Department of Corporations

Acting Commissioner: William Kenefick ♦ (916) 445-7205 ♦ (213) 576-7500 ♦
Toll-Free Complaint Line—Health Plan Division: (800) 400-0815 ♦ Internet: www.corp.ca.gov

The Department of Corporations (DOC) is part of the cabinet-level Business, Transportation and Housing Agency (BTH), and is empowered under section 25600 of the California Corporations Code. The Commissioner of Corporations, appointed by the Governor, oversees and administers the duties and responsibilities of the Department. The regulations promulgated by the Department are set forth in Division 3, Title 10 of the California Code of Regulations (CCR).

The Department administers several major statutes. Perhaps the most important is the Knox-Keene Health Care Service Plan Act of 1975, Health and Safety Code section 1340 *et seq.*, which is intended to promote the delivery of health and medical care to Californians who enroll in or subscribe to services provided by a health care service plan or specialized health care service plan. A "health care service plan" (health plan), more commonly known as a "health maintenance organization" (HMO) or "managed care organization" (MCO), is defined broadly as any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

The Department's Health Plan Division (HPD) is responsible for administering the Knox-Keene Act. The Division's staff of attorneys, financial examiners, health plan analysts, physicians and other health care professionals, consumer services representatives, and support staff assist the Corporations Commissioner in licensing and regulating more than 100 health plans in California. Licensed health plans include HMOs and other full-service health plans, as well as the following categories of specialized health plans: prepaid dental, vision, mental health, chiropractic, and pharmacy. HMOs and other full-service health plans provide health care services to approximately 23 million California enrollees. Specialized health plans arrange for specialized health services for nearly 35 million California enrollees. Total enrollment in all health plans exceeded 58 million as of May 1999.

DOC's Health Plan Enforcement Division, created on October 1, 1998, is responsible for enforcing the Knox-Keene Act. With offices in Sacramento and Los Angeles, it investigates alleged violations of the Act and DOC's regulations implementing the Act, and is authorized to take administrative and civil actions, as well as to refer criminal matters for prosecution, to ensure compliance with the statutory and regulatory requirements.

With regard to HMO regulation, the legislature has expressly instructed the Corporations Commissioner to assure the continued role of the professional as the determiner of the patient's health needs; assure that subscribers and enrollees are educated and informed of the benefits and services available in order to make a rational consumer choice in the marketplace; prosecute malefactors who make fraudulent solicitations or who use misrepresentations or other deceptive methods or practices; help to assure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers; promote effective representation of the interests of subscribers and enrollees; assure the financial stability of subscribers and enrollees by means of proper regulatory procedures; and assure that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of health care.

No later than July 1, 2000, AB 78 (Gallegos) (Chapter 525, Statutes of 1999) will transfer the regulation of managed care organizations and the administration of the Knox-Keene Health Care Service Plan Act of 1975 from the Department of Corporations to the newly-created Department of Managed Care in the Business, Transportation and Housing Agency (see MAJOR PROJECTS). The Department of Corporations will continue to administer the Corporate Securities Law of 1968 and numerous other statutes regulating business entities, including finance lenders, mortgage lenders, franchise investments, and escrow agents; coverage of these DOC activities is found below, under "Business Regulatory Agencies."

At the heart of the package is AB 78 (Gallegos) (Chapter 525, Statutes of 1999), which at long last removes the responsibility for regulating the managed care industry from DOC to a new Department of Managed Care.

MAJOR PROJECTS

Governor Signs Legislation Removing Managed Care Regulation from DOC

After months of anticipation and behind-closed-doors negotiation sessions that—for the most part—excluded consumer advocates, Governor Gray Davis signed a 21-bill package of legislation intended to reform the regulation of managed care in California on September 27 (see LEGISLATION for a description of these bills).

At the heart of the package is AB 78 (Gallegos) (Chapter 525, Statutes of 1999), which at long last removes the responsibility for regulating the managed care industry from DOC to a new Department of Managed Care (DMC). The bill is consistent with 1998 and 1999 recommendations by

the State Auditor *[16:2 CRLR 183–84; 16:1 CRLR 214]* and a 1998 report by former Governor Pete Wilson's Managed Health Care Improvement Task Force *[16:1 CRLR 23]*. In fact, AB 78 is almost identical to a reorganization plan proposed by then-Governor Wilson in 1998 and rejected by the Senate that same year. The bill essentially splits the Department of Corporations into two agencies—one is devoted to the regulation of managed care and the other will continue the securities regulation and other business regulatory activities currently performed by DOC. Both departments will be run by gubernatorial appointees, and both departments will reside in BTH. The Senate and the Little Hoover Commission rejected former Governor Wilson's similar proposal due to concerns that the new managed care regulatory agency should function from a parent agency that is more familiar with the delivery of health care than is BTH, and should be run by a multimember regulatory board instead of a single gubernatorial appointee. Although the 1998 legislature passed SB 406 (Rosenthal), which would have created a Board of Managed Health Care in the State and Consumer Services Agency, Wilson vetoed that bill and almost every other managed care reform bill that reached his desk in 1998. *[16:1 CRLR 23–26]*

In fact, AB 78 is almost identical to a reorganization plan proposed by then-Governor Wilson in 1998 and rejected by the Senate that same year.

Frustrated with Wilson's intransigence over managed care reform, the legislature introduced over 70 bills dealing with various managed care issues once Governor Davis took office in 1999. Overwhelmed by the sheer number of bills and their piecemeal nature, the Governor requested that the legislature pare back its efforts to a minimal number of bills and issues (without indicating his position on any of them). Throughout the summer, consumer advocates worried as the Governor's aides met with HMO executives and representatives in private meetings to which consumer groups were not invited, and Davis accepted contribution after contribution from managed care organizations and insurers in a spate of unprecedented campaign fundraising.

Managed care trade associations warned that the guaranteed second opinions, external review system, additions to required coverage, and new liability created by SB 21 (Figueroa) (Chapter 536, Statutes of 1999) will impose increased costs on the health care system that will be passed on to employers who purchase coverage and to enrollees through higher deductibles and co-payments.

Finally, on August 18, Governor Davis outlined his platform on managed care reform, giving the legislature only three weeks before the end of the legislative year in which to hurriedly revise pending measures to meet his specifications. As noted above, the Governor's proposals include a "facelift" change in the nature of California's managed care regulator; as described below (see LEGISLATION), they also address common consumer complaints about managed care by shortening the grievance process that patients must endure when a managed care entity denies or delays a requested procedure or treatment; guaranteeing second opinions; establishing a system of independent external review of HMO decisions to deny care; requiring health care decisions to be made by physicians or other licensed health care providers and on the basis of accepted standards of medical practice and not fiscal concerns; safeguarding the privacy of medical records in the hands of HMOs; and enabling a patient to sue a managed care organization for compensatory and punitive damages when treatment is denied or delayed and the patient suffers substantial physical harm. The bills signed by the Governor also attempt to ensure the fiscal solvency of physician-owned medical groups that contract with HMOs, and require HMOs to cover certain procedures and services—including breast cancer screening, hospice care, phenylketonuria (PKU) testing and treatment, severe mental illness, prescription contraceptives, and diabetes services and supplies—as part of basic care.

Most observers agree that the reforms are modest, centrist, and long-overdue, and may put pressure on Congress to enact similar legislation. Managed care trade associations warned that the guaranteed second opinions, external review system, additions to required coverage, and new liability created by SB 21 (Figueroa) (Chapter 536, Statutes of 1999) will impose increased costs on the health care system that will be passed on to employers who purchase coverage and to enrollees through higher deductibles and co-payments. Specifically, the managed care industry expressed serious concern about the potential cost of AB 88 (Thomson) (Chapter 534, Statutes of 1999), which requires HMOs to cover treatment for severe mental illness in adults and severe emotional disturbance in children. For their part, some consumer advocates complained that the provision authorizing patient lawsuits against HMOs is overly restrictive, and noted that the package wholly fails to prevent HMOs from including mandatory arbitration provisions in their contracts—thus preventing consumers from accessing the courts to settle disputes with HMOs and defeating the purpose of SB 21. Several legislators announced their intent to seek legislation in 2000 preserving patients' access to the courts in resolving disputes with managed care organizations.

