

AMENDED IN ASSEMBLY SEPTEMBER 7, 1999

AMENDED IN ASSEMBLY JULY 7, 1999

AMENDED IN SENATE MAY 28, 1999

AMENDED IN SENATE APRIL 28, 1999

AMENDED IN SENATE APRIL 19, 1999

AMENDED IN SENATE MARCH 2, 1999

SENATE BILL

No. 260

Introduced by Senator Speier

(Principal coauthor: Assembly Member Corbett)

January 28, 1999

~~An act to add Chapter 2.25 (commencing with Section 1399.80) to Division 2 of the Health and Safety Code, relating to add Sections 1347.1, 1375.4, 1375.5, and 1375.6 to, and to add and repeal Section 1349.3 of, the Health and Safety Code, relating to health.~~

LEGISLATIVE COUNSEL'S DIGEST

SB 260, as amended, Speier. Health care coverage: ~~Department of Corporations: regulatory duties~~ *risk-bearing organizations: financial solvency.*

Existing law regulates health care coverage in a variety of contexts, including (a) the Knox-Keene Health Care Service Plan Act of 1975, under which health care service plans are regulated by the Commissioner of Corporations, (b) the Medi-Cal Act, administered by the State Department of Health Services under which qualified low-income persons



are provided with health care services, (c) the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, which arranges for the provision of health care services, including dental and vision care, to eligible children.

~~This bill would additionally require that all risk-bearing provider organizations annually register with the Commissioner of Corporations and submit a quarterly financial statement, as provided, to the commissioner. This bill would impose related requirements on the commissioner and the department.~~

~~This bill would create the Health Care Guarantee Fund in the State Treasury, under the administration of the department. The bill would provide that the fund shall be responsible for the payment of the approved costs of providing health care services when a licensee responsible for providing that care is financially unable to fund or provide the care.~~

~~It would require every entity operating pursuant to a license issued in accordance with the bill's provisions to pay an actual fee, as determined by the department, which shall be deposited into the fund for the purposes specified.~~

Legislation is pending that would transfer the functions and duties of the Department of Corporations and the Commissioner of Corporations, with respect to the regulation of health care service plans, to the Department of Managed Care and the Director of the Department of Managed Care.

This bill would establish the Financial Solvency Standards Board, within the Department of Managed Care, composed of 8 members, one of whom is the Director of the Department of Managed Care and 7 of whom are appointed by the Governor. It would require the board to take specified actions with regard to financial solvency and standards affecting the delivery of health care services.

The bill, until January 1, 2002, would prohibit a license with waivers or limited license, on or after January 1, 2000, from being issued to any person for provision of, or the arranging, payment, or reimbursement for the provision of, health care services to enrollees of another plan under certain risk-assuming contracts. It would also prohibit any licensed



health care service plan, on and after January 1, 2000, from contracting with any person, with certain exceptions, for the assumption of financial risk with respect to certain health care services and any other form of global capitation.

This bill would require every contract between a health care service plan and a risk-bearing organization, as defined, that is issued, amended, renewed, or delivered in this state on or after July 1, 2000, from including certain provisions concerning the risk-bearing organization's administrative and financial capacity, which would be effective as of January 1, 2001. The bill would require the Director of the Department of Managed Care to adopt regulations on or before June 30, 2000, with respect to, among other things, a process for reviewing or grading risk-bearing organizations based on specified criteria, and would require the director to investigate and take enforcement action against a health care service plan that fails to comply with these prescribed requirements. It would also prohibit a contract between a risk-bearing organization and a health care service plan that is issued, amended, delivered, or renewed in this state on or before July 1, 2000, from including any provision that requires a provider to accept rates or methods of payment specified in contracts with health care service plan affiliates or nonaffiliates unless the provision has been first negotiated and agreed to between the health care service plan and the risk-bearing organization.

Since a violation of the provisions relating to health care service plans is a crime, this bill, by creating new crimes, 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: ~~no~~ yes.



