AMENDED IN SENATE AUGUST 20, 2001

AMENDED IN SENATE JULY 9, 2001

AMENDED IN SENATE JUNE 27, 2001

AMENDED IN SENATE JUNE 25, 2001

AMENDED IN ASSEMBLY JUNE 4, 2001

AMENDED IN ASSEMBLY MAY 24, 2001

AMENDED IN ASSEMBLY MAY 15, 2001

AMENDED IN ASSEMBLY APRIL 30, 2001

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 and repeal Section 1373.22~~ *amend Section 1394* of the Health and Safety Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

AB 1600, as amended, Keeley. Health care service plans~~: provider contracts~~.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation and licensure of health care service plans by the Department of Managed Health Care and makes a willful violation

of the act's provisions a crime. ~~The act, among other matters, requires that a plan's contracts with providers be fair, reasonable, and consistent with the act's objectives, which include ensuring that high-quality health care coverage is provided in the most efficient and cost-effective manner possible.~~

~~This bill would authorize health care providers on a class basis and health care service plans to negotiate any contract term or condition and upon an impasse, as defined, to submit the dispute to facilitated negotiation and, if unsuccessful, to refer the matter to advisory arbitration and would require the filing of the contract, facilitated negotiation agreement, or advisory arbitration award with the department. The bill would require the department to make public all parts of the contract which are not considered proprietary or confidential, and allow public comment. The bill would also require the department to approve, modify, or reject the contract, agreement, or award and to adopt regulations prior to July 1, 2002, pertaining to these facilitated negotiation and advisory arbitration processes. The bill would specify that its provisions become inoperative on July 1, 2004, and are repealed on January 1, 2005, unless a later enacted statute that is enacted before January 1, 2005, deletes or extends these dates.~~

~~Because this bill would specify requirements for the facilitated negotiation and advisory arbitration processes, the violation of which would be punishable as a misdemeanor offense, it would expand the scope of an existing crime, thereby imposing a state-mandated local program.~~ *Existing law provides that the civil, criminal, and administrative remedies available to the Director of the Department of Managed Health Care are not exclusive, and may be sought and employed in any combination deemed advisable by the director to enforce these provisions.*

This bill would allow any interested person to obtain equitable relief in any court of competent jurisdiction from any person or entity licensed under these provisions with respect to violations or threatened violations of these provisions, with certain exceptions. The bill would provide for the court to invite the parties to resolve their dispute through an independent external review process, as specified. The bill would require the department, by September 1, 2002, to accredit at least 3 independent external review organizations in this regard. The bill would provide that a waiver of these provisions is contrary to public policy and is therefore unenforceable and void. The bill would also declare that

certain of its provisions are declaratory of existing law. The bill would enact other related provisions.

Because willful violation of these provisions by health care service plans would be a crime, this bill would thereby 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.

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. (a) The Legislature finds and declares the~~

SECTION 1. Section 1394 of the Health and Safety Code is amended to read:

1394. *(a)* The civil, criminal, and administrative remedies available to the director pursuant to this article are not exclusive, and may be sought and employed in any combination deemed advisable by the director to enforce the provisions of this chapter.

(b) (1) Any interested person may obtain equitable relief from any licensee as to any violation or threatened violation of this chapter in any court of competent jurisdiction. This remedy is not exclusive, but is cumulative to other remedies or penalties available under all other laws of this state and under federal law.

(2) Within five days after the deadline set for the respondent or defendant to file its answer to an action brought pursuant to this subdivision, the court may invite the parties to consider resolving their dispute through an independent external review process. In order to utilize that process, the following shall apply:

(A) Both parties agree to submit their dispute to the independent external review process.

(B) The department shall not review the decision of the independent external review organization.

(C) The costs of the independent external review shall be borne equally by the parties. However, if the independent external review organization apportions fault between the parties, the costs shall

be apportioned between the parties based on the percentage outlined by the organization.

(D) The recommendation of the independent external review organization shall be in writing and shall describe the reasons for the recommendation.