Consumer advocates also noted that the state reforms fail to provide as much protection to individuals who purchase their health coverage through private employers as the federal courts' interpretation of the Employee Retirement Income Security Act (ERISA) provides to government employees (including Governor Davis and all state legislators). ERISA, a federal statute originally enacted to protect consumers from fraud by private pension plan managers, has been interpreted by the federal courts to preempt state law and state remedies

governing private "employee benefit plans," including employer-subsidized health care coverage provided through managed care organizations. SB 21 (Figueroa) attempts to skirt ERISA by characterizing managed care as "the business of insurance," to which ERISA does not apply, and authorizes some lawsuits by non-government employees against HMOs for delayed or denied care. However, such individuals must first exhaust all internal HMO grievance remedies and the new independent medical review process created by AB 55 (Migden) (Chapter 533, Statutes of 1999) (see LEGISLATION), and must have suffered "substantial harm." Thus, under the current judicial interpretation of ERISA, government employees still enjoy more protection from HMO abuses than do non-government employees; however, several cases in which the longstanding interpretation of ERISA is at issue are moving through the federal courts (see LITIGATION).

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The implementation of the new state legislative reforms now passes to the new Department of Managed Care, which—at this writing—has no director and no budget. The new Department will become operative either on the date Governor Davis establishes it by executive order or July 1, 2000, whichever occurs first.

Consumer Groups Blast DOC—"The Invisible Regulator"

In June 1999, Consumers Union and the Center for Health Care Rights released a critique which should become the blueprint for the managed care consumer outreach and education activities of the Davis administration and its new Department of Managed Care.

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In *Manage to Care: How California Can Better Inform Consumers About Managed Care*, the groups examined DOC's "public face"—the way in which DOC has presented itself to the public—and documented "the very limited and flawed efforts that the Department has undertaken" to inform California consumers about managed care. Calling DOC "the invisible regulator," the consumer groups found that "few people know that the Department is the state agency that regulates HMOs." Although DOC was required by state law to institute a toll-free hotline to accept consumer inquiries and complaints about managed care organizations and did so in October 1995 *[15:4 CRLR 146]*, the groups argued that DOC has failed to adequately publicize the existence of either the toll-free line or its annual report on complaint hotline data. Similarly, the groups noted that DOC is not listed in many telephone directories, has failed to list the hotline in all but one telephone directory reviewed, and—contrary to existing law—has not published educational materials for consumers about its regulatory role or about managed care generally (whose regulation is fragmented among a number of different state agencies).

The groups made several recommendations: (1) the Department should dramatically increase its visibility by launching an ongoing media campaign, increasing telephone book listings, developing educational materials, and promoting the reports that it does publish; (2) DOC should develop its materials with a focus on effective communication with consumers and should—to the extent possible—consolidate managed care information from all state sources; and (3) the Department should also develop a plan to provide all Californians with comparative information ("report cards") on HMOs and medical groups in their area.

CU and CHCR also examined the various reports published by the Department—its "annual hotline report" documenting complaints made to its hotline, its "late grievance reports" on the timeliness of HMOs' internal grievance procedures, and its "medical survey reports" on periodic reviews of HMOs' compliance with medical and organizational requirements. The groups noted that these reports contain mostly raw numbers and lack any analysis or comparison of those numbers that would be meaningful to consumers. Regarding the annual hotline report, the groups noted that the report does not show whether individual complaints are upheld or denied, nor does it state how long DOC takes to resolve complaints. The groups recommended that DOC include information on all calls received, the disposition of complaints, and on how long the Department takes to resolve complaints; further, the report should analyze and present information in a more consumer-friendly manner, including complaints about medical groups as well as HMOs.

Late grievance reports must be filed with DOC by HMOs on a quarterly basis, and must disclose information about grievances filed by consumers that have been pending with an HMO for 30 days or more. Although individual HMOs file late grievance reports with DOC, the Department does not summarize them in a way that would facilitate comparison among HMOs. In addition, inconsistent definitions and reporting standards, including possible differences in how HMOs define the term "grievance," make valid comparisons about grievance handling impossible. The groups recommended that DOC standardize for HMOs which grievances to include in the late grievance report; clarify whether pending or only closed grievances should be reported and define when a grievance is closed for reporting purposes;

and publicize a consumer-friendly annual summary report with useful comparative measures, such as rates of late grievances per 10,000 enrollees, late grievances as a percentage of all grievances filed, time taken to resolve grievances, and percentage of grievances upheld or overturned.

At least once every three years, DOC is required to conduct a review of each HMO's compliance with medical and organizational requirements ("medical survey"), followed by a publicly available report within 180 days of the survey's completion. Both Consumers Union in 1996 and the State Auditor in 1999 *[16:2 CRLR 183–84]* found that DOC was not conducting medical surveys or publishing medical survey reports in a timely fashion. Further, the medical survey reports and their summaries were difficult for consumers to get, and those that were obtained were difficult to understand. According to the groups' latest report, "regrettably, the Department's performance regarding medical surveys is largely unchanged since our 1996 report. In fact, the Department met the 3-year timeframe for completing surveys in only 1 of the 12 medical surveys we reviewed. Furthermore, for each Medical Survey Report we reviewed, the Department failed to comply with the requirement of publishing the report within 180 days of completing the corresponding medical survey. On average, the Department took more than a year to release Medical Survey Reports. In addition to being dilatory, the Department has made the Medical Survey Reports difficult to understand. The summaries of Medical Survey Reports, meant particularly for the public, have similar weaknesses. They are too long and are almost incomprehensible due to their reliance on medical and legal jargon." The groups recommended that DOC perform the surveys and release the Medical Survey Reports in a timely fashion; standardize the report format; and prepare consumer-friendly, jargon-free summaries that are readily accessible to consumers.

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The report concluded by noting that Governor Davis and his administration must face a number of critical issues before oversight by the state can catch up to the reality of the health care system in California. "The Davis Administration must make the State's regulatory oversight of HMOs credible. To that end, communicating with the consumers of California is key. That is the subject of this report. With the new Administration, the time has come to change course, shift the focus toward educating consumers, and move California into the vanguard of managed care consumer protection and information."

DOC Relinquishes Control of MedPartners Provider Network

In October, physicians under contract to MedPartners Provider Network (MPN)—a California subsidiary of Alabama-based MedPartners Inc. that was seized by DOC in March and placed in bankruptcy—finally began receiving payments for an estimated $50 million in patient care they had rendered almost one year earlier.

MPN is a physician management company which—prior to DOC's takeover—ran 117 clinics and employed 1,000 physicians who provided health care to 1.3 million Californians. The Department placed MPN in Chapter 11 bankruptcy and appointed a conservator following its March 5 release of the public report on its financial examination of MPN, in which DOC asserted that MPN had been extremely slow in processing claims, prompting some health plans to withhold payments to the company. Additionally, MPN overpaid hospitals by $21.5 million over the past three years, and its cash flow further suffered because it failed to collect any of the overpayment. *[16:2 CRLR 7–8]* DOC's goals in taking over the company were to ensure continued patient care and payments to physicians for services rendered.

Throughout the spring and summer, MPN's parent company negotiated with MPN's creditors, the State of California, and the California Medical Association—a physician trade association which has sounded several alarms about the unstable fiscal solvency of medical groups forced to accept managed care contracts which they are unable to negotiate and for which they bear all the financial risk. In 1998, CMA sought Department intervention when another "middleman" physician management group, FPA Medical Management of California, went bankrupt after it had been paid by the health plans with which it had contracted; essentially, CMA sought a DOC order requiring health plans to pay twice—once to FPA (which then went bankrupt and failed to pay its physician contractors), and again to the physicians who actually provided the care but were not paid by FPA. DOC declined to intervene, and said CMA should have protected its members' interests by intervening in FPA's bankruptcy proceeding. *[16:1 CRLR 29]* Dissatisfied with DOC's response, CMA recently sued eight California HMOs to recover payments for physicians "stiffed" by FPA (see LITIGATION).

Recently, CMA participated actively in MPN's bankruptcy proceeding to ensure that the physicians who contracted with it are paid for their services. In July, DOC returned control of MPN to its owners, on condition that its parent company pay all outstanding debts. After several additional months of dispute over the precise method of paying physician providers, the parties on October 6 agreed to a "release" system under which MPN agreed to pay physicians a large portion of the money owed in exchange for releases preventing the physicians from suing MPN or the health plans that contracted with MPN. CMA estimates that physicians who agree to the proposal will receive about 75% of what is owed to them without further litigation, and encouraged its affected members to sign the releases.