The people of the State of California do enact as follows:

1 ~~SECTION 1. Chapter 2.25 (commencing with~~
2 *SECTION 1. Section 1347.1 is added to the Health and*
3 *Safety Code, to read:*
4 *1347.1. (a) There is hereby established in the*
5 *Department of Managed Care the Financial Solvency*
6 *Standards Board composed of eight members. The*
7 *members shall consist of the director, or the director's*
8 *designee, and seven members appointed by the*
9 *Governor. The seven members appointed by the*
10 *Governor may be, but are not necessarily limited to,*
11 *individuals with training and experience in the following*
12 *subject areas or fields: medical and health care*
13 *economics; accountancy, with experience in integrated*
14 *or affiliated health care delivery systems; excess loss*
15 *insurance underwriting in the medical, hospital, and*
16 *health plan business; actuarial studies in the area of health*
17 *care delivery systems; management and administration*
18 *in integrated or affiliated health care delivery*
19 *systems/investment banking; and information*
20 *technology in integrated or affiliated health care delivery*
21 *systems. The members appointed by the Governor shall*
22 *be appointed for a term of three years, but may be*
23 *removed or reappointed by the Governor before the*
24 *expiration of the term.*
25 *(b) The purpose of the board is to do all of the*
26 *following:*
27 *(1) Advise the director on matters of financial*
28 *solvency affecting the delivery of health care services.*
29 *(2) Develop and recommend to the director financial*
30 *solvency requirements and standards relating to plan*
31 *operations, plan-affiliate operations and transactions,*
32 *plan-provider contractual relationships, and*
33 *provider-affiliate operations and transactions.*
34 *(3) Periodically monitor and report on the*
35 *implementation and results of the financial solvency*
36 *requirements and standards.*
37 *(c) Financial solvency requirements and standards*
38 *recommended to the director by the board may, after a*



1 *period of review and comment not to exceed 45 days and,*
2 *notwithstanding Section 1347, shall be noticed for*
3 *adoption as regulations under the rulemaking provisions*
4 *of the Administrative Procedure Act (Chapter 3.5*
5 *(commencing with Section 11340) of Part 1 of Division 3*
6 *of Title 2 of the Government Code). During the director's*
7 *45-day review and comment period, the director, in*
8 *consultation with the board, may postpone the adoption*
9 *of the requirements and standards pending further*
10 *review and comment. Within five business days of receipt*
11 *by the director of the recommendation of the board, the*
12 *director shall send an information-only copy of the*
13 *recommendations to the members of the Health Care*
14 *Policy and Operations Advisory Committee. Nothing in*
15 *this subdivision prohibits the director from adopting*
16 *regulations, including emergency regulations, under the*
17 *rulemaking provisions of the Administrative Procedure*
18 *Act.*

19 *(d) Except as provided in subdivision (e), the board*
20 *shall meet at least quarterly and at the call of the chair.*
21 *In order to preserve the independence of the board, the*
22 *director shall not serve as chair. The members of the*
23 *board may establish their own rules and procedures. All*
24 *members shall serve without compensation, but shall be*
25 *reimbursed from department funds for expenses actually*
26 *and necessarily incurred in the performance of their*
27 *duties.*

28 *(e) During the two years from the date of the first*
29 *meeting of the board, the board shall meet monthly in*
30 *order to expeditiously fulfill its purpose under*
31 *subparagraphs (A) and (B) of paragraph (1) of*
32 *subdivision (b).*

33 *(f) For purposes of this section, "board" means the*
34 *Financial Solvency Standards Board.*

35 *SEC. 2. Section 1349.3 is added to the Health and*
36 *Safety Code, to read:*

37 *1349.3. (a) On or after January 1, 2000, no license*
38 *with waivers or limited license shall be issued to any*
39 *person, including a provider or an affiliate of a provider,*
40 *for the provision of, or the arranging, payment, or*



1 reimbursement for the provision of, health care services
2 to enrollees of another plan under a contract or other
3 arrangement whereby the person assumes financial risk
4 for the provision of at least both physician services and
5 hospital inpatient and ambulatory care services to the
6 enrollees of the plan with which the person proposes to
7 contract or make an arrangement. On and after January
8 1, 2000, no licensed health care service plan shall contract
9 with any person, other than a licensed health care service
10 plan or licensed health care service plan with waivers, for
11 the assumption of financial risk with respect to the
12 provision of both institutional and noninstitutional health
13 care services and any other form of global capitation.

14 (b) An applicant for a license with waivers or a limited
15 license that has an application on file with the director on
16 August 1, 1999, shall be entitled to a refund of the
17 application filing fee paid as of January 1, 2000.

18 (c) This section shall remain in effect only until
19 January 1, 2002, and as of that date is repealed, unless a
20 later enacted statute, that is enacted before January 1,
21 2002, deletes or extends that date.

