

ASSEMBLY BILL

No. 1600

Introduced by Assembly Member Keeley

February 23, 2001

An act to add Title 9.6 (commencing with Section 1299.20) to Part 3 of the Code of Civil Procedure, to amend Section 1367 of, and to add Section 1367.001 to, the Health and Safety Code, and to add Section 10178.4 to the Insurance Code, relating to arbitration.

LEGISLATIVE COUNSEL'S DIGEST

AB 1600, as introduced, Keeley. Arbitration: health care provider disputes.

Existing law provides, in general, for contract arbitration, and establishes special provisions for the arbitration of certain issues.

This bill would establish special provisions for the arbitration of health care provider disputes and would set forth the findings and declarations of the Legislature in this regard.

Existing law, contained in the Knox-Keene Health Care Service Plan Act of 1975, sets forth the process for the review of disputes with a health care service plan by health care providers concerning health care services provided to plan enrollees, as specified. A violation of the provisions of that act is a misdemeanor.

This bill would revise various requirements for the operation of a dispute resolution process to deal with provider disputes concerning matters arising out of plan-provider contracts and to conform with the bill's arbitration provisions. The bill would make certain conduct by a health care service plan directed at providers unlawful.

Existing law provides for the regulation of disability insurers by the Insurance Commissioner.

This bill would establish parallel dispute resolution provisions to govern a dispute between providers and insurers issuing policies of disability insurance, and would make health care provider disputes with disability insurers subject to the bill’s arbitration provisions. This bill would make certain conduct by a disability insurer directed at providers unlawful.

Because this bill would revise the requirements for the establishment and operation of a dispute resolution procedure by a health care service plan and would make certain actions by a plan directed at providers unlawful, this bill would create a state-mandated local program by creating new crimes and changing the definitions of existing crimes.

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. Title 9.6 (commencing with Section 1299.20) is
2 added to Part 3 of the Code of Civil Procedure, to read:

3

4 TITLE 9.6. ARBITRATION OF HEALTH CARE
5 PROVIDER DISPUTES

6

7 CHAPTER 1. LEGISLATIVE FINDINGS

8

9 1299.20. The findings and declarations of legislative intent
10 contained in this chapter govern the construction of this title.

11 1299.21. It is the policy of the State of California to ensure
12 that its citizens have access to health care that is both cost effective
13 and of high quality.

14

15 CHAPTER 2. ARBITRATION

16

17 1299.40. Any dispute resolution process established by a
18 health care service plan pursuant to Section 1367 of the Health and



1 Safety Code or by an insurer pursuant to Section 10178.4 of the
2 Insurance Code shall provide that a provider may either file a civil
3 action pursuant to this code or, by written notification to the plan,
4 request that their differences be submitted to an arbitration panel,
5 whenever any of the following events occur:

6 (a) The parties have been participating in the process for more
7 than 30 days.

8 (b) The parties are unable to agree to the appointment of a
9 mediator.

10 (c) If a mediator agreed to by the parties is unable to effect
11 settlement of a dispute between the parties within 30 days after his
12 or her appointment.

13 1299.41. Within three days after receipt of the written
14 notification, unless the parties otherwise agree to a single
15 arbitrator, each party shall designate a person to serve as its
16 member of an arbitration panel. Within five days thereafter, or
17 within additional periods to which they mutually agree, the two
18 members of the arbitration panel appointed by the parties shall
19 designate an impartial person to act as chairperson of the
20 arbitration panel.

21 1299.42. In the event that the parties are unable or unwilling
22 to agree upon a third person to serve as chairperson, the two
23 members of the arbitration panel shall jointly request from the
24 American Arbitration Association a list of seven impartial and
25 experienced persons who are familiar with matters concerning
26 health care contracting. The two panel members may, as an
27 alternative, jointly request a list of seven names from the
28 California State Mediation and Conciliation Service, or a list from
29 either entity containing more or less than seven names, so long as
30 the number requested is an odd number. If after five days of receipt
31 of the list, the two panel members cannot agree on which of the
32 listed persons shall serve as chairperson, they shall, within two
33 days, alternately strike names from the list, with the first panel
34 member to strike names being determined by lot. The last person
35 whose name remains on the list shall be chairperson.

