

AMENDED IN ASSEMBLY MAY 10, 1995
AMENDED IN ASSEMBLY APRIL 25, 1995
AMENDED IN ASSEMBLY APRIL 17, 1995

CALIFORNIA LEGISLATURE—1995–96 REGULAR SESSION

ASSEMBLY BILL

No. 1152

**Introduced by Assembly Member Bordonaro
(Principal coauthor: Assembly Member Gallegos)**

February 23, 1995

An act to add Section 1373.95 to the Health and Safety Code, to amend Section 11512 of, and to add Section 10133.55 to, the Insurance Code, relating to health coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1152, as amended, Bordonaro. Health coverage: reimbursement of traditional or terminated provider.

Existing law provides for the licensure and regulation of health care service plans administered by the Commissioner of Corporations. Under existing law, willful violation of any of these provisions is a misdemeanor. Existing law also provides for the regulation of policies of disability insurance and nonprofit hospital service plan contracts administered by the Insurance Commissioner. Existing law requires that health care service plans, disability insurers, and nonprofit hospital service plans provide coverage for certain benefits and services.

This bill would require every health care service plan contract, nonprofit hospital service plan contract, or disability

insurance policy, issued, amended, delivered, or renewed on or after January 1, 1996, to, in certain circumstances, provide coverage or be responsible for payment for services provided by an enrollee’s or insured’s traditional provider, as defined, or terminated provider. By changing the definition of the crime applicable to health care service plans, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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

1 SECTION 1. The Legislature finds and declares all of
2 the following:

3 (a) The health care delivery system in California is
4 increasingly relying upon various forms of managed care
5 to control the costs of providing health care.

6 (b) “Closed panel” managed care programs, including
7 health care service plans, nonprofit hospital service plans,
8 and exclusive provider organizations offered by insurers,
9 substantially limit the freedom patients have to choose
10 their own providers of health care.

11 (c) Enrollment in a closed panel managed care
12 program often results in disruption of long-term,
13 traditional provider-patient relationships by requiring
14 the patients to transfer care to panel providers of the
15 managed care program who are unfamiliar with the
16 patient.

17 (d) Traditional, ongoing provider-patient
18 relationships, particularly for patients with chronic or
19 severe medical conditions, substantially contribute to the
20 quality of care received by those patients.

21 (e) There is a strong public interest in improving the
22 public health by enabling patients with ongoing health



1 care needs who are enrolled in closed panel managed
2 care programs to maintain their traditional, ongoing
3 provider-patient relationships for a reasonable period of
4 time after enrollment.

5 SEC. 2. Section 1373.95 is added to the Health and
6 Safety Code, immediately following Section 1373.9, to
7 read:

8 1373.95. (a) Every health care service plan,
9 including specialized health care service plans, shall, at
10 the enrollee's request, be responsible for payment for
11 health care services rendered by an enrollee's traditional
12 provider, other than for the plan's contracting provider
13 copayments, to the enrollee who is under a specific course
14 of care by the traditional provider, regardless of whether
15 the traditional provider is employed by or under contract
16 with the plan, under all of the following conditions:

17 (1) The services rendered relate only to a specific
18 course of care for an injury, illness, or condition for which
19 diagnosis, care, or treatment was recommended or
20 received by the enrollee from the enrollee's traditional
21 provider during the 12 months immediately preceding
22 the enrollee's effective date of enrollment with the plan.
23 *For purposes of this section, "an injury, illness, or*
24 *condition" means pregnancy or those injuries, illnesses,*
25 *or conditions that have resulted in, or if left untreated*
26 *could reasonably be expected to result in, any of the*
27 *following:*

28 (A) *Placing the patient's health in significant*
29 *jeopardy.*

30 (B) *Significant impairment to bodily functions or*
31 *mental health.*

32 (C) *Significant dysfunction of any bodily organ or*
33 *part.*

34 (2) The services rendered would otherwise be
35 covered by the plan under enrollee's plan contract if
36 provided or authorized by a provider employed by or
37 under contract with the plan, either directly or through
38 any medical group, independent practice association or
39 other contractual arrangement.



