

AMENDED IN SENATE AUGUST 7, 2002

AMENDED IN SENATE JUNE 28, 2002

AMENDED IN SENATE JUNE 20, 2002

AMENDED IN ASSEMBLY MAY 14, 2002

AMENDED IN ASSEMBLY APRIL 11, 2002

CALIFORNIA LEGISLATURE—2001–02 REGULAR SESSION

ASSEMBLY BILL

No. 2907

**Introduced by Assembly Members Cohn and Thomson
(Coauthors: Assembly Members Corbett, Correa, Goldberg,
Pavley, Richman, and Steinberg)**

February 25, 2002

An act to ~~add Section 513 to the Business and Professions Code, and~~ to amend Section 1386 of, *and to add Section 1375.7 to, the Health and Safety Code, and to add Section 10133.65 to the Insurance Code,* relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2907, as amended, Cohn. Provider contracts.

The Knox-Keene Health Care Service Plan Act of 1975 provides for the regulation and licensing of health care service plans by the Department of Managed Health Care and makes the willful violation of any of its provisions a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, a plan and a health insurer are prohibited from including

certain provisions in a contract with a licensed health care practitioner regarding the practitioner’s provision of care to an enrollee or insured.

This bill would prohibit provisions in a contract between a health care service plan or health insurer and a health care provider, as defined, that would allow the plan or insurer to unilaterally change a material term of the contract without ~~complying with~~ *meeting* specified requirements, that would require the provider to accept additional patients if, in the provider’s *professional* judgment doing so would endanger patient care, subject to specified exceptions, and that would pertain to other specified aspects of the provider’s practice. The bill would provide that a contract violating any of these prohibitions would be void, unlawful, and unenforceable and would make a plan’s violation of these requirements grounds for disciplinary action. *The bill would authorize an individual provider to terminate a relationship with a patient under specified circumstances.* The bill would also require the Department of Insurance to report annually to the Legislature and the Governor complaints it receives concerning these requirements and would require the Department of Managed Health Care to report annually to the Legislature and the Governor information it receives from plans concerning their dispute resolution mechanism.

By creating new prohibitions applicable to health care service plans, the violation of which would be a crime, the bill would 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:

- 1 SECTION 1. Section ~~513~~ 1375.7 is added to the ~~Business and~~
- 2 ~~Professions~~ *Health and Safety Code*, to read:
- 3 ~~513.~~
- 4 1375.7. (a) This section shall be known and may be cited as
- 5 the Health Care Providers’ Bill of Rights.



1 (b) The purpose of this section is to ensure that health care
2 service plans ~~and health insurers~~ do not enter into contracts that
3 interfere with any ethical responsibility or legal right of health care
4 providers.

5 (c) No contract *issued, amended, or renewed on or after*
6 *January 1, 2003*, between a ~~health care service plan or health~~
7 ~~insurer plan~~ and a health care provider for the provision of health
8 care services to a plan enrollee or ~~an insured subscriber~~ shall
9 contain any of the following terms:

10 (1) (A) Authority for the ~~health care service plan or health~~
11 ~~insurer plan~~ to change a material term of the ~~contract, unless the~~
12 ~~contract requires at least 45 days' notice to the health care provider~~
13 ~~of the change and the provision change~~ has first been negotiated
14 and agreed to by the provider and the plan or ~~health insurer. the~~
15 ~~change is necessary to comply with state or federal law or~~
16 ~~regulations or any accreditation requirements of a private sector~~
17 ~~accreditation organization. In any event, the plan shall provide at~~
18 ~~least 45 business days' notice of its intent to change a material~~
19 ~~term, unless a change in state or federal law or regulations or any~~
20 ~~accreditation requirements of a private sector accreditation~~
21 ~~organization require a shorter time frame for compliance.~~
22 *However, if the parties mutually agree, the 45 business day notice*
23 *requirement may be waived. Nothing in this subparagraph limits*
24 *the ability of the parties to mutually agree to the proposed change*
25 *at any time after the provider has received notice of the proposed*
26 *change.*

27 (B) If a contract between a provider and a plan ~~or health insurer~~
28 provides benefits to enrollees, ~~subscribers, or insureds or~~
29 ~~subscribers~~ through a preferred provider arrangement, the
30 contract may contain provisions permitting a material change to
31 the contract by the plan ~~or health insurer~~ if the plan ~~or health~~
32 ~~insurer~~ provides at least 45 *business days'* notice to the provider
33 of the change and the provider has the right to terminate the
34 contract prior to the implementation of the change.

