (Chair), Aghazarian (Vice Chair), Berg, Cohn, Frommer, Gordon, Jones, Montanez, Ridley-Thomas, and Strickland)

March 2, 2005

An act to amend Section 1345 of the Health and Safety Code, relating to health care service plans, and to repeal Sections 1371.36, 1371.37, 1371.38, and 1371.39 of the Health and Safety Code, and to repeal Section 14005.20 of the Welfare and Institutions Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 1744, as amended, Committee on Health. ~~Preferred provider organization.~~ *Health care.*

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. The act defines "health care service plan" and various other terms for its purposes.

This bill would define "preferred provider organization" for purposes of the act.

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

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

- 1 SECTION 1. Section 1345 of the Health and Safety Code is
- 2 amended to read:
- 3 1345. As used in this chapter:

1 (a) “Advertisement” means any written or printed
2 communication or any communication by means of recorded
3 telephone messages or by radio, television, or similar
4 communications media, published in connection with the offer or
5 sale of plan contracts.

6 (b) “Basic health care services” means all of the following:

7 (1) Physician services, including consultation and referral.

8 (2) Hospital inpatient services and ambulatory care services.

9 (3) Diagnostic laboratory and diagnostic and therapeutic
10 radiologic services.

11 (4) Home health services.

12 (5) Preventive health services.

13 (6) Emergency health care services, including ambulance and
14 ambulance transport services and out-of-area coverage. “Basic
15 health care services” includes ambulance and ambulance
16 transport services provided through the “911” emergency
17 response system.

18 (7) Hospice care pursuant to Section 1368.2.

19 (c) “Enrollee” means a person who is enrolled in a plan and
20 who is a recipient of services from the plan.

21 (d) “Evidence of coverage” means any certificate, agreement,
22 contract, brochure, or letter of entitlement issued to a subscriber
23 or enrollee setting forth the coverage to which the subscriber or
24 enrollee is entitled.

25 (e) “Group contract” means a contract which by its terms
26 limits the eligibility of subscribers and enrollees to a specified
27 group.

28 (f) “Health care service plan” or “specialized health care
29 service plan” means either of the following:

30 (1) Any person who undertakes to arrange for the provision of
31 health care services to subscribers or enrollees, or to pay for or to
32 reimburse any part of the cost for those services, in return for a
33 prepaid or periodic charge paid by or on behalf of the subscribers
34 or enrollees.

35 (2) Any person, whether located within or outside of this state,
36 who solicits or contracts with a subscriber or enrollee in this state
37 to pay for or reimburse any part of the cost of, or who undertakes
38 to arrange or arranges for, the provision of health care services
39 that are to be provided wholly or in part in a foreign country in

1 return for a prepaid or periodic charge paid by or on behalf of the
2 subscriber or enrollee.

3 (g) “License” means, and “licensed” refers to, a license as a
4 plan pursuant to Section 1353.

5 (h) “Out-of-area coverage,” for purposes of paragraph (6) of
6 subdivision (b), means coverage while an enrollee is anywhere
7 outside the service area of the plan, and shall also include
8 coverage for urgently needed services to prevent serious
9 deterioration of an enrollee’s health resulting from unforeseen
10 illness or injury for which treatment cannot be delayed until the
11 enrollee returns to the plan’s service area.

12 (i) “Provider” means any professional person, organization,
13 health facility, or other person or institution licensed by the state
14 to deliver or furnish health care services.

15 (j) “Person” means any person, individual, firm, association,
16 organization, partnership, business trust, foundation, labor
17 organization, corporation, limited liability company, public
18 agency, or political subdivision of the state.

19 (k) “Service area” means a geographical area designated by
20 the plan within which a plan shall provide health care services.

21 (l) “Solicitation” means any presentation or advertising
22 conducted by, or on behalf of, a plan, where information
23 regarding the plan, or services offered and charges therefor, is
24 disseminated for the purpose of inducing persons to subscribe to,
25 or enroll in, the plan.

26 (m) “Solicitor” means any person who engages in the acts
27 defined in subdivision (l).

28 (n) “Solicitor firm” means any person, other than a plan, who
29 through one or more solicitors engages in the acts defined in
30 subdivision (l).

31 (o) “Specialized health care service plan contract” means a
32 contract for health care services in a single specialized area of
33 health care, including dental care, for subscribers or enrollees, or
34 which pays for or which reimburses any part of the cost for those
35 services, in return for a prepaid or periodic charge paid by or on
36 behalf of the subscribers or enrollees.

37 (p) “Subscriber” means the person who is responsible for
38 payment to a plan or whose employment or other status, except
39 for family dependency, is the basis for eligibility for membership
40 in the plan.

1 (q) Unless the context indicates otherwise, “plan” refers to
2 health care service plans and specialized health care service
3 plans.