1 (3) The traditional provider shall be subject to the
2 same credentialing, utilization review and quality
3 assurance activities as are imposed upon the plan's
4 contracting providers.

5 (4) The rate of payment to the traditional provider for
6 the services rendered shall equal the plan's average rate
7 of payment for the same or similar services made to the
8 plan's contracting providers in the geographic area in
9 which the traditional provider's office is located.

10 (b) The duration of care by the traditional provider
11 shall continue until a time that the specific course of care
12 is completed. *If the course of care by the traditional*
13 *provider is not completed after a period of 18 months, the*
14 *plan may make a reasonable and medically appropriate*
15 *provision for the assumption of the services by a network*
16 *provider.*

17 (c) Nothing in this section shall be construed to
18 require a plan to provide coverage for a preexisting
19 condition unless the plan is required to do so under any
20 other applicable provision of law or unless the plan
21 otherwise would provide coverage for the preexisting
22 condition pursuant to the terms of the enrollee's plan
23 contract.

24 (d) "Traditional provider" means a provider, as
25 defined in subdivision (h) of Section 1345, from whom an
26 enrollee has received ongoing diagnosis, care, or
27 treatment for any injury, illness, or condition at any time
28 during the 12 months preceding the enrollee's effective
29 date of enrollment with the plan.

30 (e) A health care service plan shall, upon termination
31 of a provider contract, remain liable for covered services
32 rendered by the provider, other than for the plan's
33 contracting provider copayments, to an eligible enrollee
34 who is under a specific course of treatment by the
35 provider at the time of termination, and this liability shall
36 continue until the course of treatment is completed,
37 unless the plan makes a reasonable and medically
38 appropriate provision for the assumption of those services
39 by another contracting provider or the provider has been
40 terminated for reasons related to quality of care.



1 (f) *This section shall not apply to health plans that*
2 *offer the enrollee an out of network option under which*
3 *the enrollee is able to obtain services from the enrollee's*
4 *traditional provider.*

5 (g) *This section shall not apply if an enrollee*
6 *voluntarily changes plans.*

7 (h) This section shall apply to all plan contracts
8 issued, amended, renewed, or delivered on or after
9 January 1, 1996.

10 SEC. 3. Section 10133.55 is added to the Insurance
11 Code, to read:

12 10133.55. (a) Insurers, self-insured governmental
13 plans, as defined in Section 12671, and nonprofit hospital
14 service plans that negotiate and enter into contracts with
15 professional or institutional providers to provide services
16 at alternative rates of payment pursuant to Section 10133
17 or 11512 shall, in every policy or plan contract that limits
18 payments to services secured by insureds or enrollees
19 from professional or institutional providers charging
20 alternative rates, provide coverage, at the enrollee's
21 request, for health care services provided by an enrollee's
22 traditional provider, other than for the plan's contracting
23 provider copayments, to the enrollee who is under a
24 specific course of care by the traditional provider,
25 regardless of whether the traditional provider has
26 entered into an alternative rate contract with the insurer
27 or plan, under all of the following conditions:

28 (1) The services rendered relate only to a specific
29 course of care for an injury, illness, or condition for which
30 diagnosis, care, or treatment was recommended or
31 received by the insured or enrollee from the insured's or
32 enrollee's traditional provider during the 12 months
33 immediately preceding the insured's or enrollee's
34 effective date of enrollment under the policy or plan. *For*
35 *purposes of this section, "an injury, illness, or condition"*
36 *means pregnancy or those injuries, illnesses, or conditions*
37 *that have resulted in, or if left untreated could reasonably*
38 *be expected to result in, any of the following:*

39 (A) *Placing the patient's health in significant*
40 *jeopardy.*



1 (B) Significant impairment to bodily functions or
2 mental health.

3 (C) Significant dysfunction of any bodily organ or
4 part.

5 (2) The services rendered would otherwise be
6 covered under the policy or plan contract if provided or
7 authorized by a provider that has entered into an
8 alternative rate contract with the insurer or plan, either
9 directly or through any medical group, independent
10 practice association, or other contractual arrangement.