35 (2) A provision that requires a health care provider to accept
36 additional patients if, in the *professional* judgment of the provider,
37 accepting additional patients would endanger patients' access to or
38 continuity of care.

39 (3) A requirement to comply with quality improvement or
40 utilization management programs or procedures of a ~~health care~~



1 ~~service plan or a health insurer plan~~, unless the requirement is
 2 fully disclosed to the health care provider at least 30 *business days*
 3 prior to the provider executing the contract. *However, the plan may*
 4 *make a change to the quality improvement or utilization*
 5 *management programs or procedures at any time if the change is*
 6 *necessary to comply with state or federal law or regulations or any*
 7 *accreditation requirements of a private sector accreditation*
 8 *organization. A change to the quality improvement or utilization*
 9 *management programs or procedures shall be made pursuant to*
 10 *paragraph (1).*

11 (4) A provision that waives or ~~is inconsistent with~~ *undermines*
 12 ~~any provision of the Knox-Keene Health Care Service Plan Act~~
 13 ~~(Chapter 2.2 (commencing with Section 1340) of Division 2 of the~~
 14 ~~Health and Safety Code) or the Insurance Code.~~ *provision of this*
 15 *chapter. This paragraph shall not apply to the extent that a*
 16 *contract provision enhances provider rights or protections and*
 17 *does not adversely affect patient care.*

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

21 (6) *A provision that requires the contract to apply to patients*
 22 *other than those enrolled directly with the plan if the provisions of*
 23 *another contract would apply to the health care provider, unless*
 24 *the other contract terms do not vary from the underlying contract,*
 25 *or unless the other contract terms have otherwise been first*
 26 *negotiated and agreed to by the plan and the provider.*

27 (d) Any contract *provision* that violates subdivision (c) shall be
 28 void, unlawful, and unenforceable.

29 (e) The Department of Managed Health Care shall compile the
 30 information submitted by ~~health care service~~ plans pursuant to
 31 subdivision (h) of Section 1367 of the Health and Safety Code into
 32 a report and submit the report to the Governor and the Legislature
 33 by March 15 of each calendar year.

34 ~~(f) The Department of Insurance shall annually compile all~~
 35 ~~provider complaints if receives under this section and report to the~~
 36 ~~Legislature and the Governor the number and nature of those~~
 37 ~~complaints by March 15 of each calendar year.~~

38 ~~(g)~~

39 (f) Nothing in this section shall be construed or applied as
 40 setting the rate of payment to be included in contracts between



1 ~~health care service plans or health insurers~~ *plans* and health care
2 providers. ~~Nothing~~

3 (g) (1) *Nothing* in this section shall require ~~a~~ *an individual*
4 provider to continue a relationship with a patient who fails to
5 comply with the provider's posted office policies or who behaves
6 in a manner that is abusive, offensive, or dangerous to patients,
7 office staff, or ~~health care personnel, if the patient and the patient's~~
8 ~~health care service plan or health insurer are given at least 30 days'~~
9 ~~notice of the termination for those reasons.~~

10 ~~(h)~~ *health care personnel if the provider notifies the plan of the*
11 *patient's behavior and the plan reassigns the patient to another*
12 *provider. For the purposes of this paragraph, "individual*
13 *provider" means an individual licensed under Division 2*
14 *(commencing with Section 500) of the Business and Professions*
15 *Code or licensed under the Osteopathic Act or the Chiropractic*
16 *Act.*

