ASSEMBLY BILL No. 2081

Introduced by Assembly Member Grove

February 17, 2016

An act to amend Section 1367 of the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 2081, as introduced, Grove. Health care service plans.

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. Existing law requires health care service plans and, if applicable, specialized health care service plans, to meet specified criteria, including requiring the appropriate licensure of facilities and personnel. Willful violation of that act a crime.

This bill would make technical, nonsubstantive changes to these provisions.

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

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

SECTION 1. Section 1367 of the Health and Safety Code is amended to read:

1367. A health care service plan and, if applicable, a specialized health care service plan shall meet the following requirements:

(a) Facilities located in this ~~state~~ *state,* including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by

the plan shall be licensed by the State Department of Public Health, where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(b) Personnel employed ~~by~~ *by,* or under contract ~~to~~ *with,* the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

(c) Equipment required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law.

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

(e) (1) All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.

(2) To the extent that telehealth services are appropriately provided through telehealth, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, these services shall be considered in determining compliance with Section 1300.67.2 of Title 28 of the California Code of Regulations.

(3) The plan shall make all services accessible and appropriate consistent with Section 1367.04.

(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

(h) (1) Contracts with subscribers and enrollees, including group contracts, and contracts with providers, and other persons furnishing services, equipment, or facilities ~~to~~ *to,* or in connection ~~with~~ *with,* the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes

to the plan, and requiring the plan to inform its providers upon contracting with the ~~plan,~~ *plan* or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.

(2) A health care service plan shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.

(3) ~~On and after January 1, 2002, a~~ *A* health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes.

(i) A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service consistent with Section 1367.006 or 1367.007, provided that the copayments, deductibles, or other cost sharing are reported to the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363. Nothing in this chapter shall prohibit a health care service plan from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

(j) *(1)* A health care service plan shall not require registration under the federal Controlled Substances Act (21 U.S.C. Sec. 801 et seq.) as a condition for participation by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 of the Business and Professions Code.

~~Nothing in this~~

(2) This section shall *not* be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services.

~~The~~

(3) The director's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.

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(4) The obligation of the plan to comply with this chapter shall not be waived when the plan delegates ~~any~~ services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.

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