11 (3) The traditional provider shall be subject to the
12 same credentialing, utilization review, and quality
13 assurance activities as are imposed upon the insurer’s or
14 plan’s contracting providers.

15 (4) The rate of payment to the traditional provider for
16 the services rendered shall equal the insurer’s or plan’s
17 average rate of payment for the same or similar services
18 made to the insurer’s or plan’s contracting providers in
19 the geographic area in which the traditional provider’s
20 office is located.

21 (b) The duration of care by the traditional provider
22 shall continue until a time that the specific course of care
23 is completed. *If the course of care by the traditional
24 provider is not completed after a period of 18 months, the
25 insurer or plan may make a reasonable and medically
26 appropriate provision for the assumption of the services
27 by a network provider.*

28 (c) Nothing in this section shall be construed to
29 require an insurer or plan to provide coverage for a
30 preexisting condition unless the insurer or plan is
31 required to do so under any other applicable provision of
32 law or unless the insurer or plan otherwise would provide
33 coverage for the preexisting condition pursuant to the
34 terms of the insured’s policy or enrollee’s plan contract.

35 (d) “Traditional provider” means a professional or
36 institutional provider from whom an insured or enrollee
37 has received ongoing diagnosis, care, or treatment for any
38 injury, illness, or condition at any time during the 12
39 months preceding the insured’s or enrollee’s effective
40 date of enrollment under the policy or plan.



1 (e) Insurers, self-insured governmental plans as
2 defined in Section 12671, and nonprofit hospital service
3 plans that negotiate and enter into contracts with
4 professional or institutional providers to provide services
5 at alternative rates of payment pursuant to Section 10133
6 or 11512 shall, in every policy or plan contract that limits
7 payments to services secured by insureds or enrollees
8 from professional or institutional providers charging
9 alternative rates, provide for continued coverage for
10 covered services rendered by a provider upon
11 termination of the providers contract, other than for the
12 plan's contracting provider copayments, for an eligible
13 enrollee who is under a specific course of treatment by
14 the provider at the time of termination, and this liability
15 shall continue until the course of treatment is completed,
16 unless the plan makes a reasonable and medically
17 appropriate provision for the assumption of those services
18 by another contracting provider or the provider has been
19 terminated for reasons related to quality of care.

20 (f) *This section shall not apply to any policy or plan*
21 *contract that offers the insured or enrollee an out of*
22 *network option under which the insured or enrollee is*
23 *able to obtain services from the insured's or enrollee's*
24 *traditional provider.*

25 (g) *This section shall not apply if an enrollee*
26 *voluntarily changes plans.*

27 (h) This section shall apply to all policies or plan
28 contracts issued, amended, renewed, or delivered on or
29 after January 1, 1996.

30 SEC. 4. Section 11512 of the Insurance Code is
31 amended to read:

32 11512. No hospital service contract shall be entered
33 into between a corporation proposing to furnish or
34 provide any one or more of the services authorized under
35 this chapter and a subscriber:

36 (a) Unless the entire consideration therefor is
37 expressed in the contract;

38 (b) Unless the times at which the benefits or services
39 to the subscriber take effect and terminate are stated in



1 a portion of the contract above the evidence of its
2 execution;

3 (c) If the contract purports to entitle more than one
4 person to benefits or services except family hospital
5 service contracts issued under Section 11512.1, group
6 hospital service contracts issued under Section 11512.2
7 and blanket contracts issued under Section 11512.4;

8 (d) Unless every printed portion and any
9 endorsement or attached papers is plainly printed in type
10 of which the face is not smaller than 10 points;

11 (e) Except for group hospital service contracts and
12 blanket contracts issued under Section 11512.2, unless the
13 exceptions of the contract are printed with greater
14 prominence than the benefits to which they apply;

15 (f) Except for group hospital service contracts and
16 blanket contracts issued under Section 11512.2, unless, if
17 any portion of the contract purports, by reason of the
18 circumstances under which an illness, injury or
19 disablement is incurred to reduce any service to less than
20 that provided for the same illness, injury or disablement
21 incurred under ordinary circumstances, that portion is
22 printed in boldface type and with greater prominence
23 than any other text of the contract;

