AMENDED IN ASSEMBLY APRIL 23, 2001

CALIFORNIA LEGISLATURE—2001–02 REGULAR SESSION

ASSEMBLY BILL No. 1600

Introduced by Assembly Member Keeley
(Coauthor: Assembly Member Richman)

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 amended, 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:

SECTION 1. Title 9.6 (commencing with Section 1299.20) is added to Part 3 of the Code of Civil Procedure, to read:

TITLE 9.6. ARBITRATION OF HEALTH CARE PROVIDER DISPUTES

CHAPTER 1. LEGISLATIVE FINDINGS

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

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

CHAPTER 2. ARBITRATION

1299.40. Any dispute resolution process established by a health care service plan pursuant to Section 1367 of the Health and Safety Code or by an insurer pursuant to Section 10178.4 of the Insurance Code shall provide that a provider may either file a civil action pursuant to this code or, ~~by written notification to the plan,~~ *in the event the provider chooses not to file such an action, that both parties may* request that their differences be submitted to an arbitration panel, whenever any of the following events occur:

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

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

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

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

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

1299.43. All parties to an arbitration shall have the right to counsel and full and comprehensive discovery coextensive with Article 3 (commencing with Section 2016) of Chapter 3 of Title 3 of Part 4. In addition, no health care service plan or disability insurer may shorten the applicable statute of limitations provided for arbitration under this code, and there shall be no limitations on the amount or nature of damages that may be awarded in an arbitration other than those that would otherwise be recoverable under a court of law. *In addition, the arbitration panel may order a party, the party's attorney, or both, to pay reasonable expenses, including attorney's fees, incurred by another party as a result of bad faith actions or tactics that are frivolous or that are solely intended to cause unnecessary delay.*

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

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

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

(a) The stipulations of the parties.

(b) The interest and welfare of patients.

(c) The patients' access to care.

(d) The ability of providers to render quality health care services.

(e) The cost of providing the services, taking into consideration the increasing age of the population, new pharmaceuticals, the increasing sophistication of medical technology, and the medical demographics of the population of the plan's enrollees.

(f) The reasonableness of the reimbursement rates, particularly when compared to utilization levels and costs of services to be provided under the contract, adjusted for geographic region and the benefit plan. If capitated payments are involved, the actuarial soundness of the rates based on the appropriate reimbursement rates set forth above should be compared.

(g) Any supplemental information as the arbitration panel may deem necessary or proper to enable it to reach a determination.

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

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

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

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

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

1299.51. Notwithstanding Section 1285, the court, when considering an arbitration award issued pursuant to arbitration under contracts entered into pursuant to Section 1367 of the Health and Safety Code or Section 10178.4 of the Insurance Code shall, in addition to its powers pursuant to Section 1286, consider whether the award is supported by substantial evidence in light of

the factors set forth in Section 1367.001 of the Health and Safety Code and Section 10178.4 of the Insurance Code, and shall modify the award as necessary to ensure that the award is supported by such evidence.

1299.52. Nothing in this chapter is intended to impair the ability of a health care service plan or disability insurer to terminate a contractual relationship consistent with the principles enunciated by the California Supreme Court in Potvin v. Metropolitan Life Insurance Co. (2000) 22 Cal.4th 1060.

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

1367. Each health care service plan and, if 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) (1) 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.

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

(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) (1) 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. *Any contractual provision that requires providers to waive any provision set forth in this title, or any other provision of law, or that allows the plan to unilaterally amend the contract is void as contrary to public policy.* All plans shall establish a fast, fair, and cost-effective dispute resolution mechanism under which providers, individually or jointly, may submit disputes to the plan at any time if they contend that the current or ~~proposed~~ *renewal* provider contracts~~, on their face or as implemented,~~ violate this section or any other provision of law, compromise patient care; or are otherwise unfair or unreasonable.

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

(i) Services covered under the contract.

~~(ii) The definition or application of medical necessity and other conditions of coverage.~~

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

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

~~(v) Drug formularies and standards and procedures for prescribing off-formulary drugs.~~

~~(vi) The confidentiality of medical information.~~

~~(vii)~~

(ii) Any matters that arise after a contract has been executed, such as increased reimbursement for new technology and

pharmaceutical therapeutics, and new unanticipated uses of existing technology.

~~(viii)~~

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

~~(ix)~~

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

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

(4) Each health care service plan shall ensure that a dispute resolution mechanism is accessible to noncontracting providers *for the purpose of resolving billing and claims disputes*. Where providers jointly utilize the dispute resolution process established by the plan, the providers shall designate one person or entity to represent them. The provider may retain and utilize counsel to represent them.

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

(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 director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director 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 director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

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

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

The director'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. 3. Section 1367.001 is added to the Health and Safety Code, to read:

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

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

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

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

10178.4. (a) Every insurer issuing group or individual policies of disability insurance that covers hospital, medical, or surgical expenses shall establish a fast, fair, and cost-effective dispute resolution mechanism under which providers, individually or jointly, may submit disputes to the insurer at any time if they contend that the current or ~~proposed~~ *renewal* provider contracts~~, on their face or as implemented,~~ violate any provision of law, compromise patient care, or are otherwise unfair or unreasonable.

The term ‘‘provider’’ shall have the same meaning as set forth in Section 10178.3. *All contracts with providers shall be fair, reasonable, and consistent with the objectives of this section. Any contractual provision that requires providers to waive any provision set forth in this section or any other provision of law, or that allows the plan to unilaterally amend the contract is void as contrary to public policy.*

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

(1) Services covered under the contract.

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

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

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

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

(6) The confidentiality of medical information.

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

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

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

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

(d) Each insurer shall ensure that a dispute resolution mechanism is accessible to noncontracting providers *for the purpose of resolving billing and claims disputes.* Where providers jointly utilize the dispute resolution process established by the plan, the providers shall designate one person or entity to represent them. Providers may retain and utilize counsel to represent them.

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

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

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

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

SEC. 5. 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.

O