

conspiracy to commit abuse of process, and malicious prosecution.

Trear has filed a petition for review in the California Supreme Court.

RECENT MEETINGS

With five vacancies and one member absent due to illness, the Board did not achieve a quorum at its February 5 meeting, thus precluding it from taking action on any agenda items. Instead, the Board met as a committee, and made

recommendations which will be considered by the Board when it achieves a quorum. BBS deferred its officer elections to its June 4 meeting.

FUTURE MEETINGS

- June 4, 1999 in Sacramento.
- July 28-29, 1999 in San Diego.
- October 28-29, 1999 in Riverside.

Department of Corporations

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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 rules 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" 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 (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.

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

State Auditor Renews Call for Removal of Managed Care Regulation from DOC and BTH

In April, California State Auditor Kurt Sjoberg and the Bureau of State Audits (BSA) released a report entitled

Department of Corporations' Regulation of Health Plans: Despite Recent Budget Increases, Improvements in Consumer Protection Are Limited, in which Sjoberg reiterated his call for the transfer of the state's managed care regulatory program out of DOC and BTH. The Auditor recommended placement of this responsibility "within an agency better suited to understanding the needs of a health care-related organization, such as the Health and Human Services Agency" (formerly the Health and Welfare Agency). Sjoberg's recommendation repeated a similar suggestion in BSA's 1998 study entitled *Department of Corporations: To Optimize Health Plan Regulation, This Function Should Be Moved to the Health and Welfare Agency*. [16:1 CRLR 24]

Sjoberg reiterated his call for the transfer of the state's managed care regulatory program out of DOC and BTH.

Sjoberg's recommendation came in the context of a report in which he audited the use of an August 1997 \$6.5 million budget increase to DOC's Health Plan Division (HPD), and the extent to which the increase improved protection of enrollees in health plans. The substantial increase authorized HPD to add 94 positions to its existing staff; "in essence, the budget increase expanded by more than 70 percent the size of the Department's staff devoted to health plan regulation." However, in concluding that DOC's implementation of the large budget increase has produced only "limited" results, BSA made the following findings:

To ensure that enrollees are protected from health plans that are financially unsound, the Knox-Keene Act requires DOC to review every health plan's financial status no less frequently than once every five years.

◆ **Delays in Completing Medical Surveys.** The Knox-Keene Act requires DOC to conduct onsite evaluations, or "medical surveys," of all health plans no less frequently than once every three years. The culmination of a medical survey is HPD's release of a final, public report describing the survey's results. If HPD identifies weaknesses during a routine medical survey, its public report will discuss those deficiencies and any actions the health plan has taken or plans to correct the problems. Despite its substantial budget increase, BSA found that HPD "has not eliminated a backlog of routine medical surveys for 40 health plans....Thus, enrollees in these health plans may not receive the level of health care to which they are entitled."

◆ **Failure to Issue Public Reports Promptly.** In addition to its failure to conduct medical surveys of health plans as required by law, HPD also failed to comply with a provision of the Knox-Keene Act requiring the issuance of public reports within 180 days of completion of the surveys it did conduct. "Specifically, of the 45 reports released from January 1996 through December 1998, the Division issued 44 late. On average, the Division released these 44 reports more than six months late."

◆ **Completion of Financial Examinations.** To ensure that enrollees are protected from health plans that are financially

unsound, the Knox-Keene Act requires DOC to review every health plan's financial status no less frequently than once every five years. These reviews, performed by HPD staff, are called "financial examinations." A financial examination ends with

HPD's issuance of a final, public report describing the results found. If HPD identifies weaknesses during a routine financial examination, its public report will discuss those deficiencies and any

actions the health plan has taken or plans to correct the problems. BSA found that the number of routine financial examination reports issued in fiscal year 1997-98 dropped dramatically from the prior year (from 24 to 15), "despite the authorization of 14 new financial examination positions by the budget increase." Nevertheless, BSA found that HPD substantially complied" with the Act's requirement that it conduct financial examinations of all licensed health plans once every five years. However, BSA noted that "the disappointingly small number of reports covering follow-up

financial examinations indicates...that areas in the financial examination function still need improvement. Despite the budget increase, the Division is currently not issuing more reports for follow-up financial examinations than it did before."