17 (2) *Notwithstanding paragraph (1), for plans that do not assign*
18 *providers, the provider may terminate the relationship with the*
19 *patient by providing at least 20 business days' notice of the*
20 *termination to the patient and the plan.*

21 (3) *For plans that assign providers, the following requirements*
22 *shall apply:*

23 (A) *Within 10 business days of the notification from the*
24 *provider, the plan shall provide a warning to the patient that if the*
25 *behavior does not cease, the patient will be reassigned to a new*
26 *provider.*

27 (B) *If the patient is reassigned to a new provider, the plan shall*
28 *provide 15 business days' notice to the patient and the provider of*
29 *the reassignment.*

30 (C) *The provider shall continue to provide health care services*
31 *to the patient until the patient is reassigned.*

32 (D) *Notwithstanding subparagraphs (A), (B), and (C), a plan*
33 *shall take immediate action, upon notification from the provider,*
34 *if the patient poses a threat to the health and safety of the provider,*
35 *other patients, office staff, or health care personnel.*

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

37 (1) *"Health care provider" means a person who is described in*
38 ~~subdivision (f) of Section 900 and who either contracts with or is~~
39 ~~considering a contract to provide health care services to health care~~
40 ~~service plan enrollees or insureds.~~



1 ~~(2) “Health care service plan” means any person licensed~~
2 ~~pursuant to the Knox Keene Health Care Service Plan Act of 1975~~
3 ~~(Chapter 2.2 (commencing with Section 1340) of Division 2 of the~~
4 ~~Health and Safety Code).~~

5 ~~(3) “Health insurer” means any admitted insurer writing~~
6 ~~health insurance, as defined in Section 106 of the Insurance Code.~~

7 ~~(4) any professional person, medical group, independent~~
8 ~~practice association, organization, health facility, or other person~~
9 ~~or institute licensed by the state to deliver or furnish health~~
10 ~~services.~~

11 (2) “Material” means a proposed provision in a contract ~~that~~
12 ~~is substantive and would affect the decision of an individual or~~
13 ~~entity to accept the terms of the contract. to which a reasonable~~
14 ~~person would attach importance in determining the action to be~~
15 ~~taken upon the provision.~~

16 SEC. 2. Section 1386 of the Health and Safety Code is
17 amended to read:

18 1386. (a) The director may, after appropriate notice and
19 opportunity for a hearing, by order suspend or revoke any license
20 issued under this chapter to a health care service plan or assess
21 administrative penalties if the director determines that the licensee
22 has committed any of the acts or omissions constituting grounds
23 for disciplinary action.

24 (b) The following acts or omissions constitute grounds for
25 disciplinary action by the director:

26 (1) The plan is operating at variance with the basic
27 organizational documents as filed pursuant to Section 1351 or
28 1352, or with its published plan, or in any manner contrary to that
29 described in, and reasonably inferred from, the plan as contained
30 in its application for licensure and annual report, or any
31 modification thereof, unless amendments allowing the variation
32 have been submitted to, and approved by, the director.

33 (2) The plan has issued, or permits others to use, evidence of
34 coverage or uses a schedule of charges for health care services that
35 do not comply with those published in the latest evidence of
36 coverage found unobjectionable by the director.

37 (3) The plan does not provide basic health care services to its
38 enrollees and subscribers as set forth in the evidence of coverage.
39 This subdivision shall not apply to specialized health care service
40 plan contracts.



1 (4) The plan is no longer able to meet the standards set forth in
2 Article 5 (commencing with Section 1367).

3 (5) The continued operation of the plan will constitute a
4 substantial risk to its subscribers and enrollees.

5 (6) The plan has violated or attempted to violate, or conspired
6 to violate, directly or indirectly, or assisted in or abetted a violation
7 or conspiracy to violate any provision of this chapter, any rule or
8 regulation adopted by the director pursuant to this chapter, or any
9 order issued by the director pursuant to this chapter.

