

## Assembly Bill No. 1840

### CHAPTER 774

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.

[Approved by Governor October 11, 1995. Filed  
with Secretary of State October 12, 1995.]

#### LEGISLATIVE COUNSEL'S DIGEST

AB 1840, 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.

*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. Each health care service plan, and where applicable, each specialized health care service plan, shall meet the following requirements:

(a) All facilities located in this 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 Health Services, 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) All personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

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

(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) All contracts with subscribers and enrollees, including group contracts, and all contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a 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, 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.

(i) Each 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 commissioner may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The commissioner shall by rule define the scope of each basic health care service which health care service plans shall be 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 or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the commissioner and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

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

The commissioner'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.

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

1371.25. A plan, any entity contracting with a plan, and providers are each responsible for their own acts or omissions, and are not liable for the acts or omissions of, or the costs of defending, others. Any provision to the contrary in a contract with providers is void and unenforceable. Nothing in this section shall preclude a finding of liability on the part of a plan, any entity contracting with a plan, or a provider, based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability.

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

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

(b) When a plan terminates a contractual arrangement with an individual provider within a medical group or individual practice association, the plan may request that the medical group or



individual practice association notify the enrollees who are patients of that provider of the termination.

(c) 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.

(d) Notwithstanding subdivision (c), 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.

SEC. 4. 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.

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