22 SEC. 3. Section 1375.4 is added to the Health and
23 Safety Code, to read:

24 1375.4. (a) Every contract between a health care
25 service plan and a risk-bearing organization that is issued,
26 amended, renewed, or delivered in this state on or after
27 July 1, 2000, shall include the following provisions
28 concerning the risk-bearing organization's
29 administrative and financial capacity, which shall be
30 effective as of January 1, 2001:

31 (1) The risk-bearing organization shall furnish
32 financial information to the health care service plan or
33 the plan's designated agent and meet any other financial
34 requirements that assist the health care service plan in
35 maintaining the financial viability of its arrangements for
36 the provision of health care services in a manner that does
37 not adversely affect the integrity of the contract
38 negotiation process.

39 (2) The health care service plan shall disclose
40 information to the risk-bearing organization that enables



1 *the risk-bearing organization to be informed regarding*
2 *the financial risk assumed under the contract.*

3 (3) *The contract between a health care service plan*
4 *and a risk-bearing organization shall specify that a*
5 *contract may continue between the health care service*
6 *plan and the risk-bearing organization's individual*
7 *providers upon insolvency of the risk-bearing*
8 *organization.*

9 (b) *In accordance with subdivision (a) of Section 1344,*
10 *the director shall adopt regulations on or before June 30,*
11 *2000, to implement this section which shall, at a*
12 *minimum, provide for the following:*

13 (1) (A) *A process for reviewing or grading*
14 *risk-bearing organizations based on the following criteria:*

15 (i) *The risk-bearing organization meets criterion 1 if*
16 *it reimburses, contests, or denies claims for health care*
17 *services it has provided, arranged, or for which it is*
18 *otherwise financially responsible in accordance with the*
19 *timeframes and other requirements described in Section*
20 *1371 and in accordance with any other applicable state*
21 *and federal laws and regulations.*

22 (ii) *The risk-bearing organization meets criterion 2 if*
23 *it estimates its liability for incurred but not reported*
24 *claims pursuant to a method that has not been held*
25 *objectionable by the director; records the estimate at*
26 *least quarterly as an accrual in its books and records, and*
27 *appropriately reflects this accrual in its financial*
28 *statements.*

29 (iii) *The risk-bearing organization meets criterion 3 if*
30 *it maintains at all times a positive tangible net equity, as*
31 *defined in subdivision (e) of Section 1300.76 of Title 10 of*
32 *the California Code of Regulations.*

33 (iv) *The risk-bearing organization meets criterion 4 if*
34 *it maintains at all times a positive level of working capital*
35 *(excess of current assets over current liabilities).*

36 (B) *A risk-bearing organization may reduce its*
37 *liabilities for purposes of calculating tangible net equity,*
38 *pursuant to clause (iii) of subparagraph (A), and working*
39 *capital, pursuant to clause (iv) of subparagraph (A), by*
40 *the amount of any liabilities the payment of which is*



1 guaranteed by a sponsoring organization pursuant to a
2 qualified guarantee. A sponsoring organization is one that
3 has a tangible net equity of a level to be established by the
4 director that is in excess of all amounts that it has
5 guaranteed to any person or entity. A qualified guarantee
6 is one that meets all of the following:

7 (i) It is approved by a board resolution of the
8 sponsoring organization.

9 (ii) The sponsoring organization agrees to submit
10 audited annual financial statements to the plan within 90
11 days of the end of the sponsoring organization's fiscal
12 year.

13 (iii) The guarantee is unconditional except for a
14 maximum monetary limit.

15 (iv) The guarantee is not limited in duration with
16 respect to liabilities arising during the term of the
17 guarantee.

18 (v) The guarantee provides for six months' advance
19 notice to the plan prior to its cancellation.

20 (2) The information required from risk-bearing
21 organizations to assist in reviewing or grading these
22 risk-bearing organizations, including balance sheets,
23 claims reports, and designated annual, quarterly, or
24 monthly financial statements prepared in accordance
25 with generally accepted accounting principles, to be used
26 in a manner, and to the extent necessary, provided to a
27 single external party as approved by the director to the
28 extent that it does not adversely affect the integrity of the
29 contract negotiation process between the health care
30 service plan and the risk-bearing organizations.

31 (3) Audits to be conducted in accordance with
32 generally accepted auditing standards and in a manner
33 that avoids duplication of review of the risk-bearing
34 organization.