(E) The independent external review organization shall complete its review and submit its written decision to the parties no later than 30 days from the time the dispute is submitted to it for independent external review, unless a later specified time is agreed to by the parties.

(3) The department, shall, by September 1, 2002, accredit at least three independent external review organizations. The department may, at its discretion grant and revoke accreditation, and shall develop, apply and enforce accreditation standards that ensure the independence of each organization and the qualifications and independence of its reviewers. In order to receive accreditation for the purposes of this subdivision, an organization shall meet all of the following requirements:

(A) The organization shall be an organization that has as its primary function the provision of mediation and arbitration services and that receives a majority of its revenues from these services.

(B) The organization shall submit to the department the following information upon initial application for accreditation and annually thereafter upon any change to any of the following information:

(i) The names of all stockholders and owners of more than 5 percent of any stock or options of the organization, if a publicly held organization.

(ii) The names of all holders of bonds or notes of the organization in excess of one hundred thousand dollars ($100,000), if any.

(iii) The names of all corporations and organizations that the organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business.

(iv) The names and biographical sketches of all directors, officers, executives, and reviewers of the organization, as well as a statement regarding any relationships its directors, officers, executives, and mediators may have with any health care service

plan, disability insurer, managed care organization, provider group, or board or committee.

(v) A description of the system the organization uses to identify and recruit reviewers, the number of reviewers credentialed and the types of cases the reviewers are credentialed to handle.

(vi) A description of the areas of expertise available from reviewers retained by the organization.

(vii) A description of how the organization ensures compliance with the conflict-of-interest provisions of this subdivision.

(4) If the court invites the parties to consider an independent external review process, the parties shall notify the court within 30 days if they have selected a mutually acceptable independent external review organization and appropriate reviewers. If the parties have not made their selection within 30 days, the action shall proceed. The court shall not draw any implication, favorable or otherwise, from the refusal by a party to accept the invitation by the court to consider utilizing an independent external review process.

(5) Nothing in this subdivision shall preclude the parties, by mutual consent, from using the independent external review process at any other time.

(6) (A) Notwithstanding any provision of law to the contrary, all time limits with respect to an action shall be tolled while the matter is pending in the independent external review process.

(B) Ninety days after the commencement of the review and every 90 days thereafter, the action shall be reactivated unless the parties to the action do either of the following:

(i) Arrive at a settlement and implement it in accordance with the provisions of current law.

(ii) Agree by written stipulation to extend the independent external review process for another 90-day period.

(C) Section 703.5 and Chapter 2 (commencing with Section 1115) of Division 9 of the Evidence Code apply to any review conducted pursuant to the subdivision.

(7) If the contract between a licensee and provider expires during the pendency of an action brought pursuant to this subdivision, the court shall issue an order extending the contract for a 180-day period, in order to provide continuing care to enrollees. The current contract rates and terms shall stay in effect during the 180-day period, subject to appropriate adjustment by

the court to ensure enrollee access to health care. This period may be extended by mutual agreement of the parties.

(8) It shall not be a defense in an action brought pursuant to this subdivision that a provision of this chapter that is at issue has been contractually waived. Provisions of contracts of health care service plans or their contracting intermediaries that require beneficiaries or providers to waive any provision of this chapter are prohibited and unenforceable.

(9) It shall be unlawful for a licensee to terminate, retaliate against, or otherwise penalize plan enrollees or providers for exercising their rights under this subdivision.

(10) This subdivision does not apply to disputes that are subject to Section 1368, 1368.01, 1368.02, 1368.03, 1368.04, 1368.1, 1370.4, 1374.30, 1374.31, 1374.32, 1374.33, 1374.34, 1374.35, or 1374.36.

(11) A health care service plan shall not seek indemnity, whether contractual or equitable, from a provider, employer, or employer group purchasing organization for any liability imposed pursuant to this subdivision.

(12) Any waiver of this subdivision is contrary to public policy and therefore shall be unenforceable and void.

(13) All provisions of this subdivision, other than those set forth in paragraphs (3) to (7), inclusive, confirm, and are declarative of, rather than constituting a change in, existing law.