Physician Association Warns of Impending Medical Group Crisis

In a related matter, in September CMA released a report entitled *The Coming Medical Group Failure Epidemic*, which included the results of a study performed by the accounting firm of PriceWaterhouseCoopers. In its study, PWC identified 113 medical groups (including FPA and MPN) that have already gone out of business during the past three years, predicted that 34 more medical groups in California will go bankrupt within a year, and stated that 70% of the remaining groups are in "serious financial trouble." According to CMA's Dr. Jack Lewin, "medical groups and independent physicians associations are going bankrupt across the state because HMOs are forcing doctors to do more with less. They have placed the burden of paying for patients' health care on the physicians through capitation and then squeezed capitation rates down to the point where they are often insufficient to cover the cost of care."

At the core of the problem, says CMA, is a combination of factors that have hurt physicians and threaten patient care: (1) the power of large coverage purchasers that are able to negotiate low HMO premiums for their members/employees, (2) the fact that five health plans control at least 75% of the California managed care market; and (3) the failure or inability of medical groups contracting with HMOs to adequately scrutinize their contracts to ensure they can provide sufficient care for the compensation provided. When physician groups strapped by low capitation rates get into financial trouble, the incentives to delay or deny care to patients are momentous, and quality of care suffers.

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Another component of this problem is the fact that physician medical groups (such as FPA and MPN) are being granted "limited licenses" as "mini-HMOs" by DOC under the Knox-Keene Act; under a "limited license," a physician-owned medical group or physician-hospital network (rather than the HMO with which the group contracts) manages patient care in exchange for agreeing to accept the risk that patient costs (both hospital and outpatient) may exceed the money allotted by the HMO to cover them. Thus, in exchange for greater autonomy and a more direct opportunity to cut or save costs, the medical group—rather than the HMO—becomes the "risk-bearing organization" in the transaction. According to CMA, DOC has issued 13 limited licenses to physician groups since 1995. Seven were issued very recently and no fiscal data are yet available on them; however, of the remaining six, two have gone bankrupt, two surrendered their licenses, one is on "monthly fiscal watch," and only one is in good shape. DOC's ability to monitor the financial stability of these limited licensees who have assumed the entire risk is in question.

SB 260 imposes a moratorium on the issuance of further "limited licenses" while the new Department of Managed Care adopts regulations setting up a "financial grading system" for physician medical groups, enabling DMC, health plans, and the groups themselves to ensure that they are not contracting to provide more services than they can handle.

As described below (see LEGISLATION), Governor Davis recently took a first step toward addressing this problem by signing SB 260 (Speier) (Chapter 529, Statutes of 1999). SB 260 imposes a moratorium on the issuance of further "limited licenses" while the new Department of Managed Care adopts regulations setting up a "financial grading system" for physician medical groups, enabling DMC, health plans, and the groups themselves to ensure that they are not contracting to provide more services than they can handle. Once again, the responsibility for implementing this somewhat skeletal legislation is delegated to the yet-to-be-named Director of the Department of Managed Care.

DOC Releases 1998 Complaint Data

On August 5, DOC released *Health Care Service Plan Complaint Data: 1998 Requests for Assistance*, a compilation of DOC statistics on the number of complaints and requests for assistance filed by consumers with DOC against health plans in California during calendar year 1998. DOC cautions that the report, which is published pursuant to Health and Safety Code section 1397.5(a), is provided for statistical purposes only; the Commissioner has neither investigated nor determined whether the complaints compiled are reasonable or valid.

A "request for assistance" (RFA) is defined as a grievance or complaint received by DOC's Health Plan Division against a health plan. In order to have a complaint classified as a RFA, a consumer must have first participated in the plan's internal grievance process for at least 60 days before seeking assistance from HPD. DOC classifies its RFAs into four broad categories: accessibility, benefits/coverage, claims, and quality of care.

Among the full service health plans with the most enrollees (over one million), PacifiCare of California and Health Net were the subject of the highest number of RFAs per 10,000 enrollees in 1998, at 1.7461 and 1.2310, respectively. PacifiCare had the highest ratio of quality of care RFAs as well, at 1.1795 per 10,000 enrollees. The report contains similar statistical data for dental, vision, psychological, and other specialized health plans. The report also identifies new health plans licensed in 1998, as well as plans which surrendered their Knox-Keene licenses in 1998.

DOC Ends Investigation of Health Plans' Prescription Drug Formularies

As part of its early 1999 investigation into the drug formularies of six managed care organizations in California, DOC ordered five of the six plans to restore certain prescription drugs that had been deleted from the plans' formularies as of January 1. Specifically, DOC required: (1) Health Net to restore 14 drugs (but found it could delete 58 drugs); (2) Aetna U.S. Healthcare of California to restore seven medications (but could delete 37 others); (3) Kaiser Permanente to restore one drug (but could delete five others); (4) Key Health Plan to restore one drug (but could delete 17 others); and (5) Molina Medical Centers to restore two drugs (but could delete 15 others). DOC also told all six HMOs under investigation (including United HealthCare of California) to obtain Department approval of future formulary changes. *[16:2 CRLR 8]*

DOC officials began its investigation in late 1998 at the behest of Citizens for the Right to Know, a Sacramento-based coalition of consumer and health care provider groups, when the organization received an increasing number of calls from enrollees complaining about prescription drug denials or switches by their health plans. The coalition alleged that the timing of the complaints indicated two potential problems: (1) the companies may have lured new enrollees with full prescription drug formularies during the fall 1998 "open enrollment period," and then delisted many previously listed drugs; and (2) the plans may have been trying to avoid the impact of AB 974 (Gallegos) (Chapter 68, Statutes of 1998), which—effective July 1, 1999—prohibits plans from limiting or excluding coverage for a drug for an enrollee if the drug previously has been approved for coverage by the plan and the plan's physician continues to prescribe the drug. *[16:1 CRLR 32]* Some speculated that the plans wanted to dump expensive medications so as to preclude new enrollees from accessing them after July 1.

On June 14, DOC notified Kaiser Permanente that it found no wrongdoing on Kaiser's part and was dropping the investigation as to Kaiser. Later in the fall, the Department ended its investigation of the other five HMOs as well, prompting representatives of managed care trade associations to express outrage that DOC had commenced the investigation and publicized its allegations without seeking an explanation from the HMOs. The HMO association asserted that while some drugs were deleted as part of a routine, annual review of their formularies, many more drugs had been added to the formularies than deleted.

Managed Care Rulemaking

On June 25, DOC amended section 1300.71.4, Title 10 of the CCR, on an emergency basis. Section 1300.71.4 sets forth emergency medical condition and post-stabilization responsibilities of health plans for medically necessary health care services. The amendments, which clarify that a health plan is responsible for post-stabilization emergency care regardless of whether the services are administered by a contracting or non-contracting provider, are required under AB 682 (Morrow) (Chapter 1015, Statutes of 1998). AB 682 amended Health and Safety Code section 1371.4(h) to require the DOC Commissioner to adopt regulations by July 1, 1999 governing instances when a health plan enrollee, in the opinion of the treating provider, requires necessary medical care following stabilization of an emergency medical condition.

On July 9, the Department published notice of its intent to permanently adopt the amendments to section 1300.71.4. DOC held no public hearing on its proposal, but accepted written comments until August 27. Thereafter, Acting DOC Commissioner William Kenefick approved the proposal; at this writing, the rulemaking file on the amendments is pending at the Office of Administrative Law.

LEGISLATION

AB 78 (Gallegos), as amended September 8, transfers responsibility for the administration and implementation of the Knox-Keene Health Care Service Plan Act of 1975, under which most managed care plans are regulated, from the Department of Corporations to a new Department of Managed Care within the Business, Transportation and Housing Agency. The Department will be headed by a Director who is appointed by and serves at the pleasure of the Governor. The bill also establishes within DMC (1) an Advisory Committee on Managed Care to assist and advise the DMC Director on various issues, and produce an Internet-accessible annual public report that will, at minimum, contain recommendations made to the Director; (2) an Office of the Patient Advocate to develop educational and informational guides for consumers describing enrollee rights and responsibilities, inform enrollees on effective ways to exercise their rights to secure health care service, and render advice and assistance to enrollees, and (3) a Clinical Advisory Panel to provide expert assistance to the Director in ensuring that the external independent medical review system under AB 55 (Migden) (see below) is meeting the quality standards necessary to protect the public's interest; the panel will review the decisions made in external review to ensure that the decisions are consistent with best practices and make recommendations for improvements where necessary.

