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 Code of Corporations. The Commissioner of Corporations, appointed by the Governor, oversees and administers the duties and responsibilities of the Department. The rules promulgated by the Department are set forth in Division 3, Title 10 of the California Code of Regulations.

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" or "HMO," 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 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 22 million California enrollees. Specialized health plans arrange for specialized health services for nearly 34 million California enrollees. Total enrollment in all health plans exceeded 55 million as of the quarter ending March 31, 1998.

DOC's Health Plan Enforcement Division, newly 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 deceptive methods, misrepresentations, 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.

The Department also administers the Corporate Securities Law of 1968 and numerous 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."

**Major Projects**

**Managed Care Regulation Debate Awaits Davis Administration**

The battle over the appropriate location, structure, and parameters of managed care regulation will rage on into 1999, as 1998 produced yet another stalemate between the executive and legislative branches.

Only one thing is clear: None of the parties to the debate believes that managed care regulation should remain within the Department of Corporations. In 1998, Governor Wilson proposed to abolish DOC and create, in its place, two departments within the Business, Transportation and Housing Agency—one of which would be devoted to the regulation of managed care; however, the legislature rejected that plan. The legislature appears to want to turn managed care regulation over to a multimember board located within an agency with some expertise in health care delivery and consumer protection; however, the Governor vetoed one bill to that effect, and his threat to veto most other managed care bills discouraged many legislators from expending work on them.

And the legislature wants to finetune some of the important particulars of managed care regulation—it passed several bills requiring HMO decisionmakers who determine whether a proposed treatment is medically necessary to be licensed as physicians in California, creating independent review boards to entertain consumer grievances about treatment denials, and requiring health plans to provide independent second opinions.
Governor Wilson vetoed all of these bills (see LEGISLATION).

The debate over managed care regulation in California has lasted for years. The following is a brief description of several of the most recent skirmishes, and the issues which now confront the Davis administration.

* The Managed Health Improvement Task Force. Over the past several years, consumer and legislative dissatisfaction with DOC's regulation of the managed care industry has soared, and the legislature has forwarded to Governor Wilson dozens of bills which would restructure the regulation of managed care. In 1996, he vetoed most of them and instead signed AB 2343 (Richter) (Chapter 815, Statutes of 1996), which created the "Managed Health Care Improvement Task Force." The Task Force was delegated a formidable charge—
to review and report on the history and impacts of managed health care in California, and to propose improvements to the state's oversight and regulatory role related to managed care.

The bill required the Task Force to be composed 30 members (20 of whom were appointed by the Governor), including equal representation from health plans, employers who purchase health care, health care enrollees, providers of health care, representatives of consumer groups. In addition, seven non-voting ex officio members (five gubernatorial appointments and two members appointed by the Senate Rules Committee) participated in the task force's work.

After holding numerous hearings all over the state during 1998, the Task Force issued a report in early 1998 which made over 100 recommendations in three major issue areas: (1) improving government regulation of managed care; (2) making competition work for patients; and (3) improving the quality of care provided by managed care entities. The full text of the Task Force's report and recommendations is beyond the scope of this journal. A comprehensive discussion of all of the Task Force's findings and recommendations is beyond the scope of this journal.

As to the critical issue of the state's regulation of managed care, however, the Task Force noted that the major regulator of managed care entities is DOC, which is located within the Business, Transportation and Housing Agency, "the primary regulator for business in California. As such, it regulates many kinds of businesses, not just health care service plans. Therefore its leader does not focus 100% of his or her attention on health care service plans or other emerging health care issues. Recently, DOC's leader has been a securities lawyer... Given the size, the complexity, and the high degree of public interest, health care service plans ought to have their own regulatory entity, headed by a person or a board who devotes his or her complete attention to the industry and who has had substantial experience and expertise in health services."

The Task Force also found that managed care organizations are regulated in fragmented fashion by many different government and private entities. On the state level, DOC's Health Plan Division regulates "health care service plans" as defined by the Knox-Keene Act; the Department of Insurance regulates "preferred provider organizations" (PPOs), another form of managed care entity; the Department of Health Services has jurisdiction over managed care organizations which provide care to Medi-Cal beneficiaries; and the Department of Industrial Relations has jurisdiction over health plans which provide services under the state's workers' compensation program. In addition, the Managed Risk Medical Insurance Board contracts with many managed care organizations involved in other state health insurance programs; and the Department of Consumer Affairs contains over a dozen occupational licensing boards which regulate physicians, nurses, dentists, pharmacists, optometrists, and other health care professionals. On the federal level, health care service plans are overseen by the Health Care Financing Administration and the Office of Personnel Management. The private sector supplements these state and federal regulatory agencies through a variety of quality measurement and accreditation organizations that help employers and consumers to evaluate their purchases by providing information.

On this critical structural issue, the Task Force recommended that "a new state entity for regulation of managed health care should be created to regulate health care service plans currently regulated by DOC." Over time, the regulation of PPOs and other contractual arrangements that result in the provision of health care should also be phased in to the new regulatory entity; additionally, the Task Force recommended that medical groups, independent practice associations, and other providers that contract with managed care entities and bear significant risk (some of which are currently unregulated) should be directly regulated by the new state entity.

As to the structure of the regulator, the Task Force could not agree. However, it said the new oversight agency should be led either by a multimember board or by "an individual of stature in the health services field" appointed by the Governor and confirmed by the Senate; "in either case, the leadership of the organization should have a sympathetic understanding of the problems of patients and their families and an understanding of the health care market."

* Governor's Reorganization Plan No. 1 of 1998. To implement this threshold recommendation of the Task Force, Governor Wilson forwarded a reorganization plan to the legislature on June 1, 1998. Under his plan, DOC would be abolished. Its existing regulatory activities would be split between two agencies: (1) its regulation of managed care organizations under the Knox-Keene Act would be transferred to a new Department of Managed Health Care, and (2) its regulation of non-health care businesses would be transferred to the existing Department of Financial Institutions, which would be renamed as the "Department of Financial Services." Under the Governor's proposal, both the Department of Managed Health Care and the Department of Financial Services would remain.
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Within the Business, Transportation and Housing Agency, and both would be headed by a single gubernatorial appointee.

Although the new Department of Managed Health Care would have the same budget and the same number of employees as does DOC's Health Plan Division, and would function under the same enabling act, the Wilson administration argued that its proposal is superior to DOC's existing regulation of health plans because (1) the home of managed care regulation would be elevated to "department" status, instead of "division" status within an existing department; (2) its chief would be directly appointed by the Governor (and confirmed by the Senate), and not simply hired by the director of the department within which the regulatory entity is housed; (3) the new managed care regulatory entity would have a dedicated consumer services unit and enforcement unit; and (4) the 20-member advisory committee which has existed for almost 25 years to assist DOC with managed care regulation would be expanded to include four additional public members, for a total of ten public members on a 24-member board.

