

**Introduced by Committee on Insurance (Senators Speier (Chair), Escutia, Figueroa, Hughes, Johnson, Johnston, Leslie, Lewis, Schiff, and Sher)**

February 25, 2000

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An act to amend Section 1375.4 of the Insurance Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

SB 2094, as introduced, Committee on Insurance. Health care service plans: risk-bearing organizations: financial solvency.

Existing law provides for the regulation and licensing of health care service plans by the Department of Managed Care, effective no later than July 1, 2000, or earlier pursuant to an executive order of the Governor.

Existing law requires every contract between a health care service plan and a risk-bearing organization, as defined, to include certain provisions concerning the risk-bearing organization's administrative and financial capacity, as of January 1, 2001, and requires the Director of the Department of Managed Care to adopt regulations on or before June 30, 2000, with respect to these provisions.

This bill would make a technical change by correcting an erroneous section reference.

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

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

1 SECTION 1. Section 1375.4 of the Health and Safety  
2 Code is amended to read:

3 1375.4. (a) Every contract between a health care  
4 service plan and a risk-bearing organization that is issued,  
5 amended, renewed, or delivered in this state on or after  
6 July 1, 2000, shall include provisions concerning the  
7 following, as to the risk-bearing organization's  
8 administrative and financial capacity, which shall be  
9 effective as of January 1, 2001:

10 (1) A requirement that the risk-bearing organization  
11 furnish financial information to the health care service  
12 plan or the plan's designated agent and meet any other  
13 financial requirements that assist the health care service  
14 plan in maintaining the financial viability of its  
15 arrangements for the provision of health care services in  
16 a manner that does not adversely affect the integrity of  
17 the contract negotiation process.

18 (2) A requirement that the health care service plan  
19 disclose information to the risk-bearing organization that  
20 enables the risk-bearing organization to be informed  
21 regarding the financial risk assumed under the contract.

22 (3) A requirement that the health care service plans  
23 provide payments of all risk arrangements, excluding  
24 capitation, within 180 days after close of the fiscal year.

25 (b) In accordance with subdivision (a) of Section 1344,  
26 the director shall adopt regulations on or before June 30,  
27 2000, to implement this section which shall, at a  
28 minimum, provide for the following:

29 (1) (A) A process for reviewing or grading  
30 risk-bearing organizations based on the following criteria:

31 (i) The risk-bearing organization meets criterion 1 if  
32 it reimburses, contests, or denies claims for health care  
33 services it has provided, arranged, or for which it is  
34 otherwise financially responsible in accordance with the  
35 timeframes and other requirements described in Section  
36 1371 and in accordance with any other applicable state  
37 and federal laws and regulations.



1 (ii) The risk-bearing organization meets criterion 2 if  
2 it estimates its liability for incurred but not reported  
3 claims pursuant to a method that has not been held  
4 objectionable by the director, records the estimate at  
5 least quarterly as an accrual in its books and records, and  
6 appropriately reflects this accrual in its financial  
7 statements.

8 (iii) The risk-bearing organization meets criterion 3 if  
9 it maintains at all times a positive tangible net equity, as  
10 defined in subdivision (e) of Section 1300.76 of Title 10 of  
11 the California Code of Regulations.

12 (iv) The risk-bearing organization meets criterion 4 if  
13 it maintains at all times a positive level of working capital  
14 (excess of current assets over current liabilities).

15 (B) A risk-bearing organization may reduce its  
16 liabilities for purposes of calculating tangible net equity,  
17 pursuant to clause (iii) of subparagraph (A), and working  
18 capital, pursuant to clause (iv) of subparagraph (A), by  
19 the amount of any liabilities the payment of which is  
20 guaranteed by a sponsoring organization pursuant to a  
21 qualified guarantee. A sponsoring organization is one that  
22 has a tangible net equity of a level to be established by the  
23 director that is in excess of all amounts that it has  
24 guaranteed to any person or entity. A qualified guarantee  
25 is one that meets all of the following:

26 (i) It is approved by a board resolution of the  
27 sponsoring organization.

28 (ii) The sponsoring organization agrees to submit  
29 audited annual financial statements to the plan within 120  
30 days of the end of the sponsoring organization's fiscal  
31 year.

32 (iii) The guarantee is unconditional except for a  
33 maximum monetary limit.

34 (iv) The guarantee is not limited in duration with  
35 respect to liabilities arising during the term of the  
36 guarantee.

37 (v) The guarantee provides for six months' advance  
38 notice to the plan prior to its cancellation.

39 (2) The information required from risk-bearing  
40 organizations to assist in reviewing or grading these



1 risk-bearing organizations, including balance sheets,  
2 claims reports, and designated annual, quarterly, or  
3 monthly financial statements prepared in accordance  
4 with generally accepted accounting principles, to be used  
5 in a manner, and to the extent necessary, provided to a  
6 single external party as approved by the director to the  
7 extent that it does not adversely affect the integrity of the  
8 contract negotiation process between the health care  
9 service plan and the risk-bearing organizations.