24 (g) If the contract contains any provisions purporting
25 to make any portion of the charter, constitution or bylaws
26 of a nonprofit corporation a part of the contract unless
27 that portion is set forth in full in the contract;

28 (h) Except for a comprehensive health care contract
29 issued under subdivision (e) of Section 11493, unless the
30 contract for hospital service contains in boldface type not
31 less than 10-point the following provisions:

32 Nothing in this contract contained shall in any way or
33 manner restrict or interfere with the right of any
34 individual entitled to hospital service and care hereunder
35 to select the contracting hospital or to make a free choice
36 of his or her attending physician, who shall be the holder
37 of a valid and unrevoked physician and surgeon's
38 certificate and who is a member of, or acceptable to, the
39 attending staff and board of directors of the hospital in



1 which said hospital services are to be provided and
2 rendered.

3 A contract need not contain the foregoing provisions of
4 this subdivision when a plan has negotiated and entered
5 into contracts for alternative rates of payment with
6 professional or institutional providers, and offers the
7 benefits of those alternative rates to group contractors or
8 individual subscribers who select those providers. A
9 contract need not contain the foregoing provisions when
10 a plan, by agreement with group contractors, limits
11 payments under a contract to services secured by
12 subscribers from professional or institutional providers
13 charging alternative rates pursuant to contract with that
14 plan.

15 (i) Contracts for alternative rates of payment with
16 institutional and professional providers made pursuant to
17 subdivision (h) of this section shall be executed in the
18 name of the plan and fully disclosed to the contracting
19 providers.

20 A contract which, by agreement with group
21 contractors, limits payments to services secured by
22 subscribers from providers charging alternative rates
23 shall meet *the requirements of* Section 10133.5 and
24 10133.55 of the Insurance Code.

25 A contract which, by agreement with group
26 contractors limits payments under a contract to services
27 secured by subscribers from institutional providers
28 charging alternative rates pursuant to contract with a
29 plan, and after July 1, 1983, to services secured by both
30 professional and institutional providers, shall include
31 programs for the continuous review of the quality of care,
32 performance of medical personnel, utilization of services
33 and facilities and costs by professionally recognized
34 unrelated third parties utilizing in the case of professional
35 providers similarly licensed providers for each medical
36 and dental service covered under the plan and utilizing
37 in the case of institutional providers appropriate
38 professional providers. All provisions of the laws of the
39 state relating to immunity from liability and discovery
40 privileges for medical and dental peer review shall apply



1 to the licensed providers performing the foregoing
2 activities.

3 Nothing in this section shall be construed to authorize
4 a plan to engage in the practice of medicine, or to exercise
5 medical or dental professional judgment.

6 (j) If ~~such~~ *the* contract contains coverage for
7 sterilization operations or procedures and it imposes any
8 disclaimer, restriction on, or limitation of coverage
9 relative to the insured's reason for sterilization. All
10 contracts entered into or renewed on or after March 7,
11 1973, shall be construed to be in compliance with this
12 section, and any provision in any contract that is in
13 conflict with this section shall be of no force or effect;

14 (k) Unless, in the case of a contract which provides
15 benefits that accrue after a certain time of confinement
16 in a health care facility, the contract specifies what
17 constitutes a day of confinement or the number of
18 consecutive hours of confinement which are requisite to
19 the commencement of benefits.

20 SEC. 5. No reimbursement is required by this act
21 pursuant to Section 6 of Article XIII B of the California
22 Constitution because the only costs that may be incurred
23 by a local agency or school district will be incurred
24 because this act creates a new crime or infraction,
25 eliminates a crime or infraction, or changes the penalty
26 for a crime or infraction, within the meaning of Section
27 17556 of the Government Code, or changes the definition
28 of a crime within the meaning of Section 6 of Article
29 XIII B of the California Constitution.

30 Notwithstanding Section 17580 of the Government
31 Code, unless otherwise specified, the provisions of this act
32 shall become operative on the same date that the act
33 takes effect pursuant to the California Constitution.