A "Governor's Reorganization Plan" functions differently from a legislative bill. As required by Government Code section 12080 et seq., the Governor must submit a reorganization plan to both houses of the legislature, which in turn must refer the plan to a standing committee for study and a report. A reorganization plan will become effective unless, within 60 days of its transmission to the legislature, either house adopts by majority vote a resolution rejecting the plan; the legislature must vote up or down on the plan—it may not amend the plan. Thus, the legislature had until August 1 to take action on the plan.

Government Code section 8523 requires the Governor to forward a copy of any reorganization plan which he intends to submit to the legislature to the Milton Marks Commission on California State Government Organization and Economy (better known as the "Little Hoover Commission"); the Commission must receive the plan at least 30 days before the legislature receives it. LHC is thereafter required to study the plan and make a recommendation to the Governor and legislature.

Thus, Governor Wilson submitted Reorganization Plan No. 1 of 1998 to LHC on April 30, 1998. LHC held a public hearing on the plan on May 28, and invited testimony from interested legislators; Task Force representatives; the Wilson administration (including DOC and BTH representatives); the State Auditor; and representatives from consumer groups, businesses and health care purchasers, managed care entities, and health care profession trade associations.

After hearing BTH and DOC representatives defend DOC's regulation of managed care in light of minimal resources and constant change in the marketplace, LHC listened to Senator Herschel Rosenthal and Assemblymember Martin Gallegos urge rejection of the Governor's Plan. Senator Rosenthal called the plan "severely flawed," arguing that "the lame duck Governor should not be the architect of the state's new regulatory structure for managed care." He stated that Wilson's proposal "perpetuates BTH's philosophy that HMOs are businesses—when what they are providing is health care." Senator Rosenthal noted that numerous bills to restructure managed care regulation and to finetune the complex details of that regulation were then pending and headed for a joint legislative conference committee, and expressed hope that "the legislature would not have to micromanage managed care if we had a credible regulator." Assemblymember Gallegos agreed with Senator Rosenthal that LHC should recommend rejection of the Governor's plan, and took the Governor to task for his administration's refusal to participate in the legislature's negotiation of the many managed care bills heading for the conference committee. According to Assemblymember Gallegos, "we've invited the administration to participate on these issues on many occasions but have received no response—just this reorganization plan."

Next, State Auditor Kurt Sjoberg of the Bureau of State Audits (BSA) summarized a recent report entitled Department of Corporations: To Optimize Health Plan Regulation, This Function Should Be Moved to the Health and Welfare Agency (May 1998). Sjoberg noted that his audit predated the Governor's Reorganization Plan, and came in response to a legislative request for recommendations on whether there is a "better fit" for managed care regulation than DOC and BTH. BSA evaluated the functions, mission, management focus, and skills of eleven different agencies, and focused in on the Department of Insurance, the Department of Consumer Affairs, and the Department of Health Services as the potential future home of managed care regulation. BSA ultimately concluded that managed care regulation should be moved out of BTH. If it is moved to an existing department, BSA recommended that it be transferred to the Department of Health Services; if it is moved to a "stand-alone" agency, BSA suggested that the new agency be located within the Health and Welfare Agency (see report on BSA for more detail on this report).

At LHC's public hearing, consumer groups and representatives of health care provider trade associations unanimously recommended rejection of the Governor's reorganization plan, denouncing it as "a cosmetic reshuffling which would preserve the status quo." They argued that managed care regulation must be transferred from DOC and BTH to a new home where health care is a priority and an area of expertise; most argued that the new regulator should take the form of a multimember board within either the Health and Welfare Agency or the State and Consumer Services Agency (which houses the Department of Consumer Affairs and the occupational licensing agencies which regulate physicians, nurses, dentists, and other health care providers). Those arguing for a multimember board structure noted that state boards are subject to the Bagley-Keene Open Meeting Act...
and are required to meet in public and accept public comment in order to adopt regulations and make policy decisions; according to board proponents, “the public nature of a board meeting, and the chance for a shared decision, means more public credibility and confidence in the outcome.” Several noted the need for a substantial influx of resources to the new agency and substantive changes to the Knox-Keene Act (which cannot be accomplished in a Governor’s Reorganization Plan).

Representatives of the managed care industry generally supported the Governor’s proposal, agreeing that managed care deserves a dedicated agency and that it should be headed by a “single appointed professional who is subject to confirmation by a legislative body.” Additionally, the industry noted the need for additional staff (and more diversified staff) capable of processing amendments and material modifications to health plans more quickly.

Following receipt of testimony and internal deliberations, LHC voted 5-4 to recommend rejection of the Governor’s Reorganization Plan on June 25. The Commission’s three-paragraph rejection letter noted that “in discussing the merits of the plan, individual Commissioners raised a number of issues: Some Commissioners were concerned that the plan does not consolidate the State’s oversight of health plans into the new department. Some Commissioners were concerned about placing the new department within the Business, Transportation and Housing Agency, rather than within the State and Consumer Services Agency or the Health and Welfare Agency. Other Commissioners believed the new entity should be an agency unto itself or should be governed by a board.”

On July 2, the Senate rejected the Governor’s reorganization plan on a straight party-line vote; 22 Democrats voted against it, and 15 Republicans supported it.

Legislative Action to Restructure Managed Care Regulation. During the summer, the legislature entertained a number of bills to relocate managed care regulation within state government. SB 406 (Rosenthal) reached the Governor’s desk on August 30; the bill would have established a Board of Managed Health Care within the State and Consumer Services Agency to take over DOC’s Knox-Keene responsibilities effective July 1, 1999. By July 1, 2001, the new board would also take over administration and enforcement of the regulation of disability insurers that cover hospital, medical, and surgical benefits, preferred provider organizations, exclusive provider organizations, and any other preferred provider insurers. Under SB 406, the Board would be composed of five members—three (including the chair) would be appointed by the Governor and confirmed by the Senate, one would be appointed by the Senate Rules Committee, and one by the Assembly Speaker. The board chair would hold a full-time position; the remaining board members would hold part-time positions. The Board would be fully subject to the Bagley-Keene Open Meeting Act.