10 (3) Audits to be conducted in accordance with  
11 generally accepted auditing standards and in a manner  
12 that avoids duplication of review of the risk-bearing  
13 organization.

14 (4) A process for corrective action plans, as mutually  
15 agreed upon by the health care service plan and the  
16 risk-bearing organization and as approved by the  
17 director, for cases where the review or grading indicates  
18 deficiencies that need to be corrected by the risk-bearing  
19 organization, and contingency plans to ensure the  
20 delivery of health care services if the corrective action  
21 fails. The corrective action plan shall be approved by the  
22 director and standardized, to the extent possible, to meet  
23 the needs of the director and all health care service plans  
24 contracting with the risk-bearing organization. If the  
25 health care service plan and the risk-bearing organization  
26 are unable to determine a mutually agreeable corrective  
27 action plan, the director shall determine the corrective  
28 action plan.

29 (5) The disclosure of information by health care  
30 service plans to the risk-bearing organization that enables  
31 the risk-bearing organization to be informed regarding  
32 the risk assumed under the contract, including:

33 (A) Enrollee information monthly.

34 (B) Risk arrangement information, information  
35 pertaining to any pharmacy risk assumed under the  
36 contract, information regarding incentive payments, and  
37 information on income and expenses assigned to the  
38 risk-bearing organization quarterly.

39 (6) Periodic reports from each health care service plan  
40 to the director that include information concerning the



1 risk-bearing organizations and the type and amount of  
2 financial risk assumed by them, and, if deemed necessary  
3 and appropriate by the director, a registration process for  
4 the risk-bearing organizations.

5 (7) The confidentiality of financial and other records  
6 to be produced, disclosed, or otherwise made available,  
7 unless as otherwise determined by the director.

8 (c) The failure by a health care service plan to comply  
9 with the contractual requirements pursuant to this  
10 section shall constitute grounds for disciplinary action.  
11 The director shall, as appropriate, within 60 days after  
12 receipt of documented validation from a risk-bearing  
13 organization, investigate and take enforcement action  
14 against a health care service plan that fails to comply with  
15 these requirements and shall periodically evaluate  
16 contracts between health care service plans and  
17 risk-bearing organizations to determine if any audit,  
18 evaluation, or enforcement actions should be undertaken  
19 by the department.

20 (d) The Financial Solvency Standards Board  
21 established in Section ~~1347.1~~ 1347.15 shall study and  
22 report to the director on or before January 1, 2001,  
23 regarding all of the following:

24 (1) The feasibility of requiring that there be in force  
25 insurance coverage commensurate with the financial risk  
26 assumed by the risk-bearing organization to protect  
27 against financial losses.

28 (2) The appropriateness of different risk-bearing  
29 arrangements between health care service plans and  
30 risk-bearing organizations.

31 (3) The appropriateness of the four criteria specified  
32 in paragraph (1) of subdivision (b).

33 (e) This section shall not apply to specialized health  
34 care service plans.

35 (f) For purposes of this section, “provider  
36 organization” means a medical group, independent  
37 practice association, or other entity that delivers,  
38 furnishes, or otherwise arranges for or provides health  
39 care services, but does not include an individual or a plan.



1 (g) (1) For the purposes of this section, a  
2 “risk-bearing organization” means a professional medical  
3 corporation, other form of corporation controlled by  
4 physicians and surgeons, a medical partnership, a medical  
5 foundation exempt from licensure pursuant to  
6 subdivision (l) of Section 1206, or another lawfully  
7 organized group of physicians that delivers, furnishes, or  
8 otherwise arranges for or provides health care services,  
9 but does not include an individual or a health care service  
10 plan, and that does all of the following:

11 (A) Contracts directly with a health care service plan  
12 or arranges for health care services for the health care  
13 service plan’s enrollees.

14 (B) Receives compensation for those services on any  
15 capitated or fixed periodic payment basis.

16 (C) Is responsible for the processing and payment of  
17 claims made by providers for services rendered by those  
18 providers on behalf of a health care service plan that are  
19 covered under the capitation or fixed periodic payment  
20 made by the plan to the risk-bearing organization.  
21 Nothing in this subparagraph in any way limits, alters, or  
22 abrogates any responsibility of a health care service plan  
23 under existing law.

24 (2) Notwithstanding paragraph (1), risk-bearing  
25 organizations shall not be deemed to include a provider  
26 organization that meets either of the following  
27 requirements:

28 (A) The health care service plan files with the  
29 department consolidated financial statements that  
30 include the provider organization.

31 (B) The health care service plan is the only health care  
32 service plan with which the provider organization  
33 contracts for arranging or providing health care services  
34 and, during the previous and current fiscal years, the  
35 provider organization’s maximum potential expenses for  
36 providing or arranging for health care services did not  
37 exceed 115 percent of its maximum potential revenue for  
38 providing or arranging for those services.

39 (h) For purposes of this section, “claims” include, but  
40 are not limited to, contractual obligations to pay



1 capitation or payments on a managed hospital payment  
2 basis.

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