◆ **HPD Response to Consumer Complaints.** HPD's Consumer Services Unit is charged with operating a toll-free telephone hotline to receive complaints from health plan enrollees. Meritorious complaints are referred to HPD's Enforcement Unit for investigation and possible enforcement action. BSA examined several performance measures related to HPD's processing of incoming consumer complaints, and found that "the Division's protection of health plan enrollees through the complaint resolution function actually worsened in the year the Division received the budget increase." The number of complaints open at the end of fiscal year 1997-98 was 20% higher than at the end of 1996-97; HPD's 1997-98 complaint backlog increased by 47% (from 377 to 556) over the prior year. Although HPD's complaint figures improved during the last six months of 1998, "as of March 5, 1999, more than 200 complaints from consumers were still open even though the Department had exceeded the statutorily required 60 days to resolve complaints."

In its report, BSA noted that it had previously identified DOC's deficiencies in completing medical surveys and handling consumer complaints. Seven years ago, in *The Department of Corporations Can Improve Its Management of Medical Surveys and Consumer Complaints in Its Health Care Service Plan Division* (May 1992), BSA (then the Office of the Auditor General) concluded that DOC did not always effectively manage its medical surveys of health plans, allowed excessive delays in the release of survey reports, failed

to take follow-up and enforcement actions, and failed to promptly process consumer complaints against their health plans. [12:4 CRLR 35-36, 141]

According to BSA, primarily to blame for HPD's problems and its poor protection of health plan enrollees is "deficient management." Some of the symptoms of this threshold defect include the following: (1) neither the medical survey nor the financial examination functions had permanent managers; (2) the medical survey manager's position had been vacant for the 16 months since the budget increase authorized the position; (3) although HPD's Consumer Services Unit and Enforcement Unit conducted internal reviews and made procedural changes following the budget increase, neither the medical survey nor financial examination units conducted similar internal reviews; (4) as of December 31, 1998, 67% (or 12) of HPD's analyst positions remained vacant, and 10 of these have been vacant for nearly 16 months; (5) although HPD attorneys are responsible for reviewing all medical survey reports before publication and assisting Consumer Services in resolving consumer complaints, 35% of HPD's authorized attorney positions were vacant as of December 31, 1998; and (6) the Department lacks adequate internal tracking tools to ensure that it complies with the Act's requirement to perform medical surveys of each plan once every three years.

In addition to reiterating its call for removal of managed care regulation from DOC and BTH, BSA made the following recommendations to DOC: (1) to ensure its functions are properly managed, DOC should fill the vacant leadership position within the medical survey function as soon as a qualified individual is found, and DOC should promptly create and fill a leadership position for the financial examination function; (2) to protect consumers more effectively through its medical survey and financial examination functions, DOC should examine in depth and revise as necessary the policies and procedures used by the staff of these functions; (3) to bring its budget more in line with actual costs, DOC should reassess its workload estimates for the medical survey, financial examination, and complaint resolution functions, and then revise the related staffing levels and budget as necessary; and (4) to ensure better compliance with applicable laws concerning the release of reports for routine medical surveys, DOC should establish sound administrative controls and develop and implement adequate tracking systems.

In response to Sjoberg's report, newly-appointed BTH Secretary Maria Contreras-Sweet confirmed that the Davis

administration "has inherited an organization with deficiencies in key management and operational areas." She called the backlogs "unacceptable," and noted that she has directed DOC to redirect resources and eliminate the backlogs. Contreras-Sweet stated that the Davis administration "is committed to improving the regulation of managed care in California."

DOC Takes Over MedPartners Provider Network

In an unprecedented move on March 11, the Department seized MedPartners Provider Network (MPN), a California subsidiary of Alabama-based MedPartners Inc. MPN is a physician management company which runs 117 clinics and employs 1,000 physicians who provide health care to 1.3 million Californians. The Department placed MPN in Chapter 11 bankruptcy and appointed a conservator, Eugene Froelich, who was charged with ensuring that patient care would continue uninterrupted.

DOC's first-ever takeover of a full service health plan followed 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. In addition to releasing its report questioning MPN's financial stability, DOC issued a cease and desist order prohibiting the company from moving funds out of California until the Department is sure there is enough to pay claims against MPN and ensure continued patient care and physician payment.