Meanwhile, the Governor—dissatisfied with the Little Hoover Commission’s one-page rejection—asked the Commission to issue its own recommendations regarding how the new regulator should be constituted. The Commission agreed to convene to issue recommendations, but declined to reconsider its 5-4 vote on the reorganization plan. On July 31, LHC issued a ten-page letter advising the Governor to create a new managed care regulatory entity; although LHC did not reach a consensus on whether the new entity should be a department or an agency, it recommended that the new entity be governed by a single gubernatorial appointee confirmed by the Senate Rules Committee. According to LHC, the appointee should “have an extensive background in managed care and proven leadership skills.... To enhance decision-making and increase legitimacy, public procedures should be established and the role of the advisory committee should be expanded to provide for meaningful public comment, review of proposed policies, and scrutiny of the regulatory entity.” Further, LHC recommended that the new agency be given adequate resources to keep pace with the growth in the industry and the number of Californians relying on managed care providers; and that the state immediately develop feasibility plans for combining the health care oversight functions that were identified for possible consolidation by the Managed Health Care Improvement Task Force.

When Governor Wilson received SB 406 (Rosenthal), he vetoed it—relying on the Commission’s July 31 report. Wilson stated that SB 406 “fails to deliver the reform it promises. It would establish a weak and unaccountable regulatory bureaucracy with dispersed enforcement authority. The Little Hoover Commission, an independent non-partisan advisory organization, has rejected the key feature of this bill, establishing a board to regulate health plans, because the burden of collective decision making will not provide consistent and responsive leadership. The Commission instead concluded that health plans should be regulated by a focused department or agency led by a single gubernatorial appointee. The Commission found that a single appointee would be more accountable and would be in the best position to provide strong and decisive leadership, particularly on difficult issues lacking broad political consensus” (see LEGISLATION).

In addition, Governor Wilson vetoed almost every other bill relating to managed care regulation that reached his desk. These include three bills which would have required that individuals who make treatment decisions at managed care organizations be licensed as physicians by the Medical Board of California (to enable the Board to discipline a physician medical director who improperly denies, delays, or limits treatment); and a bill which would have required plans to provide second opinions by an appropriately qualified health care professional upon the request of an enrollee or his/her treating physician.

Additionally, AB 2436 (Figueroa), a bill that would have made health plans liable for damages for harm to an enrollee caused by its failure to exercise ordinary care, failed passage.
at the end of the session. AB 2436 proponents note that, due to the judicial interpretation of federal Employee Retirement Income Security Act (ERISA), most consumers are unable to sue their managed care organizations under state tort laws if they are injured due to the organization's improper denial or failure to treat. Under the so-called "ERISA loophole," state tort law remedies against managed care organizations are generally preempted; patients who purchase their health insurance through private employers (approximately 15 million Californians) are limited to the cost of the denied treatment as their sole remedy. However, patients who purchase their health insurance through government employers (including the Governor, all legislators, and their staff) are not affected by ERISA, and are able to sue their health plans for full tort damages (including pain and suffering and punitive damages) if they are injured through the health plan's failure to use ordinary care in providing health care. This inconsistency has led Congress to consider federal legislation to amend ERISA; and the state of Texas has enacted legislation to impose liability on managed care entities for failure to exercise ordinary care despite ERISA (see LITIGATION). Consumer advocates argue that managed care organizations—like other businesses—should be held liable and accountable for their negligence, and that the availability of external review panels is fairly meaningless without the deterrent-producing prospect of liability. Consumer advocates argue that managed care organizations—like other businesses—should be held liable and accountable for their negligence, and that the availability of external review panels is fairly meaningless without the deterrent-producing prospect of liability. The managed care industry vehemently opposed all bills imposing enhanced liability for negligence, arguing that such liability would only increase the overall cost of health care to the consumer and cause thousands of Californians to lose coverage.

All of these measures—including bills to remove managed care regulation from DOC and BTH—will surely be reintroduced in 1999, and will become the province of the Davis administration. ♦ HMOs Agree to Allow Independent Reviews of Treatment Denials. In December, 22 member health plans of the California Association of Health Plans—in a move calculated to stave off future liability legislation—announced their intent to voluntarily offer external independent review of treatment denials; the companies promised that they would provide a denied treatment if the panel deems it medically necessary. The review process will be applicable only to denials based on medical necessity; consumers will not be able to seek review of a decision that a desired treatment is not covered by the plan. Further, consumers must exhaust their plan's internal grievance system to pursue a treatment denial (see below) before appealing it to an external panel.

Consumer advocates questioned the efficacy of the private agreement, arguing that it would be more effective for the legislature to require a uniform process for appealing medical necessity decisions; at least 16 states have already done so. They also question the "independence" of outside reviewers hired by HMOs. Finally, consumer groups reiterate that external review will be of limited use unless it is coupled with enhanced ability to sue when care is denied.

**DOC Rulemaking Regarding Health Plan Grievance Systems**

On September 18, the Office of Administrative Law (OAL) approved DOC's amendments to section 1300.68, Title 10 of the CCR, relating to health plan grievance systems under the Knox-Keene Health Care Service Plan Act. Health and Safety Code section 1368 requires all health plans to establish and maintain a grievance system approved by DOC under which plan enrollees may submit grievances to the plan. After exhausting all remedies offered by a plan's grievance process (or participating in the process for sixty days), an enrollee may submit the grievance or complaint to DOC for review. Section 1368(c) requires each plan's grievance system to include a system of aging of complaints that are pending for thirty days or more; as of January 1, 1997, each plan must provide a quarterly report to the Commissioner of complaints pending and unresolved for thirty or more days, with separate categories of complaints for Medicare and Medi-Cal enrollees. The plan must include with the report a brief explanation of the reasons each complaint is pending and unresolved for thirty days or more. Although the quarterly reporting requirement began on January 1, 1997, DOC did not publish notice of regulations to implement this reporting requirement until May 22, 1998. Subsection 1300.68(i) sets forth the information that must be included in the quarterly report, and includes a specified format in which the report must be filed. The report must include all complaints filed by enrollees that are pending and unresolved for thirty days or more within the plan's grievance system; when a plan's grievance system provides one or more opportunities for appeal, an enrollee's complaint must be included in a plan's quarterly report until the enrollee has exhausted all opportunities for appeal or the time for appeal under the grievance system has expired. The report must also include a breakdown of the total number of pending and unresolved complaints for each category and each level of the plan's grievance system, including the number of complaints for each corresponding reason specified in the report. If complaints are pending and unresolved for reasons other than reasons specified in the quarterly report format, those other reasons must be specified in the report with the corresponding number of complaints for each reason. If a grievance system provides two or more
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levels of appeal, each level must be separately listed in the report, and must include the same information required by the report for “first-level appeals.” The quarterly report must be filed with DOC’s Health Plan Division no later than thirty days after the close of the quarter.