AB 78 requires the DMC Director, in conjunction with the Advisory Committee on Managed Care, to undertake a study to consider the feasibility and benefit of consolidating into DMC the regulation of other health insurers providing insurance through indemnity, preferred provider organization, and exclusive provider organization products, as well as through other managed care products regulated by the Department of Insurance; and to submit a report and recommendation to the Governor and the legislature no later than December 31, 2001.

AB 78 becomes effective on January 1, 2000, and become operative on the date that the Governor, by executive order, establishes the Department of Managed Care or July 1,

2000, whichever occurs first. AB 78 was signed by the Governor on September 27 (Chapter 525, Statutes of 1999).

AB 55 (Migden), as amended September 9, requires the new DMC to establish, commencing January 1, 2001, an independent medical review system (IMRS) for health plan enrollees to seek an independent review whenever health care services have been denied, delayed, or otherwise limited by a plan or one of its contracting providers based on a finding that the service is not medically necessary or appropriate; "coverage decisions" (*i.e.*, a finding that a service is included or excluded under the terms of a plan) are not reviewable by the IMRS. The DMC shall be the final arbiter when there is a question as to whether an enrollee grievance is a disputed health care service or a coverage decision. The independent reviews will be conducted by expert medical organizations independent of plans and certified by an accrediting organization, pursuant to conflict of interest provisions. The Department must adopt the determination of the independent review entity, which shall be binding on the plan. In cases where the enrollee's position prevails, the plan must either offer the enrollee the disputed health care service or reimburse the enrollee for care received if so directed by the Department. Under this bill, an enrollee would not pay any application or processing fee; the costs of the IMRS will be paid by an assessment on health plans. The bill also establishes an IMRS in the Department of Insurance for review of similar decisions by disability insurers. AB 55 was signed by the Governor on September 27 (Chapter 533, Statutes of 1999).

AB 55 (Migden), as amended September 9, requires the new DMC to establish, commencing January 1, 2001, an independent medical review system (IMRS) for health plan enrollees to seek an independent review whenever health care services have been denied, delayed, or otherwise limited by a plan or one of its contracting providers based on a finding that the service is not medically necessary or appropriate.

SB 189 (Schiff). Existing law requires every health plan to establish and maintain a grievance system approved by the Department under which enrollees and subscribers may submit their grievances to the plan; after participating for at least 60 days in, or completing, the plan's grievance process, an enrollee or subscriber may submit the grievance or complaint to the Department for review. As amended September 8, SB 189 modifies this system to require health plans to provide a written response to a grievance that includes a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan's response must describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. The bill further requires health plans to complete the grievance process in 30 days (instead of 60 days), and in three days (instead of five days) in cases involving an imminent and serious threat to the health of the patient—after which time period the patient may submit the grievance to DMC; and directs DMC to investigate and take enforcement action against health plans regarding grievances that involve plan noncompliance with the law. SB 189 was signed by the Governor on September 27 (Chapter 542, Statutes of 1999).

AB 12 (Davis), as amended September 7, requires health plans and insurers to provide or authorize a second opinion upon the request of a patient or a participating health professional treating a patient under five specified circumstances. The second opinion must be provided by an "appropriately qualified health care professional," meaning a primary care physician or a specialist who is acting within his/her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion. The bill also requires plans to authorize or deny the second opinion in an expeditious manner; requires plans and insurers to file timelines for responding to requests for second opinions by July 1, 2000, with the appropriate state agency; and requires that the timelines be made available to the public upon request. This bill was signed by the Governor on September 27 (Chapter 531, Statutes of 1999).

AB 12 (Davis), as amended September 7, requires health plans and insurers to provide or authorize a second opinion upon the request of a patient or a participating health professional treating a patient under five specified circumstances.

SB 59 (Perata), as amended September 9, sets forth procedures and timeframes within which health plans must review treatment proposed by a physician. Specifically, the bill requires health plans to approve or deny requests by providers within five business days, except when the enrollee's condition is such that five days could be detrimental or jeopardize the enrollee's recovery, in which case decisions must be made within 72 hours. The bill requires a written response denying, delaying, or modifying treatment, which must describe the criteria used and clinical reasons for the decision and also provide information on how the enrollee may file a grievance. Further, the bill requires a health plan to disclose the process by which the plan, its contracting provider groups, or any entity with which the plan contracts for services uses to authorize, modify, or deny health care services to health care providers, enrollees, or to any other person or organization upon request.

AB 59 also makes a finding that "decisions about medical care should be made by physicians and other relevant health care professionals." The bill adds section 1367.01 to

the Health and Safety Code, which expressly requires health plans to "employ or designate a medical director who holds an unrestricted license to practice medicine in this state" pursuant to the Medical Practice Act or the Osteopathic Act; if the plan is a specialized health care service plan, the plan must employ or designed a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees, complies with the requirements of this bill. The Governor signed SB 59 on September 27 (Chapter 539, Statutes of 1999).

SB 21 (Figueroa), as amended September 8, provides that health plans and managed care entities, for services rendered on or after January 1, 2001, have a duty of ordinary care to provide medically appropriate health care service to their subscribers and enrollees where such health care service is a benefit provided under the plan, and makes such entities liable for any and all harm legally caused by the failure to exercise ordinary care in arranging for the provision of, or denial of, health care services when both of the following apply: (1) the failure to exercise ordinary care results in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee; and (2) the subscriber or enrollee suffers "substantial harm." The term "substantial harm" means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss. SB 21 also provides that a person may not maintain a cause of action against a health plan unless he/she has exhausted the procedures provided by any applicable internal grievance system or independent review system, with certain exceptions. SB 21 characterizes the managed care industry as engaging "in the business of insurance." The business of insurance is not governed by ERISA (see MAJOR PROJECTS and LITIGATION).

SB 21 also prohibits health care service plans and managed care entities from seeking indemnity from providers for their violation of their duty of ordinary care to arrange for the provision of medically necessary health care service to their subscribers and enrollees, and makes any provisions to the contrary in a contract with providers void and unenforceable. Further, any waiver by a subscriber or enrollee of the liability of the health plan is contrary to public policy and unenforceable. Governor Davis signed SB 21 on September 27 (Chapter 536, Statutes of 1999).

SB 19 (Figueroa). Existing law, known as the Confidentiality of Medical Information Act, prohibits the disclosure of medical information by providers of health care, including certain health care service plans, except in specified circumstances. Unauthorized disclosure that results in economic loss or personal injury to a patient is a misdemeanor. SB 19 revises the Act's definition of "providers of health care," and makes the prohibitions on disclosure of medical information applicable also to all health plans and contractors. The bill expressly prohibits (1) negligent disposal or destruction of medical information, and (2) the intentional sharing, sale, or use of medical information for any purpose not necessary to provide health care services to the patient, except as otherwise authorized. Violation of the Act is grounds for suspension or revocation of a health plan's license and creates a right of action to recover damages for any individual whose confidential information or records are negligently released; additionally, the bill provides for specified administrative and civil penalties. SB 19 also prohibits a provider of health care or a health plan and its contractors from requiring a patient, as a condition to receiving health care services, to sign an authorization, release, consent, or waiver permitting the disclosure of any medical information subject to confidentiality protections provided by law. SB 19 further requires all health plans, by July 1, 2001, to provide all patients with a written statement describing how the plan maintains the confidentiality of medical information. Governor Davis signed SB 19 on September 27 (Chapter 526, Statutes of 1999).