4 (r) “Plan contract” means a contract between a plan and its
5 subscribers or enrollees or a person contracting on their behalf
6 pursuant to which health care services, including basic health
7 care services, are furnished; and unless the context otherwise
8 indicates it includes specialized health care service plan
9 contracts; and unless the context otherwise indicates it includes
10 group contracts.

11 ~~(s) “Preferred provider organization” means a health care~~
12 ~~service plan that negotiates and enters into a contract with a~~
13 ~~provider to provide services at alternative rates of payment, as~~
14 ~~described in Section 10133 of the Insurance Code.~~

15 *(s) “Preferred provider organization” means a health care*
16 *provider or an entity contracting with health care providers that*
17 *establishes alternative or discounted rates of payment, offers the*
18 *enrollees certain advantages for selecting the member providers,*
19 *or withholds from the enrollees certain advantages if they choose*
20 *providers other than the member providers.*

21 (t) All references in this chapter to financial statements, assets,
22 liabilities, and other accounting items mean those financial
23 statements and accounting items prepared or determined in
24 accordance with generally accepted accounting principles, and
25 fairly presenting the matters which they purport to present,
26 subject to any specific requirement imposed by this chapter or by
27 the director.

28 *SEC. 2. Section 1371.36 of the Health and Safety Code, as*
29 *added by Section 5 of Chapter 825 of the Statutes of 2000, is*
30 *repealed.*

31 ~~1371.36. (a) A health care service plan shall not deny~~
32 ~~payment of a claim on the basis that the plan, medical group,~~
33 ~~independent practice association, or other contracting entity did~~
34 ~~not provide authorization for health care services that were~~
35 ~~provided in a licensed acute care hospital and that were related to~~
36 ~~services that were previously authorized, if all of the following~~
37 ~~conditions are met:~~

38 ~~(1) It was medically necessary to provide the services at the~~
39 ~~time.~~

1 ~~(2) The services were provided after the plan's normal~~
2 ~~business hours.~~

3 ~~(3) The plan does not maintain a system that provides for the~~
4 ~~availability of a plan representative or an alternative means of~~
5 ~~contact through an electronic system, including voicemail or~~
6 ~~electronic mail, whereby the plan can respond to a request for~~
7 ~~authorization within 30 minutes of the time that a request was~~
8 ~~made.~~

9 ~~(b) This section shall not apply to investigational or~~
10 ~~experimental therapies, or other noncovered services.~~

11 *SEC. 3. Section 1371.37 of the Health and Safety Code, as*
12 *added by Section 6 of Chapter 825 of the Statutes of 2000, is*
13 *repealed.*

14 ~~1371.37. (a) A health care service plan is prohibited from~~
15 ~~engaging in an unfair payment pattern, as defined in this section.~~

16 ~~(b) Consistent with subdivision (a) of Section 1371.39, the~~
17 ~~director may investigate a health care service plan to determine~~
18 ~~whether it has engaged in an unfair payment pattern.~~

19 ~~(c) An "unfair payment pattern," as used in this section,~~
20 ~~means any of the following:~~

21 ~~(1) Engaging in a demonstrable and unjust pattern, as defined~~
22 ~~by the department, of reviewing or processing complete and~~
23 ~~accurate claims that results in payment delays.~~

24 ~~(2) Engaging in a demonstrable and unjust pattern, as defined~~
25 ~~by the department, of reducing the amount of payment or~~
26 ~~denying complete and accurate claims.~~

27 ~~(3) Failing on a repeated basis to pay the uncontested portions~~
28 ~~of a claim within the timeframes specified in Section 1371,~~
29 ~~1371.1, or 1371.35.~~

30 ~~(4) Failing on a repeated basis to automatically include the~~
31 ~~interest due on claims pursuant to Section 1371.~~

32 ~~(d) (1) Upon a final determination by the director that a~~
33 ~~health care service plan has engaged in an unfair payment~~
34 ~~pattern, the director may:~~

35 ~~(A) Impose monetary penalties as permitted under this~~
36 ~~chapter.~~

37 ~~(B) Require the health care service plan for a period of three~~
38 ~~years from the date of the director's determination, or for a~~
39 ~~shorter period prescribed by the director, to pay complete and~~
40 ~~accurate claims from the provider within a shorter period of time~~

1 than that required by Section 1371. The provisions of this
2 subparagraph shall not become operative until January 1, 2002.