36 1299.43. All parties to an arbitration shall have the right to
37 counsel and full and comprehensive discovery coextensive with
38 Article 3 (commencing with Section 2016) of Chapter 3 of Title
39 3 of Part 4. In addition, no health care service plan or disability
40 insurer may shorten the applicable statute of limitations provided



1 for arbitration under this code, and there shall be no limitations on
2 the amount or nature of damages that may be awarded in an
3 arbitration other than those that would otherwise be recoverable
4 under a court of law.

5 1299.44. The arbitration panel shall, within 10 days after its
6 establishment or any additional periods to which the parties agree,
7 meet with the parties or their representatives, either jointly or
8 separately, make inquiries and investigations, hold hearings, and
9 take any other action that the arbitration panel deems appropriate.

10 1299.45. The arbitration panel shall direct that five days prior
11 to the commencement of its hearings, each of the parties shall
12 submit the last best offer of settlement as to each of the issues that
13 are in dispute. The arbitration panel, within 15 days after the
14 conclusion of the hearing, or any additional period as to which the
15 parties agree, shall separately decide on each of the disputed issues
16 submitted by selecting, without modification, the last best offer of
17 settlement that most nearly complies with the applicable factors
18 described in Section 1299.46.

19 1299.46. The factors to be considered by the arbitrator or
20 arbitration panel when considering each party's last best offer of
21 settlement shall include, but not be limited to:

- 22 (a) The stipulations of the parties.
- 23 (b) The interest and welfare of patients.
- 24 (c) The patients' access to care.
- 25 (d) The ability of providers to render quality health care
26 services.
- 27 (e) The cost of providing the services, taking into consideration
28 the increasing age of the population, new pharmaceuticals, the
29 increasing sophistication of medical technology, and the medical
30 demographics of the population of the plan's enrollees.
- 31 (f) The reasonableness of the reimbursement rates, particularly
32 when compared to utilization levels and costs of services to be
33 provided under the contract, adjusted for geographic region and
34 the benefit plan. If capitated payments are involved, the actuarial
35 soundness of the rates based on the appropriate reimbursement
36 rates set forth above should be compared.
- 37 (g) Any supplemental information as the arbitration panel may
38 deem necessary or proper to enable it to reach a determination.



1 (h) The ability of the provider to continue to provide health care
2 to patients and to avoid bankruptcy, closure, financial insolvency,
3 or contract termination.

4 1299.47. The arbitration panel shall mail or otherwise deliver
5 a copy of the decision to the parties. However, the decision of the
6 arbitration panel shall not be binding, for a period of five days after
7 service to the parties. During that five-day period, the parties may
8 meet privately, attempt to resolve their differences and, by mutual
9 agreement, amend or modify the decision of the arbitration panel.

10 1299.48. At the conclusion of the five-day period, which may
11 be extended by mutual agreement of the parties, the arbitration
12 panel's decision, as may be amended or modified by the parties,
13 shall be binding on all parties.

14 1299.49. Each party to the arbitration shall pay his or her pro
15 rata share of the expenses and fees of the arbitrator, together with
16 other expenses of the arbitration incurred or approved by the
17 arbitrator, not including counsel fees or witness fees or other
18 expenses incurred by a party for his or her own benefit.

19 1299.50. Except as otherwise provided in this title, the
20 conduct of the arbitration shall be governed pursuant to Chapter
21 3 (commencing with Section 1282) and Chapter 4 (commencing
22 with Section 1285) of Title 9, and any party may petition the court
23 to confirm, correct, modify, or vacate the arbitration award
24 decision as set forth therein. Any award shall be made retroactive
25 to the date the provider initiated the dispute resolution process with
26 the plan.

27 1299.51. Notwithstanding Section 1285, the court, when
28 considering an arbitration award issued pursuant to arbitration
29 under contracts entered into pursuant to Section 1367 of the Health
30 and Safety Code or Section 10178.4 of the Insurance Code shall,
31 in addition to its powers pursuant to Section 1286, consider
32 whether the award is supported by substantial evidence in light of
33 the factors set forth in Section 1367.001 of the Health and Safety
34 Code and Section 10178.4 of the Insurance Code, and shall modify
35 the award as necessary to ensure that the award is supported by
36 such evidence.

37 SEC. 2. Section 1367 of the Health and Safety Code is
38 amended to read:



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

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

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

13 (c) All equipment required to be licensed or registered by law
14 shall be so licensed or registered and the operating personnel for
15 that equipment shall be licensed or certified as required by law.