35 (4) A process for corrective action plans, as mutually
36 agreed upon by the health care service plan and the
37 risk-bearing organization and as approved by the
38 director, for cases where the review or grading indicates
39 deficiencies that need to be corrected by the risk-bearing
40 organization, and contingency plans to ensure the



1 *delivery of health care services if the corrective action*
2 *fails. The corrective action plan shall be approved by the*
3 *director and standardized, to the extent possible, to meet*
4 *the needs of the director and all health care service plans*
5 *contracting with the risk-bearing organization. If the*
6 *health care service plan and the risk-bearing organization*
7 *are unable to determine a mutually agreeable corrective*
8 *action plan, the director shall determine the corrective*
9 *action plan.*

10 (5) *The disclosure of information by health care*
11 *service plans to the risk-bearing organization that enables*
12 *the risk-bearing organization to be informed regarding*
13 *the risk assumed under the contract, including:*

14 (A) *Enrollee information monthly.*

15 (B) *Risk arrangement information, information*
16 *pertaining to any pharmacy risk assumed under the*
17 *contract, information regarding incentive payments, and*
18 *information on income and expenses assigned to the*
19 *risk-bearing organization quarterly.*

20 (D) *Health care service plans shall provide payments*
21 *of all risk arrangements within 180 days after close of the*
22 *fiscal year.*

23 (6) *Periodic reports from each health care service plan*
24 *to the director that include information concerning the*
25 *risk-bearing organizations and the type and amount of*
26 *financial risk assumed by them, and, if deemed necessary*
27 *and appropriate by the director, a registration process for*
28 *the risk-bearing organizations.*

29 (7) *The confidentiality of financial and other records*
30 *to be produced, disclosed, or otherwise made available,*
31 *unless as otherwise determined by the director.*

32 (c) *The failure by a health care service plan to comply*
33 *with the contractual requirements pursuant to this*
34 *section shall constitute grounds for disciplinary action.*
35 *The director shall, as appropriate, within 60 days after*
36 *receipt of documented validation from a risk-bearing*
37 *organization, investigate and take enforcement action*
38 *against a health care service plan that fails to comply with*
39 *these requirements and shall periodically evaluate*
40 *contracts between health care service plans and*



1 risk-bearing organizations to determine if any audit,
2 evaluation, or enforcement actions should be undertaken
3 by the department.

4 (d) The Financial Solvency Standards Board
5 established in Section 1347.1 shall study and report to the
6 director on or before January 1, 2001, regarding all of the
7 following:

8 (1) The feasibility of requiring that there be in force
9 insurance coverage commensurate with the financial risk
10 assumed by the risk-bearing organization to protect
11 against financial losses.

12 (2) The appropriateness of different risk-bearing
13 arrangements between health care service plans and
14 risk-bearing organizations.

15 (3) The appropriateness of the four criteria specified
16 in paragraph (1) of subdivision (b).

17 (e) This section shall not apply to specialized health
18 care service plans.

19 (f) For purposes of this section, 'provider
20 organization' means a medical group, independent
21 practice association, or other entity that delivers,
22 furnishes, or otherwise arranges for or provides health
23 care services, but does not include an individual or a plan.

24 (g) (1) For the purposes of this section, a 'risk-bearing
25 organization' means a professional medical corporation,
26 other form of corporation controlled by physicians and
27 surgeons, a medical partnership, or a foundation for
28 medical care licensed under Chapter 5 (commencing
29 with Section 2000) of Division 2 of the Business and
30 Professions Code or under subdivision (a) of Section 1206
31 that delivers, furnishes, or otherwise arranges for or
32 provides health care services, but does not include an
33 individual or a health care service plan, and that does all
34 of the following:

35 (A) Contracts directly with a health care service plan
36 or arranges for health care services for the health care
37 service plan's enrollees.

38 (B) Receives compensation for those services on any
39 capitated or fixed periodic payment basis.



