AMENDED IN ASSEMBLY MAY 6, 2014

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~~ *amend Section 10133.65 of* the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2400, as amended, Ridley-Thomas. Health care coverage: 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 *and authorizes health insurers to contract with providers for alternative rates of payment*. 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 *health care service* plan and a provider, the plan is required to provide at least 45 business days' notice to the provider *and the provider has the right to negotiate and agree to the change and terminate the contract prior to the change*, as specified,

except that if the contract between the plan and the provider provides benefits through a preferred provider arrangement, the provider only has the right to terminate the contract prior to the change. Existing law authorizes the contract between a health insurer and a provider to contain provisions permitting a material change to the contract by the insurer if the insurer provides at least 45 business days' notice to the provider.

~~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 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 *and would require that the provider under a preferred provider arrangement have the right to negotiate and agree to the change. The bill would authorize a contract between a provider and a health insurer for alternative rates of payment to contain provisions permitting a material change to the contract by the insurer if the insurer provides at least 90 business days' notice to the provider*. The bill would also prohibit a contract between a plan *or insurer* 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~~ *without making specified disclosures*, 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 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 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.~~

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) 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 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 1. 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) A contract issued, amended, or renewed on or after January 1, 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 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 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 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 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.~~ *agreement.*

(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)~~ *(B)* 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)).~~

~~(i)~~

(h) 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. 3. Section 10133.651 is added to the Insurance Code, to read:~~

~~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 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. 2. Section 10133.65 of the Insurance Code is amended to read:

10133.65. (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 health insurer and a health care provider for the provision of covered benefits at alternative rates of payment to an insured shall *not* contain any of the following terms:

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

(2) A requirement to comply with quality improvement or utilization management programs or procedures of a health insurer, 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 health insurer 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 subdivision (c).

(3) A provision that waives or conflicts with any provision of the Insurance Code.

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

(5) 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.

(6) 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.

(c) If a contract is with a health insurer that negotiates and arranges for alternative rates of payment with the provider to provide benefits to insureds, the contract may contain provisions permitting a material change to the contract by the health insurer if the health insurer provides at least ~~45~~ *90* business days' notice to the provider of the change, and the provider has the right to terminate the contract prior to implementation of the change.

(d) With respect to a health insurance policy covering dental services or a specialized health insurance policy covering dental services, all of the following shall apply:

(1) If a material change is made to the health insurer's rules, guidelines, policies, or procedures concerning dental provider contracting or coverage of or payment for dental services, the insurer shall provide at least 45 business days' written notice to the dentists contracting with the health insurer to provide services under the insurer's individual or group health insurance policies, including specialized health insurance policies. 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.

(2) For purposes of paragraph (1), a material change made to a health insurer'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 insurer adjudicates and pays claims for treatment that may cause delays or disruptions in processing claims or making eligibility determinations, or a change to the general coverage or general policies of the insurer that affect rates and fees paid to providers.

(3) An insurer 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 subdivision (c) that have been made since the contract was issued or last renewed.

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

(f) The Department of Insurance shall annually compile all provider complaints that it receives under this section, and shall report to the Legislature and the Governor the number and nature of those complaints 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 health insurers and health care providers.

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

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

(2) "Health insurer" means any admitted insurer writing health insurance, as defined in Section 106, that enters into a contract with a provider to provide covered benefits at alternative rates of payment.

(3) "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. 4.~~

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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