AB 416 (Machado), as amended September 9, makes a number of legislative findings and declarations regarding the importance of maintaining confidentiality of information on patients undergoing mental health treatment. The bill adds section 56.104 to the Civil Code, which prohibits health care providers from releasing specified medical information created regarding an individual as a result of that person's participation in outpatient treatment with a psychotherapist, unless the person or entity requesting the information ("requester") submits a written request to both the patient and the health care provider. The written request must be signed by the requester, and must include (1) the specific information relating to a patient's participation in outpatient treatment with a psychotherapist being requested and its specific intended use or uses; (2) the length of time during which the requester will keep the information before destroying or disposing of it (a requester may extend that timeframe, provided that the requester notifies the provider of the extension and explains the specific reason for the extension, the intended use(s) of the information during the extended time, and the expected date of the destruction of the information); (3) a statement that the information will not be used for any purpose other than its intended use; and (4) a statement that the requester will destroy the information and all copies in the requester's possession or control, will cause it to be destroyed, or will return the information and all copies of it before or immediately after the length of time specified in section (2) above has expired. The bill also extends this prohibition to health care service plans and their contractors.

The bill also amends Civil Code section 56.35, to provide that a patient whose medical information has been used or disclosed in violation of Civil Code section 56.104 and who has sustained economic loss or personal injury there-

from may recover compensatory damages, punitive damages not to exceed $3,000, attorneys' fees not to exceed $1,000, and the costs of litigation. The Governor signed this bill on September 27 (Chapter 527, Statutes of 1999).

SB 260 (Speier), as amended September 8, establishes the advisory Financial Solvency Standards Board within the newly-created Department of Managed Care. The purpose of the Board is to: (1) advise the DMC Director on matters of financial solvency affecting the delivery of health care services; (2) develop and recommend to the Director financial solvency requirements and standards relating to plan operations, plan-affiliate operations and transactions, plan-provider contractual relationships, and provider-affiliate operations and transactions; and (3) periodically monitor and report on the implementation and results of the financial solvency requirements and standards. The bill also requires the DMC Director to adopt regulations containing financial solvency standards based upon the recommendations of the Financial Solvency Standards Board.

SB 260 also attempts to address the problems now facing medical groups of physicians who contract to provide services to enrollees of health plans, but fail to be paid either adequately or on a timely basis under those contracts by health plans (see MAJOR PROJECTS and LITIGATION). The bill imposes a two-year moratorium upon DMC's issuance of limited licenses to physician medical groups under the Knox-Keene Act, and creates a regulatory framework intended to ensure the fiscal solvency of medical groups that assume financial risk ("risk-bearing organizations"). In this regard, the bill requires the DMC Director to adopt regulations in the following areas on or before June 30, 2000: (1) the regulations must establish a process for the review or "grading" of risk-bearing organizations based on specified criteria; (2) the review or grading process must be based upon information provided by risk-bearing organizations, including balance sheets, claims reports, and designated annual, quarterly, or monthly financial statements prepared in accordance with generally accepted accounting principles; (3) audits must be conducted in accordance with generally accepted auditing standards and in a manner that avoids duplication of review of the risk-bearing organization; (4) the regulations must establish a process for corrective action plans, as mutually agreed upon by the health plan and the risk-bearing organization and as approved by the Director, for cases where the review or grading indicates deficiencies that need to be corrected by the risk-bearing organization, and must set forth contingency plans to ensure the delivery of health care services if the corrective action fails; (5) the regulations must require health plans to disclose specified information to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the risk assumed under the contract; (6) health plans must provide periodic reports to the Director that include information concerning the risk-bearing organizations and the type and amount of financial risk assumed by them, and, if deemed necessary and appropriate by the Director, DMC must create a registration process for the risk-bearing organizations; and (7) the regulations must ensure the confidentiality of financial and other records to be produced, disclosed, or otherwise made available, unless as otherwise determined by the Director.

SB 260 also attempts to address the problems now facing medical groups of physicians who contract to provide services to enrollees of health plans, but fail to be paid either adequately or on a timely basis under those contracts by health plans.

SB 260 also prohibits a contract between a risk-bearing organization and a health plan that is issued, amended, delivered, or renewed in California on or after July 1, 2000, from including any provision that requires a provider to accept rates or methods of payment specified in contracts with health plan affiliates or nonaffiliates unless the provision has been first negotiated and agreed to between the health plan and the risk-bearing organization. Governor Davis signed SB 260 on September 27 (Chapter 529, Statutes of 1999).

AB 215 (Soto), as amended September 10, is a technical clean-up bill to SB 260 (Speier) (see above). AB 215 was signed by the Governor on September 27 (Chapter 530, Statutes of 1999).

AB 285 (Corbett), as amended September 8, pertains to in-state and out-of-state business entities engaged in the business of providing telephone medical advice services (advice services) to California consumers; these advice services are frequently provided by health plans licensed by DOC under the Knox-Keene Act. AB 285 requires, on and after January 1, 2000, any in-state or out-of-state advice service that provides medical advice to a patient at a California address to be registered with the Department of Consumer Affairs (DCA). In order to obtain and maintain registration, advice services must comply with the requirements established by DCA, which shall include: (a) ensuring that all staff who provide advice are appropriately licensed as a physician, dentist, dental hygienist, psychologist, marriage and family therapist, optometrist, chiropractor, or osteopath in the state within which they provide advice services, and are practicing within their respective scope of practice (however, registered nurses providing advice, both in-state and from an out-of-state location, must be licensed in California); (b) maintaining records of advice services, including records of complaints, provided to patients in California for a period of at least five years; and (c) complying with all directions and requests for information made by DCA. The bill also requires health plans and disability insurers that provide advice services to ensure that their advice service is registered pursuant to this bill, and to ensure that a physician is available on an on-call basis at all times the service is advertised to be available. This bill was signed by the Governor on September 27 (Chapter 535, Statutes of 1999).

AB 88 (Thomson), as amended September 8, requires health plan contracts and disability insurance policies issued, amended, or renewed on or after July 1, 2000, to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions. Health plans and disability insurers may provide the required mental health coverage through a separate specialized health care service plan or mental health plan, subject to certain conditions. Governor Davis signed AB 88 into law on September 27 (Chapter 534, Statutes of 1999).

AB 892 (Alquist), as amended August 23, includes, on and after January 1, 2002, as a basic health care service to be offered by health plans, hospice care that must be equivalent to that provided pursuant to the federal Medicare program. The bill also requires the DMC Director to adopt regulations for the provision of hospice care, and requires the Director to submit an annual report commencing in January 2002 on changes in federal regulations that require a change in state regulations for hospice care. Governor Davis signed this bill on September 27 (Chapter 528, Statutes of 1999).

SB 148 (Alpert), as amended July 13, requires health plans and specified disability insurance policies to provide coverage, on and after July 1, 2000, for the testing and treatment of phenylketonuria. The Governor signed this bill on September 27 (Chapter 541, Statutes of 1999).

AB 39 (Hertzberg), as amended September 2, and **SB 41 (Speier)**, as amended July 2, require health plans and disability insurance policies, respectively, to cover approved prescription contraceptive methods effective January 1, 2000. Both bills permit certain religious employers to request contracts without such coverage. Governor Davis signed AB 39 on September 27 (Chapter 532, Statutes of 1999) and SB 41 on September 27 (Chapter 538, Statutes of 1999).

SB 5 (Rainey), as amended June 29, requires health plans and certain disability insurance policies to cover screening for, diagnosis of, and treatment for breast cancer after January 1, 2000; and prohibits health plans from denying enrollment solely due to a family history of breast cancer, or because one or more diagnostic procedures for breast disease was conducted where breast cancer has not developed or been diagnosed. Governor Davis signed this bill on September 27 (Chapter 537, Statutes of 1999).

SB 205 (Perata), as amended August 24, requires health plans and disability insurance policies to cover all generally medically accepted cancer screening tests after January 1, 2000. The Governor signed SB 205 on September 27 (Chapter 543, Statutes of 1999).

SB 349 (Figueroa), as amended September 7, revises the definition of "emergency services and care" to include psychiatric screening, examination, evaluation, and treatment by a physician (or other personnel to the extent permitted by applicable law and within the scope of their licensure and privileges), and clarifies that reimbursement of psychiatric facilities providing emergency services and care in such cases is an existing responsibility of health plans and not a new mandate. The Governor signed SB 349 on September 27 (Chapter 544, Statutes of 1999).

SB 64 (Solis), as amended September 9, requires health plans and disability insurance policies to cover a variety of diabetic services and supplies. Governor Davis signed this bill on September 27 (Chapter 540, Statutes of 1999).