These regulatory changes became effective on October 18.

Health Plan Amendments, Notices of Material Modifications, and Standards of Accessibility

On November 30, OAL approved DOC’s adoption of new sections 1300.52.4 and 1300.67.2.1, Title 10 of the CCR. These rules clarify when and how a health plan must file with DOC a notice of an amendment or material modification to its license application; and amplify DOC’s policy on accessibility of services provided by the plan to enrollees, as required by Health and Safety Code section 1367(e). DOC adopted these regulations after publishing them in May and holding a public hearing on August 10, 1998.

Under Health and Safety Code section 1352, whenever a health plan changes any of the information filed in its original application for licensure, it must file with DOC either an amendment to its license application or a notice of material modification, depending on the type or degree of change. Existing section 1300.52, Title 10 of the CCR, sets forth DOC’s requirements as to the filing of amendments; section 1300.52.1 sets forth DOC’s requirements as to the filing of material modifications; section 1300.52.2 provides that changes to plan personnel should be filed as an amendment, and specifies the types of personnel changes covered by the section.

New section 1300.52.4 clarifies when a change to a plan’s license application is a material modification by providing a list of specific standards for material modifications. Specifically, the following changes are deemed material modifications and should be filed as such: an expansion, contraction, or reduction of the plan’s approved service area; the offering of a new health care service plan contract by the plan in any service area if the plan proposes to use a network of providers that is materially different from the network used for any other plan contract currently being offered by the plan; a merger, consolidation, acquisition of a controlling interest, or sale of the plan or of all or substantially all of the assets of the plan, directly or indirectly; the plan’s initial offering of a plan contract for small employers, which requires the filing of a notice of material modification pursuant to section 1357.15 of the Knox-Keene Act; the plan’s initial offering of a point-of-service contract, which requires the filing of a notice of material modification pursuant to section 1374.69 of the Act; a change of plan name, which requires the filing of a notice of material modification pursuant to section 1300.66; or a change that would have a material effect on the plan or on its health care service plan operations.

In addition, new section 1300.52.4 establishes when amendments must be filed following the changes necessitating them, and when changes constituting an amendment become effective. Specifically, a plan must file an amendment to its plan license application within 30 days after the plan implements the change; a change that is the subject of an amendment required to be filed pursuant to this subsection shall become effective on the date implemented. However, an amendment will not become effective until the 31st calendar day after the amendment is filed with DOC if the plan has not been continuously licensed under the Act for the preceding 18 months and has not had group contracts in effect at all times during that period, and the amendment includes any new or modified plan contract, disclosure form, or evidence of coverage.

Section 1300.52.4(c) provides that if DOC does not object to an amendment within 30 days after the plan files the amendment, DOC may require the plan to make changes to comply with the Act and the rules adopted under the Act. The Department shall not take any disciplinary action or begin any other enforcement action against the plan with regard to the implementation of the changes described in the amendment, unless the material or any portion of the material was previously disapproved or otherwise objected to in writing by the Commissioner, or the plan knew or should have known that the material or any portion of the material violated any provision of the Act or the rules promulgated thereunder.

The Knox-Keene Act, specifically Health and Safety Code section 1367(e), requires plans to provide all services in a manner that is readily available at reasonable times to all enrollees and, to the extent feasible, make all services readily accessible to all enrollees. Existing section 1300.67.2 implements the Code by requiring that health care services be readily available and accessible to each of the plan’s enrollees within each service area of the plan. This rule, however, does not prescribe specific accessibility standards in terms of time and distance parameters; the section imposes a rule of “reasonableness.” For example, section 1300.67.2 provides that the location of facilities providing primary health care services must be within reasonable proximity of enrollees’ businesses and residences, without unreasonable barriers to accessibility. This rule also requires that hours of operation and provision for after-hours services be reasonable.

New section 1300.67.2.1 provides standards of accessibility in addition to those currently provided in sections 1300.51 and 1300.67.2, Title 10 of the CCR. The new section clarifies that a plan may rely on the standards of accessibility set forth in Item H of section 1300.51 or section 1300.67.2. However, if a plan believes that, given the facts and circumstances with regard to any portion of its service area, the standards of accessibility set forth in Item H of section 1300.51 and/or section 1300.67.2 are unreasonably restrictive, the plan
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may propose alternative standards of accessibility for that portion of its service area. The plan shall do so by including such alternative standards in writing in its plan license application or in a notice of material modification. The plan also shall include a description of the reasons justifying the less restrictive standards based on those facts and circumstances. If DOC rejects the plan’s proposal, the Department must inform the plan of its reason for doing so; inform the plan of the accessibility standards that the Department will approve, given the facts and circumstances involved; and inform the plan of the reasons justifying the accessibility standards that the Department will approve.

Under new section 1300.67.2.1(b), if DOC—in its review of a plan license application or a notice of material modification—believes the accessibility standards set forth in Item H of section 1300.51 and/or section 1300.67.2 are insufficiently prescribed or articulated, given the facts and circumstances with regard to a portion of a plan’s service area, the Department shall inform the plan that it will not allow application of those standards to that portion of the plan’s service area. The Department shall also inform the plan of its reasons for rejecting the application of those standards; of the accessibility standards that the Department will approve, given the facts and circumstances involved; and of the reasons justifying the accessibility standards that the Department will approve.

Under new section 1300.67.2.1(c), the facts and circumstances to be included in a discussion of the reasons justifying the standards of accessibility proposed by the plan or by the Department pursuant to subsection (a) or (b) of the section shall include, to the extent relevant, but shall not necessarily be limited to, the following: (1) whether the plan contract involved is a group health care service plan contract or an individual health care service plan contract; (2) whether the plan contract is a full-service health care service plan contract or a specialized health care service plan contract, and—if the latter—whether emergency services need not be covered; (3) the uniqueness of the services to be offered; (4) whether the portion of the service area involved is urban or rural; (5) population density in the portion of the service area; (6) the distribution of enrollees in the portion of the service area; (7) the availability and distribution of primary care physicians; (8) the availability and distribution of other types of providers; (9) the existence of exclusive contracts in the provider community or other barriers to entry; (10) patterns of practice in the portion of the service area; (11) driving times; (12) waiting times for appointments; (13) whether the plan or any other health care service plan currently has significant operations in that portion of the service area; and (14) other standards of accessibility that the Commissioner deems necessary or appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.

These new rules became effective on November 30.