Unlike DOC's sister agency, the Department of Insurance (DOI), DOC has no experience in taking over a health plan. While DOI has seized, conserved, and approved the sale of several insolvent insurance companies which it is charged with regulating [11:3 CRLR 129], DOC has never seized a health plan. Undoubtedly, DOC's move was prompted by the 1998 failure of FPA Medical Management, another physicians' management group, which declared bankruptcy several days after DOC decided not to take it over. DOC's seizure of a company whose solvency it is charged with monitoring also illustrates the importance of routine, comprehensive, and competent financial examinations of health plans which serve California consumers—an area of DOC performance recently criticized by the State Auditor (see above).

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At this writing, MPN is negotiating with its creditors in the context of the bankruptcy action; any agreement must be approved by DOC and the bankruptcy court. MPN is still functioning under DOC's supervision and Froelich's conservatorship. According to the Department, it is attempting to ensure "an orderly reorganization of MPN so that it is viable in the future and to ensure that providers are properly compensated." To this end, on March 19 DOC issued a cease and desist order against Blue Cross of California, which had unilaterally transferred 120,000 members away from provider groups affiliated with MPN without permission from DOC. The Department has requested all health plans that contract with MPN to notify their enrollees that health care arrangements remain unchanged and intact; make certain that MPN's contracting providers continue to furnish accessible and timely health care services; and ensure that enrollees are not billed for covered health care services.

DOC Investigates Health Plans' Prescription Drug Formularies

In late January, DOC legal counsel Brian Bartow issued letters ordering six health plans to restore access to a "significant number of prescription drugs" that he said had been removed from the plans' formularies of medications available to enrollees in recent months. The Department also requested a number of documents from each of the plans in order to determine whether the plans had violated the law when they dropped certain drugs from availability. DOC also ordered the companies to refrain from delisting any more medications during the pendency of the investigation unless approved by DOC. The health plans targeted by DOC in January are Kaiser Permanente, Aetna US Healthcare of California, Health Net, Key Health Plan, Molina Medical Centers, and United HealthCare of California.

DOC officials were alerted to the problem by 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 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 January 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 January 1. DOC is expected to investigate both aspects of the problem in the coming months; at this writing, the investigation continues.

LEGISLATION

SB 420 (Figueroa), as amended April 14, would declare that the legislature believes that it is in the public interest for the administration and enforcement of the Knox-Keene Health Care Service Plan Act of 1975 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 260 (Speier), as amended April 28, would create the California Comprehensive Health Care Agency, and create the Department of Managed Care within that agency. The bill would require the Department to license all entities that assume financial risk for providing health care services rendered in California, and would also require the Department to set fees for licenses and renewal licenses by regulation. SB 260 would also create a Health Care Guarantee Fund in the State Treasury, under the administration of the Department, which would be responsible for the payment of approved costs of providing health care services when a licensee responsible for providing that care is financially unable to do so. [*S. Jud*]

AB 78 (Gallegos), as introduced December 8, was a reintroduction of SB 406 (Rosenthal), a 1998 bill which was vetoed by Governor Wilson last October. [16:1 CRLR 25, 30] The bill would establish the Board of Managed Health Care in the State and Consumer Services Agency, with prescribed membership and duties; and require the Board, on and after March 1, 2000, to administer and enforce the regulation of health plans on and after July 1, 2000. The bill would also require 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, 2002.

As amended April 15, AB 78 would create an "unspecified entity" to take over the regulation of Knox-Keene health plans. [*A. Appr*]

SB 21 (Figueroa), as amended April 29, would require a health plan or managed care entity, for services rendered after January 1, 2000, to be legally responsible to patients to ensure that health care providers, rather than the plan, shall be in charge of health care. The bill, known as the Managed Health Care Insurance Accountability Act of 1999, would also make a health plan or managed care entity liable for any and all harm resulting from the failure to exercise ordinary care in the arranging for the provision of or denial of health care services. It would prohibit health plans or managed care entities from seeking indemnity, whether equitable or contractual, from a provider for liability imposed under this bill; and would prohibit waiver of these provisions by any member, subscriber, or enrollee. [*S. Appr*]

AB 55 (Midgen), as amended April 27, would provide that health plans have a duty of ordinary care to provide medically appropriate health services, and shall be liable for any and all harm resulting from the failure to exercise ordinary care. This bill would also allow plan enrollees to seek DOC review of unresolved grievances after 30 days (instead of the current 60 days), require plans to provide enrollees with a written status report on grievances within 15 days (instead of the current 30 days), and require plans to act on expedited grievances, including those involving severe pain, within three days from receipt of the grievance (instead of the current five days). AB 55 would also establish, commencing January 1, 2001, an independent medical review system for enrollees to seek an independent review whenever health care services have been denied, significantly delayed, terminated 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. *[A. Appr]*