SEC. 2. 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.

~~following:~~

~~(1) The principal priorities of the Legislature for health care are the following:~~

~~(A) The citizens of this state have access to the highest quality health care.~~

~~(B) Patients have the opportunity for continuing access to their own health care providers.~~

~~(C) Health care costs be reasonable and affordable.~~

~~(D) Administrative costs in the health care service plan and health care provider relationship be as low as possible in order to keep health care costs affordable.~~

~~(E) Health care service plans and health care providers remain financially solvent in order to provide the highest quality care and to retain patients' continuing access to their own health care providers.~~

~~(2) The current health care service plan and health care provider relationship is not satisfactorily meeting the state's health care priorities for the following reasons:~~

~~(A) There is evidence that some health care providers are choosing not to practice in California because of this relationship, thereby threatening the quality of, and access to, health care in this state.~~

~~(B) Some patients have not been able to have continuing access to their own health care providers because health care service plans and health care providers have been unable to reach agreement on contract extensions.~~

~~(C) Administrative costs in the health care service plan and health care provider relationship are still high, resulting in higher health care costs for both health care service plans and health care providers.~~

~~(D) A large number of providers have been economically failing, threatening the quality of, and access to, health care in this state and the continuity of care for patients.~~

~~(E) Too much of a health care provider's time is spent in the administrative aspects of the relationship, determining what care may be provided to patients and settling claims, thereby reducing the amount of time that providers spend with patients, increasing the cost of health care, reducing patient access to health care, and impairing the quality of care available.~~

~~(F) The negotiating relationship between health care service plans and health care providers is imbalanced.~~

~~(b) It is the intent of the Legislature to implement a solution to achieve the state's health care priorities, given the unsatisfactory relationship between health care service plans and health care providers. This solution would allow competing health care providers to renegotiate contracts with health care service plans, thereby allowing an improved balance in the contracting~~

~~relationship that should result in improvements in the state's priorities because of the interests of health care service plans and health care providers to resolve issues that are consistent with the interests of the state. This solution would displace unfair competitive practices and have an actively supervised state program to ensure that health care service plan contracts with health care providers are fair, reasonable, and provide appropriate reimbursement, consistent with the best interests of the patients and this act. The Legislature intends that this solution is consistent with the state action immunity doctrine, which establishes immunity from federal and state antitrust laws for conduct taken or supervised by a state. This solution does not authorize the health care providers to conduct a group boycott or to strike. Only activity specifically authorized by this bill shall receive immunity from antitrust liability.~~

~~SEC. 2. Section 1373.22 is added to the Health and Safety Code, to read:~~

~~1373.22. (a) (1) Health care providers, on a class basis, and health care service plans may agree to negotiate any contract term or condition upon renewal of a contract or during the contract term, if there is no provision for renegotiation. Any contract negotiated pursuant to this section shall be subject to the confirmation process set forth in subdivision (e). In the event a health care service plan declines to participate in these voluntary negotiations, no further action by the class that is reasonably related to the subject of the requested negotiations shall be permitted.~~

~~(2) Prior to commencing any negotiations authorized by this section, health care providers shall submit a statement to the Department of Managed Health Care indicating who will represent the providers in the negotiations, the type of licensure of the providers participating in the negotiations, and the number of providers who that person will represent in the negotiations. If the department finds that the nature of the representation is not in the best interest of enrollees or is otherwise inconsistent with the Knox-Keene Health Care Service Plan Act of 1975, it shall indicate the reasons for its findings and recommend changes to the representation to protect the best interest of enrollees and to conform with the provisions of the Knox-Keene Health Care Service Plan Act of 1975.~~

~~(b) In the event the parties reach an impasse during the negotiations, the parties, upon mutual agreement, may submit the issues in dispute to facilitated negotiation. For the purposes of this subdivision, an "impasse" means that the parties to a dispute have reached a point in meeting and negotiating where their differences in position are so substantial or prolonged that future meetings would be futile.~~