DOC Denies CMA’s Petitions for Rulemaking

DOC recently rejected two petitions for rulemaking filed by the California Medical Association (CMA), a trade association representing about 30,000 of the state’s 105,000 licensed physicians, pursuant to section 11340.6 of the Administrative Procedure Act (APA).

On October 14, CMA filed a petition requesting the Commissioner to adopt a regulation pursuant to the Health and Safety Code section 1367(h), which requires that all health plans be fair, reasonable, and consistent with the objectives of the Knox-Keene Act.

Specifically, CMA asked DOC to add subsections (f) and (g) to existing section 1300.67.8, Title 10 of the CCR. Subsection (f) would provide that all health plan contracts with providers must be fair, reasonable, and consistent with the Knox-Keene Act, and must include provisions ensuring (1) the continued role of the provider as the determinant of the patient’s health needs, (2) that patients receive accessible health care in a manner providing continuity of care, and (3) that medical decisions will not be unduly influenced by administrative and fiscal management. CMA’s proposed regulation would void the following types of provisions in plan contracts with providers as against public policy: provisions which explicitly or implicitly are designed to shift to providers liability resulting from the plan’s acts or omissions; provisions which restrict the ability of providers to recover direct, incidental, punitive, exemplary, special, or consequential damages against the plan as authorized by law; provisions which shorten the applicable statute of limitations as prescribed by law; provisions which allow the plan to unilaterally amend the contract; provisions which impose penalties against the provider, unless the penalty is clearly defined in the contract, is imposed only after the provider has been notified of the violation in writing and given the opportunity to correct the behavior, does not discourage quality care, is reasonable in relation to the violation, can be appealed, and is not imposed for utilization outside the provider’s control; provisions that require providers to waive any provision set forth in the Knox-Keene Act; provisions that require providers, as a condition of participation, to participate in additional plan product lines or in affiliate or additional plans where that plan acts as an intermediary for the provider to contract with other third-party payers; provisions which authorize the plan to make medical necessity determinations without providing appropriate deference to the treating physician’s judgments; provisions which set forth definitions of medical necessity that are at variance with community standards; provisions which restrict the provider’s ability to communicate with the patient, person, or entity who provides payment for the subscriber contract on the patient’s behalf; provisions which directly or indirectly make the plan the owner of the patient’s medical records; and provisions which restrict the ability of a provider to maintain physician/patient relationships after contract termination.

Proposed subsection (g) would require all contracts to disclose to the provider the amount of payment for each and every service to be provided under the contract. Such disclosure must include, at minimum, either a complete fee schedule for each and every service to be provided under the contract or the unit value and applicable conversion factor for each and every service provided under the contract.
On November 12, DOC denied CMA’s petition in whole, stating it fails to comply with the necessity, clarity, nonduplication, consistency, and authority standards of the APA. Regarding necessity, DOC claimed that CMA failed to provide any examples to substantiate the need for the proposed rules; according to DOC, the petition merely stated conclusions and speculation that “certain contractual provisions can be used to enforce policies that threaten health care.”

DOC also found that many of the proposed rules are vague, thus failing to meet the “clarity” requirement of the APA. If adopted, DOC claimed, the rules would fail to provide a health plan with notice of its obligations under the law. DOC also stated that the proposed rules simply restate existing law, therefore conflicting with the “nonduplication” and “consistency” requirements of the APA. Finally, DOC claimed that the petition requests DOC to interpret section 1367(h) of the Knox-Keene Act in a manner that appears to be beyond the legislative intent of the statute, thus violating the “authority” requirement of the APA.

On November 18, in the wake of the July 19 bankruptcy of FPA Medical Management of California, Inc., CMA filed another petition with DOC, requesting the Commissioner to adopt a regulation implementing Health and Safety Code section 1371, which generally requires health plans to reimburse uncontested claims by providers within 30 working days after receipt of the claim by the plan (or within 45 days of the plan’s health maintenance organization); section 1371 also states 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 claims that up to 1,600 physicians in California are owed $60 million by FPA, a physician management company. Doctors contracted with FPA to provide services to patients enrolled in HMOs; those HMOs, in turn, paid FPA specified amounts for that care, which was to include physician payments. CMA wants the plans to pay the physicians directly, even if they already paid FPA. CMA’s proposed section 1300.75, Title 10 of the CCR, would state that health plans are liable for payment to providers rendering covered services to enrollees, “notwithstanding any contractual provisions to the contrary. The liability of the health plan shall be as primary obligor and not as a guarantor, and shall not be excused by any proceedings under any applicable bankruptcy or other reorganization plans for the benefit of debtors.”

On December 29, DOC rejected CMA’s rulemaking petition on grounds that it is not authorized to adopt such a regulation; according to DOC, “federal bankruptcy law generally preempts state law regarding excusing debts during a bankruptcy or reorganization proceeding.” The Department rejected CMA’s argument that the anti-waiver language in section 1371 implies legislative intent that health plans should always be liable to providers for claims regardless of whether the plan has an independent basis of liability for the claim. DOC reminded CMA that if a plan fails to comply with section 1371, the Commissioner is authorized to take remedial action against the plan, or bring an enforcement action to fine the plan or seek other relief. DOC also noted that its primary responsibility under the Knox-Keene Act is to enrollees, not providers. The Department noted that it is currently considering the facts surrounding the failure of FPA, sympathized with providers “who are now unsecured creditors of the bankruptcy estate,” and encouraged CMA to use its resources to assist its members in protecting their interests though claims in federal bankruptcy court and potential quasi-contract claims in state court.

**DOC Releases 1997 Complaint Data**

In late June, DOC released Health Care Service Plan Complaint Data: 1997 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 1997. 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 against a health plan which has been received by DOC’s Health Plan Division. In order to have their complaint classified as an RFA, consumers must have first participated in their 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 1997, at 1.9773 and 1.1090, respectively. PacifiCare had the highest ratio of quality of care RFAs as well, at 1.4672 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 1997, as well as plans which surrendered their Knox-Keene licenses in 1997.

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DOC Goes Online

DOC has recently launched a website through which it hopes to better serve the public by providing links to each of the divisions within the DOC. Each division site answers frequently asked questions; provides information about how to get in touch with contact persons; and includes complaint forms, and recent publications, and—in some cases—licensee listings. DOC’s website also—for the first time—includes its annual Request for Assistance Complaint Data Report (see above).

