AMENDED IN ASSEMBLY APRIL 22, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 2400

Introduced by Assembly Member Ridley-Thomas

February 21, 2014

An act to *amend Section 1375.7 of, and to* add Section 1375.65 to, the Health and Safety Code, and to add Section 10133.651 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2400, as amended, Ridley-Thomas. Health care coverage: ~~physician~~ *provider* contracts.

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 Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law, *known as the Health Care Providers' Bill of Rights,* prescribes restrictions on the types of contractual provisions that may be included in agreements between health care service plans ~~or health insurers~~ and health care providers. *Under existing law, if a change is made by amending a manual, policy, or procedure document referenced in the contract between a plan and a provider, the plan is required to provide at least 45 business days' notice to the provider, as specified.*

Existing law establishes the California Health Benefit Exchange within state government, specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and small employers. Existing law provides for the Medi-Cal

program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services.

This bill would ~~prohibit a contract between a physician or physician group with a health care service plan or health insurer, that is issued, amended, delivered, or renewed in this state on or after January 1, 2015,~~ *require a health care service plan to provide at least 90 business days' notice to a contracting provider if a change is made by amending a manual, policy, or procedure document referenced in the contract. The bill would also prohibit a contract between a plan and a provider that is issued, amended, or renewed on or after January 1, 2015, from including any provision that would require a provider to accept or participate in any additional products or product networks, except as specified, or that would terminate the health care provider's contract, or the provider's eligibility to participate in other product networks, when the provider exercises the right to negotiate, accept, or refuse a material change to the contract. With respect to a physician or physician group that maintains, pursuant to a contract with a health care service plan or health insurer, an unspecified percentage of subscribers in either the Exchange or the Medi-Cal program, the bill would prohibit the contract between the physician or physician group and the plan or insurer* from including any provision that requires ~~a~~ *the* physician *or physician group*, as a condition of entering into the contract, to participate in any product that provides different rates, methods of payment, or lines of business unless that participation is negotiated and agreed to between the health care service plan or health insurer and the physician *or physician group*. The bill would require ~~any~~ *a* contract that contains a provision attempting to obligate the physician *or physician group* to participate in any product that provides different rates, methods of payment, or lines of business to contain a provision for each product permitting the physician *or physician group* to affirmatively agree to participate in each product. ~~The bill would state findings and declarations of the Legislature with respect to these provisions.~~

By expanding the scope of a crime *with respect to health care service plans*, this bill would create 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. Section 1375.65 is added to the Health and Safety Code, to read:

~~1375.65. (a) The Legislature finds and declares that prohibiting health care service plans from executing agreements with physicians that contain provisions requiring physicians to participate in all networks or products that are currently offered or that may be offered by the health plan without allowing physicians to affirmatively agree and opt-in to participate in each network or product will assist in maintaining patient access to adequate physician networks. The Legislature further finds and declares that the ability of physicians to exercise this choice will further protect patients as physicians will be able to decide on the merits of the product being offered and whether participation, in their reasonable professional judgment, would further patients' access to continuous quality of medical care.~~

~~(b)~~

1375.65. (a) A contract between a physician or physician group and a health care service plan that is issued, amended, delivered, or renewed in this state on or after January 1, 2015, shall not include any provision that requires ~~a~~ *the* physician *or physician group*, as a condition of entering into the contract, to participate in any product that provides different rates, methods of payment, or lines of business unless that participation is negotiated and agreed to between the health care service plan and the physician *or physician group*. Any contract that contains a provision attempting to obligate the physician *or physician group* to participate in any product that provides different rates, methods of payment, or lines of business shall contain a provision for each product permitting the physician *or physician group* to affirmatively agree to participate in each product. The status of a physician *or physician group* as a member of, or as being eligible for, other existing or new provider panels shall not be adversely

affected by the physician's *or physician group's* exercise of his or her *or its* right to not participate pursuant to this section.

(b) This section applies only to a physician or physician group that maintains, for the duration of the agreement, ____ percent of subscribers through either the Exchange or Medi-Cal.

(c) This section shall not apply to employee welfare benefit plans established pursuant to Section 302(c)(5) of the Taft-Hartley Act (29 U.S.C. Sec. 186(c)(5)).