SB 97 (Burton), as amended June 8, prohibits a health care facility from retaliating or discriminating against an employee, patient, or other person who files a grievance or complaint with a licensing agency or who cooperates in any investigation or proceedings of a governmental entity related to the care, services, or conditions in the facility. The bill establishes a "rebuttable presumption" that any discriminatory treatment taken by a health facility is retaliatory if it occurs against a patient within 180 days of the filing a grievance or complaint or an employee within 120 days of such a filing. SB 97 establishes civil penalties and makes violations of its provisions punishable as a misdemeanor. This bill was signed by the Governor on July 22 (Chapter 155, Statutes of 1999).

AB 58 (Davis). Early versions of this bill would have would added section 2042 to the Business and Professions Code to require any employee of a health plan licensed under the Knox-Keene Act who is responsible for the final decision, or is responsible for the process in which a final decision is made, regarding the medical necessity or medical appropriateness of any diagnosis, treatment, operation, or prescription to be a physician licensed by the Medical Board of California. As noted above, a similar provision was incorporated into SB 59 (Perata), which was signed by the Governor.

As amended September 9, AB 58 would have enacted the Leslie-Davis-Figueroa Medical Accountability Act of 1999, to require a chiropractor, dentist, osteopath, pharmacist, psychologist, optometrist, or podiatrist who makes a decision regarding medical necessity or appropriateness that denies, delays, or modifies, any health care service made by a healing arts licentiate acting within his/her scope of practice, to be licensed in California and acting within his/her scope of practice. The Governor vetoed AB 58 on October 6, noting that he had already signed SB 59 (Perata), which requires a managed care plan's medical director to be licensed in California (see above). He expressed concern that AB 58 would "preclude out-of-state experts from making determinations regarding medical necessity which will, in some cases, inhibit the best input on critical clinical questions....While the bill would allow a California physician to consult with an out-of-state physician, the final decision would have to be made by a California licensee. This effectively prohibits plans from employing top experts to make the decisions in very specialized cases."

AB 351 (Steinberg), as amended September 9, would have required the Attorney General to approve in advance any merger, acquisition, or change in control of a health plan

doing business in California to ensure that such a transaction will not substantially lessen competition or create a monopoly in the state. Governor Davis vetoed AB 351 on October 10, stating: "While I agree with the author that this issue should receive scrutiny at the state level, I think the responsibility to examine a merger or acquisitions impact on patient care and competition should reside in my new Department of Managed Care."

AB 351 (Steinberg), as amended September 9, would have required the Attorney General to approve in advance any merger, acquisition, or change in control of a health plan doing business in California to ensure that such a transaction will not substantially lessen competition or create a monopoly in the state. Governor Davis vetoed AB 351 on October 10.

SB 1053 (Poochigian), as amended September 3, would have provided that no health plan contract may prohibit an enrollee or insured from choosing to obtain covered services for a condition that, in the opinion of the enrollee's primary care or treating physician, has a likelihood of causing death, loss of limb, or loss of vital bodily function from any contracting or participating plan provider in any geographic service area in the state served by that plan regardless of the service area in which the enrollee is located in certain described circumstances. Governor Davis vetoed SB 1053 on October 10, stating that "while this bill may have merit, it was not part of my negotiated package of consumer rights and could substantially raise health plan costs and employer premiums."

SB 362 (Alpert), as amended June 29, would require health plans and disability insurers to provide coverage for the screening, diagnosis, and treatment of ovarian cancer, when medically necessary, consistent with good professional practice and according to the guidelines offered by the National Cancer Institute, the American Medical Association, the American Cancer Society, or other nationally recognized medical societies. *[S. Unfinished Business]*

SB 1177 (Perata), as amended July 2, would impose specified penalties on a health plan that fails to comply with the law regulating reimbursement of claims with regard to claims submitted by an emergency physician or hospital emergency department. The bill would require a court to award to a prevailing emergency physician the amount of the claim and the prescribed penalties plus court costs and reasonable attorney fees; however, an emergency physician or emergency hospital department would not be entitled to interest. *[S. Appr]*

SB 7 (Figueroa and Leslie), as amended May 28, and **SB 18 (Figueroa)**, as amended June 28, are similar to SB 59 (Perata) (see above), and would ensure that any person who makes a medical necessity or appropriateness decision that denies, significantly delays, terminates, or otherwise limits any diagnosis, treatment, operation, or prescription is appropriately licensed in California. *[A. Appr; A. Appr]*

SB 422 (Figueroa), as amended June 21, would require any communication by a health plan or its contracting medical groups and independent practice associations, indicating a denial or modification of a request for prior authorization for health care services to be communicated to the enrollee in writing, and to physicians or other health care providers initially by telephone and then in typewritten form. The bill would also require any written communication to a physician or other health care provider of a denial or modification of a request for prior authorization to include the name and telephone number of the health care professional responsible for the denial. *[A. Desk]*

AB 1621 (Thomson), as amended August 24, would provide that, notwithstanding any other provision of law, no health plan or nonphysician employee of a health plan may engage in the practice of medicine. *[S. Appr]*

SB 254 (Speier), as amended May 18, is similar to SB 189 (Schiff) (see above) and would require health plans to provide subscribers and enrollees with written responses to grievances, and would allow an enrollee or subscriber to submit a grievance to DMC after participating in the plan's grievance process for 30 days (rather than 60 days). The bill would require DOC to respond to each grievance in writing within 30 days. SB 254 also contains the IMRS provisions enacted in AB 55 (Migden) (see above). *[S. Appr]*

AB 138 (Gallegos), as amended August 16, would require the DMC Director to allocate funds for an independent health care ombudsprogram under which projects throughout the state would receive funding to provide health plan enrollees with counseling, assistance, and advocacy services. *[S. Appr]*

AB 368 (Kuehl), as amended August 17, would require health plans, health insurance providers, and Medi-Cal to provide coverage for prosthetic devices for "low vision" individuals (*i.e.*, visual acuity with best correction in the better eye worse than 20/60 or significant impairments in the central or peripheral field of vision, as documented by a formal visual field measurement). The term "prosthetic devices" means devices that substitute for or augment visual function for a diseased eye by providing magnification to enable the use of alternative sites of the eye for vision. Prosthetic devices include, but are not limited to, magnification devices, including spectacle-mounted devices designed for a working distance of seven inches or less, illumination-related devices, telescopes (for far or near), field expansion devices, video magnifiers, computer-based devices, and voice output devices. *[S. Appr]*

SB 265 (Speier), as amended July 8, would revise state law to conform to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), including requiring a health plan or disability insurer to issue coverage to federally eligible individuals who were previously covered under a group contract for 18 months. *[A. Health]*

AB 735 (Knox). Under existing law, health plans must reimburse claims, or any portion thereof, as soon as possible, but no later than 30 days for in-state claims (or 45 days for

out-of-state claims) after receipt of the claim, unless the claim is contested. If uncontested claims are not paid within the applicable time period, interest accrues at the rate of 10% per annum. As amended August 16, this bill would change the interest rate to 18% per annum on claims that are not contested or denied, and enact penalties for failure to pay these claims when required. This bill would also require the notice that a claim is being contested or denied to identify the contested or denied portion, provide the specific reasons for contesting or denying, and provide additional information concerning the objection and steps to take for appeal. *[S. Ins]*

SB 292 (Figueroa), as amended June 24, would require dental insurers and specialized health plans that provide dental benefits to allow an enrollee, an insured, or a participating dentist treating an enrollee or insured to obtain a second opinion from any licensed California dentist of the enrollee's choice, regardless of whether the dentist is a plan participant, when a dental care service that would otherwise be a covered benefit under a dental plan contract has been denied, significantly delayed, terminated, or otherwise limited by a decision of the plan, or by one of its contracting providers, based, in whole or in part, on a finding that the service is unnecessary or inappropriate for the enrollee's oral health condition. A dental plan shall only be required to provide one second opinion pursuant to this section per enrollee per year, and only when the fee submitted by the dentist for the disputed benefits exceeds the level of reimbursement, if any, approved by the plan by at least $250. This bill would also allow a participating dentist who is treating an enrollee or insured to act on behalf of that enrollee or insured in any applicable grievance or appeals process involving a benefit that has been denied, significantly delayed, terminated, or otherwise limited by a decision of the plan or insurer based, in whole or in part, on a finding that the service is inappropriate for the enrollee's or insured's oral health condition. *[A. Health]*

AB 1124 (Havice), as amended in April 1999, would require every health plan to permit an enrollee or subscriber to select his/her own qualified health care professional, including a primary care physician, from any qualified health care provider who is a participating plan provider in any medical group, independent practice association, or individual practice within the plan network of providers. This bill would authorize the health plan to charge additional reasonable premiums if the selected health care professional is not a member of the plan. *[S. Ins]*

Several cases that may signal a changing attitude in the federal judiciary's interpretation of the so-called "ERISA loophole" are winding their way through the federal courts.