10 (7) The plan has engaged in any conduct that constitutes fraud
11 or dishonest dealing or unfair competition, as defined by Section
12 17200 of the Business and Professions Code.

13 (8) The plan has permitted, or aided or abetted any violation by
14 an employee or contractor who is a holder of any certificate,
15 license, permit, registration, or exemption issued pursuant to the
16 Business and Professions Code or this code that would constitute
17 grounds for discipline against the certificate, license, permit,
18 registration, or exemption.

19 (9) The plan has aided or abetted or permitted the commission
20 of any illegal act.

21 (10) The engagement of a person as an officer, director,
22 employee, associate, or provider of the plan contrary to the
23 provisions of an order issued by the director pursuant to
24 subdivision (c) of this section or subdivision (d) of Section 1388.

25 (11) The engagement of a person as a solicitor or supervisor of
26 solicitation contrary to the provisions of an order issued by the
27 director pursuant to Section 1388.

28 (12) The plan, its management company, or any other affiliate
29 of the plan, or any controlling person, officer, director, or other
30 person occupying a principal management or supervisory position
31 in the plan, management company, or affiliate, has been convicted
32 of or pleaded nolo contendere to a crime, or committed any act
33 involving dishonesty, fraud, or deceit, which crime or act is
34 substantially related to the qualifications, functions, or duties of a
35 person engaged in business in accordance with this chapter. The
36 director may revoke or deny a license hereunder irrespective of a
37 subsequent order under the provisions of Section 1203.4 of the
38 Penal Code.



1 (13) The plan violates Section 510, ~~513~~, 2056, or 2056.1 of the
2 Business and Professions Code *or Section 1375.7 of the Health*
3 *and Safety Code.*

4 (14) The plan has been subject to a final disciplinary action
5 taken by this state, another state, an agency of the federal
6 government, or another country for any act or omission that would
7 constitute a violation of this chapter.

8 (15) The plan violates the Confidentiality of Medical
9 Information Act (Part 2.6 (commencing with Section 56) of
10 Division 1 of the Civil Code).

11 (c) (1) The director may prohibit any person from serving as
12 an officer, director, employee, associate, or provider of any plan
13 or solicitor firm, or of any management company of any plan, or
14 as a solicitor, if either of the following applies:

15 (A) The prohibition is in the public interest and the person has
16 committed, caused, participated in, or had knowledge of a
17 violation of this chapter by a plan, management company, or
18 solicitor firm.

19 (B) The person was an officer, director, employee, associate, or
20 provider of a plan or of a management company or solicitor firm
21 of any plan whose license has been suspended or revoked pursuant
22 to this section and the person had knowledge of, or participated in,
23 any of the prohibited acts for which the license was suspended or
24 revoked.

25 (2) A proceeding for the issuance of an order under this
26 subdivision may be included with a proceeding against a plan
27 under this section or may constitute a separate proceeding, subject
28 in either case to subdivision (d).

29 (d) A proceeding under this section shall be subject to
30 appropriate notice to, and the opportunity for a hearing with regard
31 to, the person affected in accordance with subdivision (a) of
32 Section 1397.

33 SEC. 3. *Section 10133.65 is added to the Insurance Code, to*
34 *read:*

35 *10133.65. (a) This section shall be known and may be cited*
36 *as the Health Care Providers' Bill of Rights.*

37 *(b) The purpose of this section is to ensure that health insurers*
38 *do not enter into contracts that interfere with any ethical*
39 *responsibility or legal right of health care providers.*



1 (c) No contract issued, amended, or renewed on or after
2 January 1, 2003, between a health insurer and a health care
3 provider for the provision of health services to an insured shall
4 contain any of the following terms:

5 (1) If a contract is with a health insurer that negotiates and
6 arranges for alternative rates of payment with the provider to
7 provide benefits to insureds, the contract may contain provisions
8 permitting a material change to the contract by the health insurer
9 if the health insurer provides at least 45 business days' notice to
10 the provider of the change, and the provider has the right to
11 terminate the contract prior to implementation of the change.