Legislation

Governor’s Reorganization Plan No. 1 of 1998, as forwarded to the legislature on June 1, 1998, would have dissolved DOC and transferred DOC’s health care-related regulatory programs to a new Department of Managed Care. DOC’s investment and lender-fiduciary programs would have been transferred to the existing Department of Financial Institutions, which would be renamed “Department of Financial Services.” Both of these agencies would have remained within the Business, Transportation and Housing Agency, each administered by a single gubernatorial appointee subject to Senate confirmation.

As required by Government Code section 8523, Governor Wilson forwarded a copy of the Reorganization Plan to the Little Hoover Commission on April 30, 1998. LHC held a public hearing on the plan on May 28, and voted to recommend rejection of the plan by a 5-4 vote on June 25 (see MAJOR PROJECTS).

SR 34 (Rosenthal), as adopted July 2, 1998, rejects the Governor’s Reorganization Plan No. 1 (see above).

SB 406 (Rosenthal), as amended August 25, 1997, would have stated the intent of the legislature that all licensing and regulatory responsibilities for health care service plans be transferred from DOC to a new five-member Board of Managed Health Care within the State and Consumer Services Agency. The bill would have required the Board to administer and enforce the regulation of health care service plans on and after July 1, 1999. SB 406 would also have required the Board to administer and enforce the regulation of disability insurers that cover hospital, medical, and surgical benefits, preferred provider organizations, exclusive provider organizations, and any other preferred provider insurers on and after July 1, 2001.

Governor Wilson vetoed this bill on September 24, noting that the Little Hoover Commission had recommended against the creation of a multimember board to regulate managed care (see MAJOR PROJECTS).

ACA 36 (Gallegos), as amended April 14, would have amended the California Constitution to create a Managed Health Care Oversight Board within the Health and Welfare Agency, and would have transferred all the functions and authority of DOC and the Commissioner of Corporations related to the regulation of health plans to the Board. ACA 36 would also have provided that health plans shall be directly accountable to patients, to ensure that health care providers are responsible for patient care, and would have required the exercise of ordinary care when making health care treatment decisions. This measure would further have set forth the conditions of binding arbitration between health plans and enrollees or subscribers; and provided that a plaintiff in an action against a health plan for damages for personal injury, under certain circumstances, who makes an offer of settlement, which the defendant does not accept within a specified time before trial or arbitration, shall receive interest at a prescribed rate, if the plaintiff ultimately receives a more favorable judgment. This measure died in the Assembly Committee on Elections, Reapportionment and Constitutional Amendments in June 1998.

AB 2556 (Martinez), as amended April 21, and AB 1344 (Gallegos), as amended August 25, 1997, would have stated the intent of the legislature that health plans be regulated by an agency that would best ensure quality of care and be responsive to Californians. The Governor vetoed AB 2556 on July 21, saying it is “not a serious attempt at managed care reform. It does not change the law. It does not enact any new reforms. It merely states the Legislature’s ‘intent’ to enact managed care reform. The Legislature needs to get serious about reform and approve my ‘Reorganization Plan No. 1 of 1998.’” AB 1344 died in a joint conference committee on August 20.

AB 2436 (Figueroa), as amended August 17, would have provided that a health plan has the duty to exercise ordinary care when making health care treatment decisions, and is liable for damages for harm to an enrollee proximately caused by its failure to exercise ordinary care. The bill would also have provided that a health plan is liable for damages for harm to an enrollee proximately caused by the health care treatment decisions made by employers, agents, ostensible agents, or certain representatives of the health plan. This bill failed passage in the Senate Appropriations Committee on August 19.

AB 332 (Figueroa), SB 324 (Rosenthal), and SB 557 (Leslie) would have provided that any decision or recommendation regarding the necessity or appropriateness of treatment or care that results in the denial or revision of the treatment or care originally ordered for a particular patient constitutes the practice of a healing arts profession to the same extent as the performance of the treatment or care itself. These bills would have required that any person performing the duties of a healing arts professional must have a valid license under the appropriate authorizing law, and would have made any person who makes a decision regarding medical necessity or appropriateness that affects any diagnosis, treatment, operation, or prescription without possessing a valid, revoked, or suspended certificate under the Medical Practice Act guilty of a misdemeanor.

The Governor vetoed these bills on September 29, arguing that extending Medical Board authority to medical necessity or appropriateness decisions would create too many new civil liabilities and only increase health care costs while not improving the quality of health care. In his veto messages, the Governor stated his belief that these bills would “allow trial lawyers to prey upon innocent customers and decent health care professionals” and that they are a “transparent effort to eliminate the appropriate use of utilization services.”
review and a bald attempt to increase the number of lawsuits in the health care system.”

AB 1667 (Migden), as amended August 24, and SB 1653 (Johnston), as amended August 17, would have required health plans to provide subscribers and enrollees with written responses to grievances; provided that a grievance may be submitted to DOC by an enrollee or subscriber after participating in the plan’s grievance process for 30 days; and required the Department to respond to each grievance in writing within 30 days. These bills would also have required, on and after January 1, 2000, every health plan to provide an enrollee with the opportunity to seek an independent medical review whenever health care services have been denied, terminated, or otherwise limited by the plan or by one of its contracting providers. The bill would require DOC to establish an independent medical review system whereby requests for reviews are assigned to an independent medical review organization; an enrollee would in most cases be required to pay to the Department a processing fee of $25, which would be refunded if the enrollee prevails in the review, and the remaining costs would be paid by an assessment on health plans imposed by the Department. AB 1667 died in the Senate Appropriations Committee on August 24; SB 1653 died in the Assembly Health Committee on August 17.

SB 1504 (Rosenthal), as amended August 27, would have required health plans to provide subscribers and enrollees with written responses to grievances; provided that a grievance may be submitted to DOC by an enrollee or subscriber after participating in the plan’s grievance process for 30 days; and required the Department to respond to each grievance in writing within 30 days.

This bill would also have required, on and after January 1, 2000, every health plan to provide an enrollee with the opportunity to seek an independent medical review whenever health care services have been denied, terminated, or otherwise limited by the plan or by one of its contracting providers. Beginning January 1, 2000, this bill would have established the Independent Review System in DOC, whereby enrollee grievances involving a disputed health care service or other adverse decision may be resolved by independent review organizations. The bill would have set forth the duties and responsibilities of the Department, health plans, and enrollees with respect to the system; provided that Medi-Cal and Medicare beneficiaries are not excluded from the system, to the extent that their participation is not preempted by federal law; required the Corporations Commissioner to contract with a private, nonprofit accrediting organization to accredit the independent review organizations; and required the adoption of related regulations. SB 1504 would have required the Commissioner, on or before July 1, 1999, to allocate grant funding for an independent health care ombudsprogram. It would have required the Department to contract with an independent expert entity to undertake an evaluation of the independent review system and the independent health care ombudsprogram. The bill would have required the evaluator to provide its evaluation to the Department on or before January 1, 2002, a copy of which shall be made available to the public. SB 1504 died in the Assembly Health Committee on August 27.

