

AMENDED IN SENATE AUGUST 29, 1995

AMENDED IN SENATE AUGUST 21, 1995

AMENDED IN SENATE JUNE 22, 1995

AMENDED IN ASSEMBLY JUNE 1, 1995

AMENDED IN ASSEMBLY MAY 30, 1995

AMENDED IN ASSEMBLY MAY 16, 1995

CALIFORNIA LEGISLATURE—1995–96 REGULAR SESSION

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**ASSEMBLY BILL**

**No. 1840**

**Introduced by Assembly Member Figueroa**

February 24, 1995

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An act to amend Sections 1367 and 1373.65 of, and to add Section 1371.25 to, the Health and Safety Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

AB 1840, as amended, Figueroa. Health care service plans: grievances: termination of providers: denial of services.

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 Commissioner of Corporations. Under existing law, violation of the Knox-Keene Health Care Service Plan Act of 1975 is a misdemeanor. Existing law requires plans to establish and maintain a grievance system for enrollees to submit grievances. Existing law requires plans to provide notice to group contractholders of the cancellation of

the plan contract. Existing law also provides procedures for the appeal of a contested claim.

This bill would require contracts with providers to contain provisions requiring a dispute resolution mechanism.

This bill would, with certain exceptions, require a plan, entity contracting with a plan, and providers to each be responsible for their own acts or omissions and not be liable for the acts or omissions of, or the costs of defending, others. This bill would declare that contractual provisions to the contrary are void and unenforceable.

Under existing law, when a plan terminates a contract with an individual provider within a medical group or individual practice association, an entire medical group, or an individual practice association, it is required to notify enrollees who have selected that provider, group, or association of the termination at that time.

This bill would, with certain exceptions, instead require enrollees who are receiving a course of treatment or who have selected a provider to be notified 30 days prior to the termination of the contract with an individual provider, or individual provider within a medical group or individual practice association, and would authorize the plan to request the group or association to notify the enrollees who are patients of a terminated individual provider.

By revising the definition of a crime, 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. Section 1367 of the Health and Safety
- 2 Code is amended to read:



1 1367. Each health care service plan, and where  
2 applicable, each specialized health care service plan, shall  
3 meet the following requirements:

4 (a) All facilities located in this state including, but not  
5 limited to, clinics, hospitals, and skilled nursing facilities  
6 to be utilized by the plan shall be licensed by the State  
7 Department of Health Services, ~~if such~~ *where* licensure  
8 is required by law. Facilities not located in this state shall  
9 conform to all licensing and other requirements of the  
10 jurisdiction in which they are located.

11 (b) All personnel employed by or under contract to  
12 the plan shall be licensed or certified by their respective  
13 board or agency, where ~~such~~ licensure or certification is  
14 required by law.

15 (c) All equipment required to be licensed or  
16 registered by law shall be so licensed or registered and the  
17 operating personnel for ~~such~~ *that* equipment shall be  
18 licensed or certified as required by law.

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

23 (e) All services shall be readily available at reasonable  
24 times to all enrollees. To the extent feasible, the plan shall  
25 make all services readily accessible to all enrollees.

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

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

36 (h) All contracts with subscribers and enrollees,  
37 including group contracts, and all contracts with  
38 providers, and other persons furnishing services,  
39 equipment, or facilities to or in connection with the plan,  
40 shall be fair, reasonable, and consistent with the



1 objectives of this chapter. All contracts with providers  
2 shall contain provisions requiring a dispute resolution  
3 mechanism under which providers may submit disputes  
4 to the plan, and requiring the plan to inform its providers  
5 upon contracting with the plan, or upon change to these  
6 provisions, of the procedures for processing and resolving  
7 disputes, including the location and telephone number  
8 where information regarding disputes may be submitted.

9 (i) Each health care service plan contract shall  
10 provide to subscribers and enrollees all of the basic health  
11 care services included in subdivision (b) of Section 1345,  
12 except that the commissioner may, for good cause, by rule  
13 or order exempt a plan contract or any class of plan  
14 contracts from ~~such~~ *that* requirement. The commissioner  
15 shall by rule define the scope of each basic health care  
16 service which health care service plans shall be required  
17 to provide as a minimum for licensure under this chapter.  
18 Nothing in this chapter shall prohibit a health care service  
19 plan from charging subscribers or enrollees a copayment  
20 or a deductible for a basic health care service or from  
21 setting forth, by contract, limitations on maximum  
22 coverage of basic health care services, provided that ~~such~~  
23 *the* copayments, deductibles, or limitations are reported  
24 to, and held unobjectionable by, the commissioner and  
25 set forth to the subscriber or enrollee pursuant to the  
26 disclosure provisions of Section 1363.

27 Nothing in this section shall be construed to permit the  
28 commissioner to establish the rates charged subscribers  
29 and enrollees for contractual health care services.

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

34

35 SEC. 2. Section 1371.25 is added to the Health and  
36 Safety Code, immediately following Section 1371.2 to  
37 read:

38 1371.25. A plan, any entity contracting with a plan,  
39 and providers are each responsible for their own acts or  
40 omissions, and are not liable for the acts or omissions of,



1 or the costs of defending, others. Any provision to the  
2 contrary in a contract with providers is void and  
3 unenforceable. Nothing in this section shall preclude a  
4 finding of liability on the part of a plan, any entity  
5 contracting with a plan, or a provider, based on the  
6 doctrines of equitable indemnity, comparative  
7 negligence, contribution, or other *statutory or* common  
8 law bases for liability.

9 SEC. 3. Section 1373.65 of the Health and Safety Code  
10 is amended to read:

11 1373.65. (a) Thirty days prior to terminating a  
12 contract with an entire medical group or individual  
13 practice association, the plan shall provide written notice  
14 of the termination to enrollees who are at that time  
15 receiving a course of treatment from a provider of that  
16 medical group or individual practice association, or are  
17 designated as having selected that medical group or  
18 individual practice association for their care.

19 (b) When a plan terminates a contractual  
20 arrangement with an individual provider within a  
21 medical group or individual practice association, the plan  
22 may request that the medical group or individual practice  
23 association notify the enrollees who are patients of that  
24 provider of the termination.

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

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

32 SEC. 4. No reimbursement is required by this act  
33 pursuant to Section 6 of Article XIII B of the California  
34 Constitution because the only costs that may be incurred  
35 by a local agency or school district will be incurred  
36 because this act creates a new crime or infraction,  
37 eliminates a crime or infraction, or changes the penalty  
38 for a crime or infraction, within the meaning of Section  
39 17556 of the Government Code, or changes the definition



1 of a crime within the meaning of Section 6 of Article  
2 XIII B of the California Constitution.  
3 Notwithstanding Section 17580 of the Government  
4 Code, unless otherwise specified, the provisions of this act  
5 shall become operative on the same date that the act  
6 takes effect pursuant to the California Constitution.

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