~~(c) In the event facilitated negotiation is unsuccessful, the matter may, upon mutual agreement by the parties, be referred to advisory arbitration. No advisory arbitration conducted pursuant to this section shall limit the rights and remedies otherwise available to the parties under common or statutory law. In addition, the arbitrator 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.~~

~~(d) The Department of Managed Health Care shall adopt regulations by July 1, 2002, that ensure that the facilitated negotiation and advisory arbitration processes described in this section are fair and effective. These regulations shall include a provision requiring that the facilitator and arbitrator be neutral and specify factors to be considered by the facilitator or arbitrator when resolving the issues that shall include, but not be limited to, the following:~~

~~(1) The stipulations of the parties.~~

~~(2) The interest and welfare of patients.~~

~~(3) The patient's access to care.~~

~~(4) The ability of health care providers to render quality health care services.~~

~~(5) 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, including risk adjustment for high concentrations of diseases with high treatment costs such as diabetes, multiple sclerosis, human immunodeficiency virus, and acquired immune deficiency syndrome.~~

~~(6) The reasonableness of the reimbursement rates.~~

~~(7) The impact on the costs of health care premiums to purchasers.~~

~~(e) Upon negotiation of a contract, the parties, or upon successful facilitated negotiation, the facilitator, or if the parties agree to advisory arbitration, the arbitrator, shall file a copy of the contract, facilitated negotiation agreement, or advisory arbitration award, a statement of reasons, and submitted evidence to the department for review. The department shall make public all parts of the contract which are not considered proprietary or confidential, and allow public comment. The department, after making an independent review of the evidence and considering public comment and the factors set forth in subdivision (d), shall approve, modify, or reject the contract, agreement, or award.~~

~~(f) For purposes of this section, the following definitions apply:~~

~~(1) ''Health care providers'' shall mean any health care professional licensed pursuant to, or group, corporation, or partnership of health care professionals lawfully organized under Division 2 (commencing with Section 500) of the Business and Professions Code or licensed pursuant to the Chiropractic or Osteopathic Initiative Acts. Health care providers shall also mean all primary care providers who agree to provide case management to Medi-Cal beneficiaries pursuant to Section 14088 and following of the Welfare and Institutions Code. Health care providers shall not include entities primarily organized as pharmacies or pharmacy corporations, and pharmacists licensed under Chapter 9 (commencing with Section 4000) of Division 2 of the Business and Professions Code.~~

~~(2) ''Health care service plan'' means any fully licensed health care service plan or specialized health care service plan that is licensed pursuant to this chapter.~~

~~(3) A representative may be a professional association, labor union, or any other person or entity designated by the class.~~

~~(4) ''Facilitated negotiation'' means any negotiation between the parties that utilizes a neutral, third party to resolve their differences for a contract renewal that is advisory in nature and subject to the approval, modification, or rejection of the Department of Managed Health Care.~~

~~(5) ''Advisory arbitration'' means any arbitration process that the parties utilize to resolve their differences for a contract renewal that is advisory in nature and subject to the approval, modification, or rejection of the Department of Managed Health Care.~~

~~(g) The Legislature does not intend for the dispute resolution procedures described in this section to have any application or legal effect other than as described in this section.~~

~~(h) On or after January 1, 2003, each health care service plan shall annually submit a report to the department regarding contract negotiations conducted pursuant to this section. The report shall include the number of providers who utilize the contract negotiation process and a summary of the disposition of those negotiations. The report shall also include information on the number of providers who sought to utilize the process, but did not because the health plan did not agree to the process.~~

~~(i) This section shall not affect the scope of practice of health care providers or the rights and responsibilities of health care providers mandated by law.~~

~~(j) This section shall not affect the operation of Section 16770 of the Business and Professions Code insofar as health care providers organized into a class pursuant to subdivision (b) shall not exclude from the class another health care provider where the ground for the exclusion is failure to possess the same license or certification as is possessed by the members of the class.~~

~~(k) This section shall become inoperative on July 1, 2004, and, as of January 1, 2005, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2005, deletes or extends the dates on which it becomes inoperative and is repealed.~~

~~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.~~

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