AB 341 (Sweeney), as amended August 19, would have required health plans to provide medically necessary or appropriate second opinions by an appropriately qualified health professional upon the request of an enrollee or a participating health professional treating the enrollee. For purposes of this provision, an “appropriately qualified health professional” means one with 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 plan may limit referrals to its network of providers if there is a participating plan provider who meets this standard; if there is no participating plan provider who meets this standard, then the plan shall authorize a second opinion by an appropriately qualified health professional outside of the plan’s provider network. This bill would have also required health plans to authorize or deny the second opinion in an expeditious manner, file timelines for responding to requests for second opinions with the state, and make the timelines available to the public upon request. Governor Wilson vetoed this bill on September 24. He agreed that medically necessary second opinions should be obtained, but stated there is “no evidence to believe that qualified physicians within the same medical group do not give unbiased and professional second opinions.”

AB 1726 (Bustamante), as amended July 30, would have stated legislative intent that health plans be required to ensure that enrollees and prospective enrollees are provided with accurate and complete information to assist them in making choices about their health care and to provide access to a wide range of primary and specialty health providers. This bill would also have required every health plan to provide for care in accordance with accepted medical practices, and to ensure the confidentiality of the medical information of an enrollee. The Governor vetoed this bill on September 11, finding that it is not a serious attempt at managed care reform; it does not change the law, nor enact any new reforms. According to the Governor, “this bill merely presents false hope without helping a single person.”

AB 497 (Wildman), as amended August 17, would have required health plans to establish and maintain a documented plan, approved by DOC, for ensuring timely access for enrollees to a plan representative by telephone, and to urgent, non-urgent, and referral appointments. This bill would also have specified the duties of DOC in this regard, and authorized DOC to fine or otherwise penalize health plans for failure to ensure timely access. The Governor vetoed this bill on September 18, stating it is unnecessary because existing law already requires plans to make all services readily available and accessible at reasonable times.

AB 1100 (Thomson), as amended August 24, would have required certain health plan contracts or disability insurance policies issued after July 1, 1999 to provide coverage for the diagnosis of and medically necessary treatment of biologically based severe mental illnesses for persons of all ages under the same terms and conditions applied to other medi-
cal conditions. The Governor vetoed this bill on September 28, finding that its collective costs are substantial and would contribute to the rising costs of health care, which will—in turn—cause employers to discontinue health care coverage for their employees and result in fewer people being covered. Instead, the Governor proposes that incremental change be made in this area.

AB 1112 (Hertzberg), as amended July 9, would have required certain group health plan contracts and disability insurance policies issued, renewed, or delegated after January 1, 1999 to provide coverage for a variety of prescription contraceptive methods already approved by the U.S. Food and Drug Administration. Health plans provided by certain religious organizations would have been exempt. The Governor vetoed this bill on September 11, stating that it is “inappropriate for taxpayers to pay for contraception for certain employees that earn up to 400% above the poverty level.”

AB 12 (Davis) requires every health plan to allow an enrollee or policy holder the option to seek obstetrical or gynecological physician services directly from an obstetrician or gynecologist or a family practice physician, subject to certain procedures. This bill also requires DOC to report on the implementation of these provisions to the legislature on or before January 1, 2000. The Governor signed this bill on April 16 (Chapter 22, Statutes of 1998).

AB 607 (Scott), as amended March 3, requires a health plan’s disclosure form to contain a notice providing enrollees and prospective enrollees with certain information, including the importance of reading the disclosure form and evidence of coverage, notice of the plan’s telephone numbers, and other information. This bill also requires each plan to provide a uniform Health Plan Benefits and Coverage Matrix that includes specified information in order to facilitate comparisons between contract plans. The matrix shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence: deductibles; lifetime maximums; professional services; outpatient services; hospitalization services; emergency health coverage; ambulance services; prescription drug coverage; durable medical equipment; mental health services; chemical dependency services; home health services; and other services. The bill does not prevent a plan from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements to clarify any part of the matrix that is unclear. The Governor signed this bill on April 16 (Chapter 23, Statutes of 1998).

AB 742 (Washington), as amended June 18, requires an enrollee of a health plan who has Medicare coverage and is discharged from an acute care hospital to be allowed to return to a skilled nursing facility, a continuing care retirement community, or a multilevel facility, if certain conditions are met. The bill requires the health plan to reimburse the facility to which the patient returns at one of two prescribed rates. The Governor signed this bill on July 9 (Chapter 124, Statutes of 1998).

AB 974 (Gallegos), as amended June 3, requires health plans covering prescription drug benefits to provide notice in the evidence of coverage and disclosure form to the enrollee regarding whether the plan uses a formulary. The bill requires the language to be in a format that is easily understood and to include information defining a formulary, how the plan determines which prescription drugs are included or excluded, and how often the plan reviews the contents of the formulary.

Under this bill, health plans may not limit or exclude coverage for a drug for an enrollee if the drug previously had been approved for coverage by the plan for a medical condition of the enrollee and the plan’s physician continues to provide the drug. This bill does not, however, preclude the prescribing provider from prescribing another drug that is covered by the plan and is medically appropriate. The Governor signed this bill on June 19 (Chapter 68, Statutes of 1998).

SB 625 (Rosenthal), as amended April 23, requires a health plan that provides prescription drug benefits and maintains one or more drug formularies to provide members of the public, upon request, a copy of the most current list of prescription drugs on the formulary by major therapeutic category. This bill further requires health plans to maintain an expeditious process by which prescribing providers can obtain authorization for a medically necessary non-formulary prescription drug. The Governor signed this bill on June 19 (Chapter 69, Statutes of 1998).

Litigation

On October 1, the California Supreme Court decided to review 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. Plaintiffs Keysa Johnson and her son, Adrian Broughton, sued Cigna for damages for medical malpractice based on severe injuries claimed to have been suffered by Adrian at birth. Plaintiffs also sought injunctive relief against Cigna for deceptively and misleadingly advertising the quality of medical services which would be provided to plaintiffs under its health care plan; specifically, plaintiff Johnson alleged that she received substandard prenatal medical services, and that she was denied a medically necessary Cesarean delivery. Cigna answered the complaint and moved to compel arbitration, relying on the mandatory arbitration provision included in its contract. Plaintiffs opposed the motion on various grounds, including its argument that the cause of action under the Act is not subject to arbitration under Civil Code section 1751, which states that “any waiver by a consumer of the provisions of this title is contrary to public policy and shall be unenforceable and void.” The trial court severed the causes of action, granted the motion to compel arbitration of the medical malpractice claim, but denied the motion as to the cause of action under the Act.