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

20 (e) (1) All services shall be readily available at reasonable
21 times to all enrollees. To the extent feasible, the plan shall make
22 all services readily accessible to all enrollees.

23 (2) To the extent that telemedicine services are appropriately
24 provided through telemedicine, as defined in subdivision (a) of
25 Section 2290.5 of the Business and Professions Code, these
26 services shall be considered in determining compliance with
27 Section 1300.67.2 of Title 10 of the California Code of
28 Regulations.

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

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

37 (h) (1) All contracts with subscribers and enrollees, including
38 group contracts, and all contracts with providers, and other
39 persons furnishing services, equipment, or facilities to or in
40 connection with the plan, shall be fair, reasonable, and consistent



1 with the objectives of this chapter. ~~All contracts with providers~~
2 ~~shall contain provisions requiring a~~ *plans shall establish a fast,*
3 *fair, and cost-effective dispute resolution mechanism under which*
4 *providers, individually or jointly, may submit disputes to the plan,*
5 ~~and requiring the~~ *at any time if they contend that the current or*
6 *proposed provider contracts, on their face or as implemented,*
7 *violate this section or any other provision of law, compromise*
8 *patient care; or are otherwise unfair or unreasonable.*

9 (2) *Matters subject to the dispute resolution process include all*
10 *those matters identified by the provider as being in dispute and*
11 *which arise out of the plan-health care professional contract, such*
12 *as, but not limited to:*

13 (i) *Services covered under the contract.*

14 (ii) *The definition or application of medical necessity and other*
15 *conditions of coverage.*

16 (iii) *Utilization review criteria and procedures, including*
17 *matters relating to prior authorization, and patient referral*
18 *standards, including those applicable to out-of-network referrals.*

19 (iv) *Clinical practice guidelines, medical management*
20 *policies, and quality assurance programs or audits.*

21 (v) *Drug formularies and standards and procedures for*
22 *prescribing off-formulary drugs.*

23 (vi) *The confidentiality of medical information.*

24 (vii) *Any matters that arise after a contract has been executed,*
25 *such as increased reimbursement for new technology and*
26 *pharmaceutical therapeutics, and new unanticipated uses of*
27 *existing technology.*

28 (viii) *Whether the current or proposed reimbursement or the*
29 *methodology for determining the payment for health care services*
30 *and supplies is disclosed, reasonable, or even adequate to cover*
31 *the cost of care.*

32 (ix) *Sudden costs of absorbing patients in the midst of, or*
33 *affected by delay of, care resulting from insolvencies of provider*
34 *organizations.*

35 (3) ~~The plan to~~ *shall inform its providers upon* when
36 *contracting with the plan, or upon change to these provisions,* of
37 *the procedures for processing and resolving disputes, including the*
38 *location and telephone number where information regarding*
39 *disputes may be submitted. All procedures shall also comply with*



1 Title 9.6 (commencing with Section 1299.20) of Part 3 of the Code
2 of Civil Procedure.

3 ~~(2)~~

4 (4) Each health care service plan shall ensure that a dispute
5 resolution mechanism is accessible to noncontracting providers
6 ~~for the purpose of resolving billing and claims disputes.~~

7 ~~(3).~~ Where providers jointly utilize the dispute resolution
8 process established by the plan, the providers shall designate one
9 person or entity to represent them. The provider may retain and
10 utilize counsel to represent them.

11 (5) On and after January 1, 2002, each health care service plan
12 shall annually submit a report to the department regarding its
13 dispute resolution mechanism. The report shall include
14 information on the number of providers who utilized the dispute
15 resolution mechanism and a summary of the disposition of those
16 disputes.

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

32 (j) No health care service plan shall require registration under
33 the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.)
34 as a condition for participation by an optometrist certified to use
35 therapeutic pharmaceutical agents pursuant to Section 3041.3 of
36 the Business and Professions Code.

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



1 The director’s enforcement of Article 3.1 (commencing with
2 Section 1357) shall not be deemed to establish the rates charged
3 subscribers and enrollees for contractual health care services.