1 (C) *Is responsible for the processing and payment of*
2 *claims made by providers for services rendered by those*
3 *providers that are covered under the capitation or fixed*
4 *periodic payment made by the plan to the risk-bearing*
5 *organization.*

6 (2) *Notwithstanding paragraph (1), risk-bearing*
7 *organizations shall not be deemed to include a provider*
8 *organization that meets either of the following*
9 *requirements:*

10 (A) *The health care service plan files with the*
11 *department consolidated financial statements that*
12 *include the provider organization.*

13 (B) *The health care service plan is the only health care*
14 *service plan with which the provider organization*
15 *contracts for arranging or providing health care services*
16 *and, during the previous and current fiscal years, the*
17 *provider organization's maximum potential expenses for*
18 *providing or arranging for health care services did not*
19 *exceed 115 percent of its maximum potential revenue for*
20 *providing or arranging for those services.*

21 (h) *For purposes of this section, 'claims' include, but*
22 *are not limited to, contractual obligations to pay*
23 *capitation or payments on a managed hospital payment*
24 *basis.*

25 *SEC. 4. Section 1375.5 is added to the Health and*
26 *Safety Code, to read:*

27 *1375.5. (a) Except as provided in subdivision (b), no*
28 *contract between a risk-bearing organization and a*
29 *health care service plan that is issued, amended,*
30 *delivered, or renewed in this state on or after July 1, 2000,*
31 *shall include any provision that requires the risk-bearing*
32 *organization to be at financial risk for the provision of*
33 *health care services, unless the provision has first been*
34 *negotiated and agreed to between the health care service*
35 *plan and the risk-bearing organization.*

36 (b) *Notwithstanding subdivision (a), this section shall*
37 *not prevent a risk-bearing organization from accepting*
38 *the financial risk specified in subdivision (a) pursuant to*
39 *a contract that meets the requirements of Section 1375.4.*



1 SEC. 5. Section 1375.6 is added to the Health and
2 Safety Code, to read:

3 1375.6. No contract between a risk-bearing
4 organization and a health care service plan that is issued,
5 amended, delivered, or renewed in this state on or before
6 July 1, 2000, shall include any provision that requires a
7 provider to accept rates or methods of payment specified
8 in contracts with health care service plan affiliates or
9 nonaffiliates unless the provision has been first negotiated
10 and agreed to between the health care service plan and
11 the risk-bearing organization.

12 SEC. 6. For purposes of Sections 1347.1, 1349.3, 1375.4,
13 1375.5, and 1375.6, until the Department of Managed
14 Care and the position of the Director of the Department
15 of Managed Care is established by legislative enactment
16 or executive order by July 1, 2000, the terms ‘department’
17 and ‘director’ shall mean the Department of
18 Corporations and the Commissioner of Corporations,
19 respectively.

20 SEC. 7. No reimbursement is required by this act
21 pursuant to Section 6 of Article XIII B of the California
22 Constitution because the only costs that may be incurred
23 by a local agency or school district will be incurred
24 because this act creates a new crime or infraction,
25 eliminates a crime or infraction, or changes the penalty
26 for a crime or infraction, within the meaning of Section
27 17556 of the Government Code, or changes the definition
28 of a crime within the meaning of Section 6 of Article
29 XIII B of the California Constitution.

30 ~~Section 1399.80) is added to Division 2 of the Health and~~
31 ~~Safety Code, to read:~~

32

33 CHAPTER 2.25. ~~HEALTH CARE ENTITY REGULATION~~

34

35 ~~1399.80. The Department of Corporations shall do all~~
36 ~~of the following:~~

37 ~~(a) All risk-bearing provider organizations shall~~
38 ~~annually register with the commissioner. Those who~~
39 ~~register shall submit to the commissioner a quarterly~~
40 ~~financial statement, which shall be uniform and prepared~~



1 in conformity with generally accepted accounting
2 principles. The commissioner shall apply this information
3 to a uniform standardized rating system of the
4 risk bearing provider organizations. The department
5 shall, by regulation, set a fee for the registration and
6 review process that shall be at a level sufficient to cover
7 all departmental costs associated with registration that
8 are incurred by the department.

9 (b) Institute a moratorium on the issuance of any
10 limited license, or license with waivers, to any licensee.

11 (c) Establish uniform administrative procedures to
12 facilitate interdepartmental communication of
13 standardized data.

14 1399.81. (a) The Health Care Guarantee Fund is
15 hereby created in the State Treasury, under the
16 administration of the department. The fund shall be
17 responsible for the payment of the approved costs of
18 providing health care services when a licensee
19 responsible for providing that care is financially unable to
20 fund or provide the care.

21 (b) Every entity operating pursuant to a license issued
22 in compliance with this division shall pay an annual fee,
23 to be determined by regulation of the department, which
24 shall be deposited into the fund for the purposes of this
25 section.

