

Senate Bill No. 1151

CHAPTER 515

An act to amend Section 1345 of, and to add Section 1373.3 to, the Health and Safety Code, relating to health care service plans.

[Approved by Governor October 3, 1995. Filed
with Secretary of State October 4, 1995.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1151, Rosenthal. Health care service plans: service areas: primary care physicians: restrictions.

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 defines certain terms relating to health care service plans, including "basic health care services" to include emergency services including out-of-area coverage.

This bill would define out-of-area coverage, for purposes of this definition of basic health care services to also include certain urgently needed services. This bill would also require that enrollees be permitted to select as a primary care physician any available primary care physician who contracts with the plan in the service area, as defined, where the enrollee lives or works. 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 1345 of the Health and Safety Code is amended to read:

1345. As used in this chapter:

(a) "Advertisement" means any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or similar communications media, published in connection with the offer or sale of plan contracts.

(b) "Basic health care services" means all of the following:

(1) Physician services, including consultation and referral.



(2) Hospital inpatient services and ambulatory care services.
(3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance services and out-of-area coverage.

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

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

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

(f) “Health care service plan” means any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

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

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

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

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

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

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

(m) “Solicitor” means any person who engages in the acts defined in subdivision (k) of this section.

(n) “Solicitor firm” means any person, other than a plan, who through one or more solicitors engages in the acts defined in subdivision (k) of this section.



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

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

(q) Unless the context indicates otherwise, "plan" refers to health care service plans and specialized health care service plans.

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

(s) All references in this chapter to financial statements, assets, liabilities, and other accounting items mean those financial statements and accounting items prepared or determined in accordance with generally accepted accounting principles, and fairly presenting the matters which they purport to present, subject to any specific requirement imposed by this chapter or by the commissioner.

(t) This section shall become operative April 1, 1993.

SEC. 2. Section 1373.3 is added to the Health and Safety Code, immediately following Section 1373.2, to read:

1373.3. An enrollee shall not be prohibited from selecting as a primary care physician any available primary care physician who contracts with the plan in the service area where the enrollee lives or works. This section shall apply to any plan contract issued, amended, renewed, or delivered on or after January 1, 1996.

SEC. 3. 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.