SB 420 (Figueroa), as amended in April 1999, would declare that the legislature believes that it is in the public interest for the administration and enforcement of the Knox-Keene Act to be undertaken by an entity of state government devoted exclusively to the licensing and regulation of the business of managed health care; and would transfer the administration of the Knox-Keene Act from the Department of Corporations to the Department of Managed Care Oversight to be established in the California Health and Human Services Agency. *[S. Appr]*

SB 217 (Baca), as amended in April 1999, would require, on and after September 1, 2000, that the public policy procedures of health plans include an annual survey of the plan's subscribers and enrollees to identify their satisfaction with the plan. *[S. Appr]*

AB 888 (Wayne), as introduced in February 1999, would require health plans to prepare and report to the Corporations Commissioner a calculation of their actual or expected loss ratios pursuant to formulas, definitions, and procedures established by DOC. *[A. Health]*

AB 1283 (Baugh), as introduced in February 1999, would declare the intent of the legislature to create an independent review process applicable to all health care coverage decisions. *[A. Rules]*

AB 1285 (Baugh), as introduced in February 1999, would enact provisions applicable to a health plan that prospectively reviews and approves or denies initial requests by providers for authorization of coverage for treatment, including requirements for written policies and procedures, oversight of the review process by a medical director with certain qualifications, communication of the decision upon review to providers within a specified time frame, and other related provisions. *[A. Health]*

SB 337 (Figueroa), as introduced in February 1999, would prohibit a health plan with more than 25,000 covered enrollees from expending or allocating more than 15% of its gross revenues for administrative costs. *[S. Ins]*

AB 549 (Gallegos), as amended September 3, is no longer relevant to the regulation of managed care.

LITIGATION

Several cases that may signal a changing attitude in the federal judiciary's interpretation of the so-called "ERISA loophole" are winding their way through the federal courts:

• On September 28, the U.S. Supreme Court agreed to review the U.S. Seventh Circuit Court of Appeals' decision in ***Herdrich v. Pegram***, 154 F.3d 362 (Aug. 18, 1998). In its 2–1 ruling, the Seventh Circuit held that physicians and the HMO they work for may be sued under ERISA for breach of fiduciary duty when "physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses."

Plaintiff Herdrich sued her physician and HMO for failing to promptly perform an appendectomy after her physician found a six- by eight-centimeter inflamed mass in plaintiff's abdomen. Instead of operating immediately, the HMO required plaintiff to wait eight days and seek a diagnostic procedure at another plan facility 50 miles away; dur-

ing the eight-day waiting period, plaintiff's appendix ruptured, resulting in peritonitis. Instead of avoiding ERISA, plaintiff sued her physician and HMO directly under ERISA, alleging that both defendants are "fiduciaries" to the ERISA benefit plan under which plaintiff was covered, breached their fiduciary duties to plaintiff as a health plan participant, and caused plaintiff injury. The district court sustained the HMO's demurrer but the Seventh Court reversed, finding that both defendants are "fiduciaries" with respect to the health plan under ERISA's definition of that term in 29 U.S.C. § 1002(21)(A). The appellate court went on to find that the physician and the health plan may have breached their fiduciary duties by acting to benefit their own interests under 29 U.S.C. § 1104(a)(1)(A). In this regard, the court analyzed "the intricacies of the defendants' incentive structure." According to the court, "with a jaundiced eye focused firmly on year-end bonuses, it is not unrealistic to assume that the doctors rendering care under the plan were swayed to be most frugal when exercising their discretionary authority to the detriment of their membership." Although the majority did not hold that the mere existence of incentives automatically gives rise to a breach of fiduciary duty, "we hold that incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (*i.e.*, where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses)," and remanded the case to the district court to determine whether defendants had in fact breached their fiduciary duty to plaintiff and, if so, whether that breach resulted in a cognizable loss to plaintiff. However, the U.S. Supreme Court will hear this case first.

Although the majority did not hold that the mere existence of incentives automatically gives rise to a breach of fiduciary duty, "we hold that incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (*i.e.*, where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses)."

• On September 16, the U.S. Third Circuit Court of Appeals issued its decision in ***In Re U.S. Healthcare, Inc.***, 193 F.3d 151 (1999). In this matter, plaintiffs Steven and Michelle Bauman charged that their newborn daughter died one day after she and her mother were discharged in 1995 from a New Jersey hospital because their HMO, U.S. Healthcare, required that mothers and their newborns be discharged within 24 hours of birth; because of the infant's early discharge, plaintiffs alleged that the HMO failed to detect and treat a strep infection which caused her death. In an expansively-worded opinion, the Third Circuit held that while ERISA may preempt state law claims alleging denial of benefits, it was never intended to exempt HMOs from malpractice suits alleging quality of care violations: "Patients enjoy the right to be free from medical malpractice regardless of whether care is being provided through an ERISA plan." U.S. Healthcare intends to seek U.S. Supreme Court review of the Third Circuit's decision.

In an expansively-worded opinion, the Third Circuit held that while ERISA may preempt state law claims alleging denial of benefits, it was never intended to exempt HMOs from malpractice suits alleging quality of care violations: "Patients enjoy the right to be free from medical malpractice regardless of whether care is being provided through an ERISA plan."

• In Texas, both sides have appealed U.S. District Court Judge Vanessa Gilmore's September 1998 decision upholding a significant part of Texas' Health Care Liability Act ("the Act") in ***Corporate Health Insurance Inc. v. Texas Department of Insurance***, 12 F. Supp.2d 597 (S.D. Tex. 1998). Enacted in 1997, the Texas statute allows an individual to sue a health insurance carrier, HMO, or other managed care entity for damages proximately caused by the entity's failure to exercise ordinary care when making a health care treatment decision. In addition, the law provides that these entities may be held liable for substandard health care treatment decisions made by their employees, agents, or representatives. The Act also established an independent review process for adverse benefit determinations, and requires an insured or enrollee to submit his/her claim to a review by an independent review organization if such review is requested by the managed care entity.

Judge Gilmore rejected plaintiff insurance companies' challenge that the state statute is preempted by ERISA section 514(a) [29 U.S.C. § 1144(a)], which provides that ERISA "shall supersede any and all State laws insofar as they...relate to any employee benefit plan." Similar to the Third Circuit's decision in *U.S. Healthcare* (see above), Judge Gilmore found that ERISA preempts cases stemming from an HMO's decision to deny benefits but does not preempt tort claims arising from the quality of care provided by an HMO. Plaintiff Aetna Liability Casualty Company is appealing this portion of the ruling. However, the state Attorney General's Office is appealing Judge Gilmore's findings that the Act's independent review organization (IRO) provision and other provisions "that address specific responsibilities of an HMO and further explain and define the procedure for independent review of an adverse benefit determination by an IRO" are preempted by ERISA because they "mandate employee benefit structures or their administration," citing *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995). *[16:2 CRLR*

13–14; 16:1 CRLR 33-34] As California has now enacted both an HMO liability law and an independent external review process statute, the outcome of this Texas matter pending in the U.S. Fifth Circuit Court of Appeals will be of interest.