4 SEC. 3. Section 1367.001 is added to the Health and Safety
5 Code, to read:

6 1367.001. It shall be unlawful for a health plan to do either of
7 the following:

8 (a) Impose or threaten to impose retaliation, such as contract
9 termination, on providers, discriminate or threaten to discriminate
10 against providers, or otherwise interfere with, restrain, or coerce
11 providers because of their exercise of their rights guaranteed by
12 Title 9.6 (commencing with Section 1299.20) of Part 3 of the Code
13 of Civil Procedure.

14 (b) Dominate or interfere with the ability of providers to jointly
15 utilize the dispute mechanisms established pursuant to Title 9.6
16 (commencing with Section 1299.20) of Part 3 of the Code of Civil
17 Procedure.

18 SEC. 4. Section 10178.4 is added to the Insurance Code, to
19 read:

20 10178.4. (a) Every insurer issuing group or individual
21 policies of disability insurance that covers hospital, medical, or
22 surgical expenses shall establish a fast, fair, and cost-effective
23 dispute resolution mechanism under which providers, individually
24 or jointly, may submit disputes to the insurer at any time if they
25 contend that the current or proposed provider contracts, on their
26 face or as implemented, violate any provision of law, compromise
27 patient care, or are otherwise unfair or unreasonable. The term
28 “provider” shall have the same meaning as set forth in Section
29 10178.3.

30 (b) Matters subject to the dispute resolution process include all
31 those matters identified by the provider as being in dispute and
32 which arise out of the insurer-health care professional contract,
33 such as, but not limited to:

34 (1) Services covered under the contract.

35 (2) The definition or application of medical necessity and other
36 conditions of coverage.

37 (3) Utilization review criteria and procedures, including
38 matters relating to prior authorization, and patient referral
39 standards, including those applicable to out-of-network referrals.



1 (4) Clinical practice guidelines, medical management policies,
2 and quality assurance programs or audits.

3 (5) Drug formularies and standards and procedures for
4 prescribing off-formulary drugs.

5 (6) The confidentiality of medical information.

6 (7) Any matters that arise after a contract has been executed,
7 such as increased reimbursement for new technology and
8 pharmaceutical therapeutics, and new unanticipated uses of
9 existing technology.

10 (8) Whether the current or proposed reimbursement or the
11 methodology for determining the payment for health care services
12 and supplies is disclosed, reasonable, or even adequate to cover the
13 cost of care.

14 (9) Sudden costs of absorbing patients in the midst of, or
15 affected by delay of, care resulting from insolvencies of provider
16 organizations.

17 (c) The insurer shall inform providers when contracting with
18 the insurer of the procedures for processing and resolving disputes,
19 including the location and telephone number where information
20 regarding disputes may be submitted. All procedures shall also
21 comply with Title 9.6 (commencing with Section 1299.20) of Part
22 3 of the Code of Civil Procedure.

23 (d) Each insurer shall ensure that a dispute resolution
24 mechanism is accessible to noncontracting providers. Where
25 providers jointly utilize the dispute resolution process established
26 by the plan, the providers shall designate one person or entity to
27 represent them. Providers may retain and utilize counsel to
28 represent them.

29 (e) On and after January 1, 2003, each insurer shall annually
30 submit a report to the department regarding its dispute resolution
31 mechanism. The report shall include information on the number
32 of providers who utilized the dispute resolution mechanism and a
33 summary of the disposition of those disputes.

34 (f) It shall be unlawful for an insurer to do any of the following:

35 (1) Impose or threaten to impose retaliation, such as contract
36 termination, on providers, discriminate or threaten to discriminate
37 against providers, or otherwise interfere with, restrain, or coerce
38 providers because of their exercise of their rights guaranteed by
39 Title 9.6 (commencing with Section 1299.20) of Part 3 of the Code
40 of Civil Procedure.



1 (2) Dominate or interfere with the ability of providers to jointly
2 utilize the dispute mechanisms established pursuant to Title 9.6
3 (commencing with Section 1299.20) of Part 3 of the Code of Civil
4 Procedure.

5 SEC. 5. No reimbursement is required by this act pursuant to
6 Section 6 of Article XIII B of the California Constitution because
7 the only costs that may be incurred by a local agency or school
8 district will be incurred because this act creates a new crime or
9 infraction, eliminates a crime or infraction, or changes the penalty
10 for a crime or infraction, within the meaning of Section 17556 of
11 the Government Code, or changes the definition of a crime within
12 the meaning of Section 6 of Article XIII B of the California
13 Constitution.