(d) For purposes of this section, "Exchange" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

SEC. 2. Section 1375.7 of the Health and Safety Code is amended to read:

1375.7. (a) This section shall be known and may be cited as the Health Care Providers' Bill of Rights.

(b) ~~No~~ *A* contract issued, amended, or renewed on or after January 1, ~~2003~~ *2015*, between a plan and a health care provider for the provision of health care services to a plan enrollee or subscriber shall *not* contain any of the following terms:

(1) (A) Authority for the plan to change a material term of the contract, unless the change has first been negotiated and agreed to by the provider and the plan or the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. If a change is made by amending a manual, policy, or procedure document referenced in the contract, the plan shall provide ~~45~~ *90* business days' notice to the provider, and the provider has the right to negotiate and agree to the change. If the plan and the provider cannot agree to the change to a manual, policy, or procedure document, the provider has the right to terminate the contract prior to the implementation of the change. In any event, the plan shall provide at least ~~45~~ *90* business days' notice of its intent to change a material term, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter timeframe for compliance. However, if the parties mutually agree, the ~~45-business~~ *90-business* day notice requirement may be waived. Nothing in this subparagraph limits the ability of the parties to mutually agree to the proposed change at any time after the provider has received notice of the proposed change.

~~(B) If a contract between a provider and a plan provides benefits to enrollees or subscribers through a preferred provider arrangement, the contract may contain provisions permitting a material change to the contract by the plan if the plan provides at least 45 business days' notice to the provider of the change and the provider has the right to terminate the contract prior to the implementation of the change.~~

~~(C)~~

(B) If a contract between a noninstitutional provider and a plan provides benefits to enrollees or subscribers covered under the Medi-Cal or Healthy Families Program and compensates the provider on a fee-for-service basis, the contract may contain provisions permitting a material change to the contract by the plan, if the following requirements are met:

(i) The plan gives the provider a minimum of 90 business days' notice of its intent to change a material term of the contract.

(ii) The plan clearly gives the provider the right to exercise his or her intent to negotiate and agree to the change within 30 business days of the provider's receipt of the notice described in clause (i).

(iii) The plan clearly gives the provider the right to terminate the contract within 90 business days from the date of the provider's receipt of the notice described in clause (i) if the provider does not exercise the right to negotiate the change or no agreement is reached, as described in clause (ii).

(iv) The material change becomes effective 90 business days from the date of the notice described in clause (i) if the provider does not exercise his or her right to negotiate the change, as described in clause (ii), or to terminate the contract, as described in clause (iii).

(2) A provision that requires a health care provider to accept additional patients *or product networks* beyond the contracted number or in the absence of a number if, in the reasonable professional judgment of the provider, accepting additional patients *or product networks* would endanger patients' access to, or continuity of, care.

(3) A requirement to comply with quality improvement or utilization management programs or procedures of a plan, unless the requirement is fully disclosed to the health care provider at least 15 business days prior to the provider executing the contract. However, the plan may make a change to the quality improvement

or utilization management programs or procedures at any time if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. A change to the quality improvement or utilization management programs or procedures shall be made pursuant to paragraph (1).

(4) A provision that waives or conflicts with any provision of this chapter. A provision in the contract that allows the plan to provide professional liability or other coverage or to assume the cost of defending the provider in an action relating to professional liability or other action is not in conflict with, or in violation of, this chapter.

(5) A requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

(6) A requirement or provision that terminates the health care provider's contract or participation status in the contract, or the provider's eligibility to participate in other product networks, when the provider exercises the right to negotiate, accept, or refuse a material change to the contract pursuant to this section.

(7) A requirement that a health care provider agree to accept or participate in other products or product networks, including future products that have not yet been developed or adopted by the plan, without disclosing the reimbursement rate, method of payment, and any other materially different contract terms for those products from the underlying agreement and giving the provider the right to negotiate, accept, or refuse participation in each product or product network.

(c) With respect to a health care service plan contract covering dental services or a specialized health care service plan contract covering dental services, all of the following shall apply:

(1) If a material change is made to the health care service plan's rules, guidelines, policies, or procedures concerning dental provider contracting or coverage of or payment for dental services, the plan shall provide at least 45 business days' written notice to the dentists contracting with the health care service plan to provide services under the plan's individual or group plan contracts, including specialized health care service plan contracts, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter

timeframe for compliance. For purposes of this paragraph, written notice shall include notice by electronic mail or facsimile transmission. This paragraph shall apply in addition to the other applicable requirements imposed under this section, except that it shall not apply where notice of the proposed change is required to be provided pursuant to subparagraph (C) of paragraph (1) of subdivision (b).