On August 17, the Fourth District Court of Appeal issued a controversial decision in ***McCall v. PacifiCare of California, Inc.***, 74 Cal. App. 4th 257 (1999), in which it upheld the right of a Medicare beneficiary to sue his HMO in state court for state law claims. Plaintiff McCall sued PacifiCare under various tort theories for refusing to refer him to a specialist for a lung transplant, which allegedly caused his condition to worsen. The trial court sustained PacifiCare's demurrer, finding that all of plaintiff's claims arose under the Medicare Act, which authorizes judicial review only in federal courts and only after exhaustion of administrative remedies. The Fourth District reversed, finding that while some of McCall's claims are in fact "reimbursement" claims arising under Medicare, others are straight state law claims that do not seek reimbursement for Medicare benefits; further, the Fourth District agreed with the Ninth Circuit that it is "reluctant to find state law preempted by the Medicare Act absent a clear Congressional intent." Thus, the Fourth District reversed the trial court and permitted McCall's state law claims to proceed in state court. PacifiCare has filed a petition for review with the California Supreme Court.

On July 15, the California Medical Association—dissatisfied with DOC's refusal to assist it in securing payment to its physician members for services rendered to patients of HMOs contracting with now-bankrupt FPA Medical Management (see MAJOR PROJECTS)—filed suit against eight managed care organizations in San Diego County Superior Court. CMA did not serve the lawsuit on the defendants until mid-September, after its last-ditch effort to secure assistance from Attorney General Bill Lockyer was declined. In ***California Medical Association v. Aetna U.S. Healthcare, et al.***, CMA alleges that the HMOs have violated Health and Safety Code section 1371, a provision requiring health plans to pay uncontested claims within 30 working days after receipt, and which states (in part) that "the obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services." CMA interprets this provision to require health plans to pay providers even when intermediary organizations—such as medical groups, independent practice associations, and practice management companies—do not. In addition to Aetna, the named defendants are Blue Cross of California, Blue Shield of California, Health Net, Maxicare Health Plans, PacifiCare of California, Prudential Healthcare, and United Healthcare of California.

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On May 3, the U.S. Supreme Court granted the federal government's petition for *certiorari* in ***Grijalva v. Shalala***, 152 F.3d 1115 (9th Cir. 1998), vacated the Ninth Circuit's decision in the matter, and remanded the case to the Ninth Circuit for reconsideration in light of the Court's recent decision in *American Manufacturers Mutual Insurance Company v. Sullivan*, 526 U.S. 40 (1999), the Balanced Budget Act of 1997, and the regulations of the U.S. Department of Health and Human Services (DHHS) implementing the Budget Act's provisions. In its 1998 decision, the Ninth Circuit affirmed a district court decision holding that constitutional procedural due process guarantees apply to Medicare beneficiaries when they are denied medical services by their HMOs. Under the Medicare Act, DHHS is authorized to enter into "risk-sharing" contracts with HMOs; under these contracts, HMOs provide to enrolled Medicare beneficiaries all the Medicare services provided in the statute. The Medicare Act also requires the Secretary to ensure that HMOs "provide meaningful procedures for hearing and resolving grievances between the organization...and members enrolled...." The Ninth Circuit affirmed that HMO denials of services to Medicare beneficiaries constitute state action so as to trigger constitutional guarantees (because the HMOs and the federal government "are essentially engaged as joint participants to provide Medicare services such that the actions of HMOs in denying medical services to Medicare beneficiaries and in failing to provide adequate notice may fairly be attributed to the federal government"), and that the regulations issued by the Secretary fail to provide procedural due process as required by the Medicare Act. *[16:2 CRLR 13]* In *American Manufacturers*, the U.S. Supreme Court held that a private insurer's decision to deny medical payments under Pennsylvania's workers' compensation program pending utilization review was not a due process issue.

At this writing, the California Supreme Court is reviewing several issues raised in the Second District Court of Appeal's decision in ***Broughton v. Cigna Healthplans of California***, 65 Cal. App. 4th (June 30, 1998). In its opinion, the Second District affirmed a trial court ruling that a medical malpractice plaintiff may sue her health plan for violation of the California Consumers Legal Remedies Act (the Act), Civil Code section 1750 *et seq.*, despite a mandatory arbitration clause in her health plan contract. Cigna, which seeks to enforce its arbitration provision, has appealed; the California Supreme Court has limited its review of the matter to the following issues: "(1) whether an arbitration clause in a health insurance plan compels arbitration of the cause of action for violation of the California Consumers Legal Remedies Act...where that Act authorizes an injunction as a remedy and contains an antiwaiver provision and (2) whether that construction of the

Act would violate the preemption provisions of the Federal Arbitration Act." *[16:2 CRLR 12-13]*

The California Supreme Court is also reviewing the Second District Court of Appeal's decision in ***Potvin v. Metropolitan Life Insurance Co.***, 54 Cal. App. 4th 936 (1997). In *Potvin*, the Second District affirmed a physician's right to procedural due process when being terminated by a managed care provider. The issue was whether an independent contractor physician is entitled to notice and opportunity to be heard before his membership in a mutual insurer provider network may be terminated notwithstanding an at-will provision in the agreement. In April 1997, the Second District reversed a summary judgment in favor of Metropolitan, holding that a physician who is a participating member of a managed health care network provided by an insurance company has a common law right to fair procedure before the insurance company may terminate his membership. *[16:2 CRLR 13; 16:1 CRLR 33]*

Dental Board of California

DBC—Executive Officer: Georgetta Coleman ♦ (916) 263-2300 ♦ Internet: www.dca.ca.gov/r_r/dentalbd.htm
COMDA—Executive Officer: Karen R. Wyant ♦ (916) 263-2595 ♦ Internet: www.comda.da.gov/

The Dental Board of California (DBC) is a consumer protection agency within the state Department of Consumer Affairs (DCA). DBC is charged with enforcing the Dental Practice Act, Business and Professions Code section 1600 *et seq.* The Board's regulations are located in Division 10, Title 16 of the California Code of Regulations (CCR).

DBC licenses dentists (DDS/DMD) and all categories of licensed dental auxiliaries, including registered dental assistants (RDA), registered dental assistants in extended functions (RDAEF), registered dental hygienists (RDH), registered dental hygienists in extended functions (RDHEF), and registered dental hygienists in alternative practice (RDHAP). Under Business and Professions Code section 1638 *et seq.*, the Board also issues oral and maxillofacial surgery (OMS) permits to qualified dentists and physicians.

At its December 3 meeting, the Dental Board is scheduled to entertain a September 9 petition filed by Consumers for Dental Choice, a coalition of several national organizations and individuals concerned about potential health risks associated with the use of mercury amalgams as dental fillings.

The Board is authorized to establish standards for its approval of dental schools and dental auxiliary training programs; prescribe the subjects in which its licensees should be examined; license applicants who successfully pass the examinations required by the Board; set standards for dental practice; and enforce those standards by taking disciplinary action against licensees as appropriate. DBC is also responsible for registering dental practices (including mobile dental clinics) and corporations; establishing guidelines for continuing education requirements for dentists and dental auxiliaries; issuing special permits to qualified dentists to administer general anesthesia or conscious sedation in their offices; approving radiation safety courses; and administering the Diversion Program for substance-abusing dentists and dental auxiliaries.

DBC's Committee on Dental Auxiliaries (COMDA) was created by the legislature "to permit the full utilization of dental auxiliaries in order to meet the dental care needs of all the state's citizens." COMDA is part of DBC, and assists the Board in regulating dental auxiliaries. Under Business and Professions Code section 1740 *et seq.*, COMDA has specified functions relating to the Board's approval of (1) dental auxiliary education programs, (2) licensing examinations for the various categories of auxiliaries, and (3) applicants for auxiliary licensure. Additionally, COMDA advises DBC as to needed regulatory changes related to auxiliaries and the appropriate standards of conduct for auxiliaries. COMDA is a separate nine-member panel consisting of three RDHs (at least one of whom is actively employed in a private dental office), three RDAs, one DBC public member, one licensed dentist who is a member of the Board's Examining Committee, and one licensed dentist who is neither a Board nor Examining Committee member.

The Board consists of fourteen members: eight practicing dentists, one RDH, one RDA, and four public members. The Governor appoints twelve of the Board's fourteen members (including all of the dentist members); the Senate Rules Committee and the Assembly Speaker each appoint one public member.

MAJOR PROJECTS

Consumer Group Petitions Board to Clarify Policies, Obey Law Governing Disclosures on Mercury Amalgam Fillings

At its December 3 meeting, the Dental Board is scheduled to entertain a September 9 petition filed by Consumers for Dental Choice (CDC), a coalition of several national organizations and individuals concerned about potential health risks associated with the use of mercury amalgams as dental fillings.