On June 30, 1998, the Second District affirmed. Noting that “whether an insurer may compel arbitration of a cause of action under the Act presents a question of first impression,”
the court analyzed the language of the statute, the intent of the legislature in enacting it ("to protect consumers against unfair and deceptive business practices and to provide efficient and economical procedures to secure such protection"), and the existence and language of the express anti-waiver provision. In response to Cigna's argument that the arbitration remedy merely provides a different neutral forum and does not limit the remedies available to plaintiffs, the court noted that Cigna must establish that all of the remedies available under the Act are available in an arbitration. "The basic problem with Cigna's position is the injunctive remedy provision of the Act....a private arbitrator is not empowered to award the injunctive relief sought by plaintiffs....Because arbitrators do not have the authority to issue and monitor injunctive relief, we conclude that arbitration does not provide an alternative, but equal forum to resolve claims under the Act, where injunctive relief is sought, as it is in this case."

In Potvin v. Metropolitan Life Insurance Co., 54 Cal. App. 4th 936 (1997), the Second District Court of Appeal affirmed a physician's right to procedural due process when being terminated by a managed care provider. In Potvin, 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. The court stated that membership in an association (including a hospital staff), once attained, is a valuable interest which cannot be arbitrarily withdrawn. Procedural fairness in the form of adequate notice of the charges brought against the individual and an opportunity to respond is an indispensable prerequisite for one's expulsion from membership, and "overrides a provision in the agreement between the two [parties] allowing termination without cause." The court based its decision on the premise that health plans control a physician's economic well-being by acting as gatekeepers between doctors and their patients. Metropolitan controlled substantial economic interests, as demonstrated by the number of physicians in its networks as well as the adverse effect on Potvin's practice following his "deselection." This case is currently pending in the California Supreme Court, which has agreed to review it.

In Self v. Children's Associated Medical Group, No. 695870 (San Diego County Superior Court) (Apr. 6, 1998), after almost 10 days in deliberations, a San Diego jury awarded $1.75 million in damages to Dr. Thomas Self in an employment termination case. Self, a 58-year-old double board-certified pediatric gastroenterologist, claimed that defendant medical group and its president fired him when he refused to compromise his quality of care in favor of profits to the health care group, which was becoming increasingly reliant on managed care contracts. Self claimed he repeatedly resisted pressure from defendants to spend less time on patient visits and curtal tests and other treatment, and alleged that he was terminated in violation of Business and Professions Code section 2056, which prohibits retaliation against a physician for protesting "cost containment" or advocating appropriate medical care for patients. Defendants alleged that Self's termination had nothing to do with managed care, and was in fact based on plaintiff's shortcomings which plaintiff refused to discuss with them. The jury determined that the defendants acted with malice or oppression in firing Self and that defendants violated section 2056. Self's attorneys claim that he is one of the first physicians to successfully invoke the law; such anti-retaliation laws are in place in about two dozen states, but are relatively new and untested.

In Grijalva v. Shalala, 152 F.3d 1115 (9th Cir. 1998), the U.S. Ninth Circuit Court of Appeals 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, the Secretary of the U.S. Department of Health and Human Services 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. The appellate court upheld the district court's injunction requiring certain procedural protections for Medicare beneficiaries enrolled in HMOs. The government plans to appeal to the U.S. Supreme Court. On September 20, U.S. District Court Judge Vanessa Gilmore upheld 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); this ruling may pave the way for California and other states to enact HMO liability laws such as 1998's failed AB 2436 (Figueroa) (see LEGISLATION). Texas' statute, enacted in 1997, allows an individual to sue a health insurance carrier, health maintenance organization, 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. Plaintiff insurance companies
challenged the statute, arguing primarily that it is preempted by section 514(a) of the federal Employee Retirement Income Security Act (ERISA), which provides that ERISA "shall sup­ercede any and all State laws insofar as they...relate to any employee benefit plan." 29 U.S.C. § 1144(a).

Texas officials defended the liability provision, arguing that it is targeted not at an "ERISA plan" established by an employer to provide benefits to an employee, but at health plans established by health insurance companies as a vehicle for bearing the risks of health insurance and providing coverage to an ERISA plan for those employees. Thus, Texas argued that the defendant insurance companies are operating health plans but not ERISA plans. The court agreed, stating that "the health plans provided by health insurance carriers, health maintenance organizations, or managed care entities,...and the health care entities themselves, cannot consti­tute ERISA plans" because they are not established by or maintained by an employer. "Rather, plaintiffs are medical service providers to ERISA plans and their members." The court also rejected plaintiffs' other arguments that the liability provision "relates to," "refers to," and "is connected with" ERISA plans—finding essentially that the statute applies to managed care entities' treatment decisions "regardless of whether the commercial coverage or membership therein is ultimately secured by a ERISA plan." The court concluded that ERISA does not preempt a state law claim challenging the quality of a benefit (because ERISA "simply says nothing about the quality of benefits received"), such that "the Act does not constitute an improper imposition of state law liability on the enumerated entities." However, a state law claim based on a failure to treat, where the failure is the re­sult of a determination that the requested treatment was not covered by the plan, is preempted by ERISA.

However, Judge Gilmore struck down 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." Plaintiffs argued that these provisions 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). On this claim, the court agreed with plain­tiffs, finding that such provisions are connected with ERISA plans and are precisely the kind of state-based procedures that Congress intended to preempt when it enacted ERISA.

Board of Dental Examiners

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COMDA—Executive Officer: Karen R. Wyant • (916) 263-2595 • Internet: www.comda.ca.gov/

The Board of Dental Examiners (BDE) is a consumer protection agency within the state Department of Consumer Affairs (DCA). BDE 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).

BDE 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 (RDHED), and registered dental hygienists in alternative practice (RDHAP).

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. BDE 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.

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; the Senate Rules Committee and the Assembly Speaker each appoint one public member.

BDE'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 BDE, 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 dental auxiliary edu­cation programs, licensing examinations for the various cat­egories of auxiliaries, and applicants for auxiliary licensure. Additionally, it advises BDE 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 actually employed in a private dental office), three RDAs, one BDE public member, one licensed dentist who is a member of the Board's Examining Committee, and one licensed dentist who is neither a BDE nor Examining Committee member.

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