3 (C) ~~Include a claim for costs incurred by the department in~~
4 ~~any administrative or judicial action, including investigative~~
5 ~~expenses and the cost to monitor compliance by the plan.~~

6 (2) ~~For any overpayment made by a health care service plan~~
7 ~~while subject to the provisions of paragraph (1), the provider~~
8 ~~shall remain liable to the plan for repayment pursuant to Section~~
9 ~~1371.1.~~

10 (e) ~~The enforcement remedies provided in this section are not~~
11 ~~exclusive and shall not limit or preclude the use of any otherwise~~
12 ~~available criminal, civil, or administrative remedy.~~

13 (f) ~~The penalties set forth in this section shall not preclude,~~
14 ~~suspend, affect, or impact any other duty, right, responsibility, or~~
15 ~~obligation under a statute or under a contract between a health~~
16 ~~care service plan and a provider.~~

17 (g) ~~A health care service plan may not delegate any statutory~~
18 ~~liability under this section.~~

19 (h) ~~For the purposes of this section, “complete and accurate~~
20 ~~claim” has the same meaning as that provided in the regulations~~
21 ~~adopted by the department pursuant to subdivision (a) of Section~~
22 ~~1371.38.~~

23 (i) ~~On or before December 31, 2001, the department shall~~
24 ~~report to the Legislature and the Governor information regarding~~
25 ~~the development of the definition of “unjust pattern” as used in~~
26 ~~this section. This report shall include, but not be limited to, a~~
27 ~~description of the process used and a list of the parties involved~~
28 ~~in the department’s development of this definition as well as~~
29 ~~recommendations for statutory adoption.~~

30 (j) ~~The department shall make available upon request and on~~
31 ~~its web site, information regarding actions taken pursuant to this~~
32 ~~section, including a description of the activities that were the~~
33 ~~basis for the action.~~

34 *SEC. 4. Section 1371.38 of the Health and Safety Code, as*
35 *added by Section 7 of Chapter 825 of the Statutes of 2000, is*
36 *repealed.*

37 ~~1371.38. (a) The department shall, on or before July 1, 2001,~~
38 ~~adopt regulations that ensure that plans have adopted a dispute~~
39 ~~resolution mechanism pursuant to subdivision (h) of Section~~
40 ~~1367. The regulations shall require that any dispute resolution~~

1 mechanism of a plan is fair, fast, and cost-effective for
2 contracting and noncontracting providers and define the term
3 “complete and accurate claim, including attachments and
4 supplemental information or documentation.”

5 (b) On or before December 31, 2001, the department shall
6 report to the Governor and the Legislature its recommendations
7 for any additional statutory requirements relating to plan and
8 provider dispute resolution mechanisms:

9 *SEC. 5. Section 1371.39 of the Health and Safety Code, as*
10 *added by Section 8 of Chapter 825 of the Statutes of 2000, is*
11 *repealed.*

12 ~~1371.39. (a) Providers may report to the department’s Office~~
13 ~~of Plan and Provider Relations, either through the toll-free~~
14 ~~provider line (877-525-1295) or e-mail address~~
15 ~~(plans-providers@dmhc.ca.gov), instances in which the provider~~
16 ~~believes a plan is engaging in an unfair payment pattern.~~

17 ~~(b) Plans may report to the department’s Office of Plan and~~
18 ~~Provider Relations, either through the toll-free provider line~~
19 ~~(877-525-1295) or e-mail address~~
20 ~~(plans-providers@dmhc.ca.gov), instances in which the plan~~
21 ~~believes a provider is engaging in an unfair billing pattern.~~

22 ~~(1) “Unfair billing pattern” means engaging in a demonstrable~~
23 ~~and unjust pattern of unbundling of claims, upcoding of claims,~~
24 ~~or other demonstrable and unjustified billing patterns, as defined~~
25 ~~by the department.~~

26 ~~(2) The department shall convene appropriate state agencies~~
27 ~~to make recommendations by July 1, 2001, to the Legislature and~~
28 ~~the Governor for the purpose of developing a system for~~
29 ~~responding to unfair billing patterns as defined in this section.~~
30 ~~This section shall include a process by which information is~~
31 ~~made available to the public regarding actions taken against~~
32 ~~providers for unfair billing patterns and the activities that were~~
33 ~~the basis for the action.~~

34 ~~(c) On or before December 31, 2001, the department shall~~
35 ~~report to the Legislature and the Governor information regarding~~
36 ~~the development of the definition of “unfair billing pattern” as~~
37 ~~used in this section. This report shall include, but not be limited~~
38 ~~to, a description of the process used and a list of the parties~~
39 ~~involved in the department’s development of this definition as~~
40 ~~well as recommendations for statutory adoption.~~

1 *SEC. 6. Section 14005.20 of the Welfare and Institutions*
2 *Code, as added by Section 18 of Chapter 147 of the Statutes of*
3 *1994, is repealed.*

4 ~~14005.20. (a) The State Department of Health Services shall~~
5 ~~adopt the option made available under Section 13603 of the~~
6 ~~federal Omnibus Budget Reconciliation Act of 1993 (Public Law~~
7 ~~103-66) to pay allowable tuberculosis-related services for persons~~
8 ~~infected with tuberculosis.~~

9 ~~(b) The income and resources of these persons may not exceed~~
10 ~~the maximum amount for a disabled person as described in~~
11 ~~Section 1902(a)(10)(A)(i) of Title XIX of the federal Social~~
12 ~~Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)).~~