12 (2) A provision that requires a health care provider to accept
13 additional patients, if, in the professional judgment of the provider,
14 accepting additional patients would endanger patients' access to,
15 or continuity of, care.

16 (3) A requirement to comply with quality improvement or
17 utilization management programs or procedures of a health
18 insurer, unless the requirement is fully disclosed to the health care
19 provider at least 30 business days prior to the provider executing
20 the contract. However, the health insurer may make a change to the
21 quality improvement or utilization management programs or
22 procedures at any time if the change is necessary to comply with
23 state or federal law or regulations or any accreditation
24 requirements of a private sector accreditation organization. A
25 change to the quality improvement or utilization management
26 programs or procedures shall be made pursuant to paragraph (1).

27 (4) A provision that waives or undermines any provision of the
28 Insurance Code. This paragraph shall not apply to the extent that
29 a contract provision enhances provider rights or protections and
30 does not adversely affect patient care.

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

34 (6) A provision that requires the contract to apply to patients
35 other than those insured directly with the health insurer if the
36 provisions of another contract would apply to the health care
37 provider, unless the other contract terms do not vary from the
38 underlying contract, or unless the other contract terms have
39 otherwise been first negotiated and agreed to by the insurer and the
40 provider.



1 (d) Any contract that violates subdivision (c) shall be void,
2 unlawful, and unenforceable.

3 (e) The Department of Insurance shall annually compile all
4 provider complaints that it receives under this section, and shall
5 report to the Legislature and the Governor the number and nature
6 of those complaints by March 15 of each calendar year.

7 (f) Nothing in this section shall be construed or applied as
8 setting the rate of payment to be included in contracts between
9 health insurers and health care providers.

10 (g) (1) Nothing in this section shall require an individual
11 provider to continue a relationship with a patient who fails to
12 comply with the provider's posted office policies or who behaves
13 in a manner that is abusive, offensive, or dangerous to patients,
14 office staff, or health care personnel, if the provider notifies the
15 insurer of the patient's behavior and the insurer reassigns the
16 patient to another provider. For the purposes of this paragraph,
17 "individual provider" means an individual licensed under
18 Division 2 (commencing with Section 500) of the Business and
19 Professions Code or licensed under the Osteopathic Act or the
20 Chiropractic Act.

21 (2) Notwithstanding paragraph (1), for insurers that do not
22 assign providers, the provider may terminate the relationship with
23 the patient by providing at least 20 business days' notice of the
24 termination to the patient and the insurer.

25 (3) For insurers that assign providers, the following
26 requirements apply:

27 (A) Within 10 business days of the notification from the
28 provider, the insurer shall provide a warning to the patient that if
29 the behavior does not cease, the patient will be reassigned to a new
30 provider.

31 (B) If the patient is reassigned to a new provider, the insurer
32 shall provide 15 business days' notice to the patient and to the
33 provider of the reassignment.

34 (C) The provider shall continue to provide health care services
35 to the patient until the patient is reassigned.

36 (D) Notwithstanding subparagraphs (A), (B), and (C), an
37 insurer shall take immediate action, upon notification from the
38 provider, if the patient poses a threat to the health and safety of the
39 provider, other patients, office staff, or health care personnel.



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

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

7 (2) "Health insurer" means any admitted insurer writing
8 health insurance as defined in Section 106.

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

12 SEC. 4. No reimbursement is required by this act pursuant to
13 Section 6 of Article XIII B of the California Constitution because
14 the only costs that may be incurred by a local agency or school
15 district will be incurred because this act creates a new crime or
16 infraction, eliminates a crime or infraction, or changes the penalty
17 for a crime or infraction, within the meaning of Section 17556 of
18 the Government Code, or changes the definition of a crime within
19 the meaning of Section 6 of Article XIII B of the California
20 Constitution.