(2) For purposes of paragraph (1), a material change made to a health care service plan's rules, guidelines, policies, or procedures concerning dental provider contracting or coverage of or payment for dental services is a change to the system by which the plan adjudicates and pays claims for treatment that would reasonably be expected to cause delays or disruptions in processing claims or making eligibility determinations, or a change to the general coverage or general policies of the plan that affect rates and fees paid to providers.

(3) A plan that automatically renews a contract with a dental provider shall annually make available to the provider, within 60 days following a request by the provider, either online, via email, or in paper form, a copy of its current contract and a summary of the changes described in paragraph (1) of subdivision (b) that have been made since the contract was issued or last renewed.

(4) This subdivision shall not apply to a health care service plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for the provision of professional medical services to the enrollees of the plan.

(d) (1) When a contracting agent sells, leases, or transfers a health provider's contract to a payor, the rights and obligations of the provider shall be governed by the underlying contract between the health care provider and the contracting agent.

(2) For purposes of this subdivision, the following terms shall have the following meanings:

(A) "Contracting agent" has the meaning set forth in paragraph (2) of subdivision (d) of Section 1395.6.

(B) "Payor" has the meaning set forth in paragraph (3) of subdivision (d) of Section 1395.6.

(e) Any contract provision that violates subdivision (b), (c), or (d) shall be void, unlawful, and unenforceable.

(f) The department shall compile the information submitted by plans pursuant to subdivision (h) of Section 1367 into a report and

submit the report to the Governor and the Legislature by March 15 of each calendar year.

(g) Nothing in this section shall be construed or applied as setting the rate of payment to be included in contracts between plans and health care providers.

(h) The changes made to this section by the act adding this subdivision shall not apply to employee welfare benefit plans established pursuant to Section 302(c)(5) of the Taft-Hartley Act (29 U.S.C. Sec. 186(c)(5)).

~~(h)~~

(i) For purposes of this section the following definitions apply:

(1) "Health care provider" means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

(2) "Material" means a provision in a contract to which a reasonable person would attach importance in determining the action to be taken upon the provision.

~~SEC. 2.~~

SEC. 3. Section 10133.651 is added to the Insurance Code, to read:

~~10133.651. (a) The Legislature finds and declares that prohibiting health insurers from executing agreements with physicians or physician groups that contain provisions requiring physicians to participate in all networks or products that are currently offered or that may be offered by the health insurer without allowing physicians to affirmatively agree and opt-in to participate in each network or product will assist in maintaining patient access to adequate physician networks. The Legislature further finds and declares that the ability of physicians to exercise this choice will further protect patients as physicians will be able to decide on the merits of the product being offered and whether participation, in their reasonable professional judgment, would further patients' access to continuous quality of medical care.~~

~~(b)~~

10133.651. (a) A contract between a physician or physician group and a health insurer that is issued, amended, delivered, or renewed in this state on or after January 1, 2015, shall not include any provision that requires ~~a~~ *the* physician *or physician group*, as a condition of entering into the contract, to participate in any

product that provides different rates, methods of payment, or lines of business unless that participation is negotiated and agreed to between the health insurer and the physician *or physician group*. Any contract that contains a provision attempting to obligate the physician *or physician group* to participate in any product that provides different rates, methods of payment, or lines of business shall contain a provision for each product permitting the physician *or physician group* to affirmatively agree to participate in each product. The status of a physician *or physician group* as a member of, or as being eligible for, other existing or new provider panels shall not be adversely affected by the physician's *or physician group's* exercise of his or her *or its* right to not participate pursuant to this section.

(b) This section applies only to a physician or physician group that maintains, for the duration of the agreement, ____ percent of subscribers through either the Exchange or Medi-Cal.

(c) This section shall not apply to employee welfare benefit plans established pursuant to Section 302(c)(5) of the Taft-Hartley Act (29 U.S.C. Sec. 186(c)(5)).

(d) For purposes of this section, "Exchange" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

~~SEC. 3.~~

SEC. 4. 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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