AB 58 (Davis), as amended March 17, would 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 licensed as a physician in California. *[A. Appr]*

SB 18 (Figueroa), as amended April 29, provides 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, and such a decision or recommendation shall be performed only by a healing arts licentiate acting within his/her scope of practice who possesses a valid license under law that authorizes the licentiate to make or perform the treatment or care. The bill specifies various exceptions to these provisions. SB 18 also provides that a violation of these provisions by a healing arts licentiate constitutes unprofessional conduct and is grounds for suspension or revocation of the license, certification, or registration of the licentiate; also, a violation of these provisions would be a misdemeanor. *[S. Appr]*

SB 7 (Figueroa and Leslie), as amended April 6, provides that any person who makes a decision regarding medical necessity or appropriateness that affects any diagnosis, treatment, operation, or prescription without possessing a valid, unrevoked, and unsuspended physician's license from the Medical Board of California is engaged in the practice of medicine and would be guilty of a misdemeanor. *[S. Appr]*

AB 1621 (Thomson), as amended April 27, also provides that any person who makes a decision regarding medical necessity or appropriateness that affects any diagnosis, treatment, operation, or prescription without possessing a valid, unrevoked, and unsuspended physician's license from the Medical Board of California is engaged in the practice of medicine and would be guilty of a misdemeanor.

Additionally, AB 1621 would allow health plan enrollees to seek DOC review of unresolved grievances after 30 days (instead of the current 60 days), require plans to provide enrollees with a written status report on grievances within 15 days (instead of the current 30 days), and require plans to act on emergency grievances within three days from receipt of the grievance (instead of the current five days); add the Attorney General (AG) to the list of agencies to which DOC may refer a complaint for investigation and authorize the AG, upon notifying DOC, to enforce any and all provisions of laws regulating health plans, with any civil, criminal, or administrative remedies available to the AG; and—commencing January 1, 2000—establish an independent medical review system that requires health plans to provide enrollees the opportunity to seek an independent medical review whenever health care services have been denied, significantly delayed, terminated, or otherwise limited by a plan or one of its contracting providers based in whole or in part on a finding that the proposed health care services are not medically necessary or medically appropriate. *[A. Appr]*

SB 254 (Speier). Existing law requires every health plan to establish and maintain a grievance system approved by DOC 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 DOC for review. As amended March 17, this bill 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 DOC after participating in the plan's grievance process for 30 days. The bill would require DOC to respond to each grievance in writing within 30 days.

Existing law requires every health plan and disability insurer to establish a reasonable external, independent review process to examine coverage decisions regarding experimental or investigational therapies for individual enrollees or insureds who have a terminal condition and meet certain specified criteria. This bill would repeal these provisions on January 1, 2001, and thereafter instead require every health plan and disability insurer that covers hospital, surgical, or medical benefits to provide an enrollee or insured with the opportunity to seek an independent medical review whenever health care services have been denied, significantly delayed, terminated, or otherwise limited by the plan or insurer, or by one of its contracting providers. This bill would establish, beginning January 1, 2001, the Independent Review System in DOC and DOI, whereby enrollee or insured grievances involving a disputed health care service or other adverse decision may be resolved by independent review organizations. The bill sets forth the duties and responsibilities of the departments, health plans, disability insurers, and enrollees and insureds with respect to the system. Medi-Cal and Medicare beneficiaries would not be excluded from the system, to the extent that their participation is not preempted

by federal law. The bill would require the Corporations Commissioner and the Insurance Commissioner to contract with a private, nonprofit accrediting organization to accredit the independent review organizations, and would further require the adoption of related regulations.

Both commissioners, on or before July 1, 2000, would be required to allocate grant funding for an independent health care ombudsprogram. The departments would be required to contract with independent expert entities to undertake evaluations of the independent review systems and the independent health care ombudsprograms. The bill would require the evaluators to provide their evaluations to the departments on or before January 1, 2003, a copy of which would be required to be made available to the public. [*S. Jud*]

SB 189 (Schiff), as introduced January 15, would—on and after January 1, 2000—require every health plan and disability insurer to provide an enrollee or insured with the opportunity to seek an independent medical review whenever health care services have been denied, significantly delayed, terminated, or otherwise limited by the plan or insurer. DOC and DOI would be required to establish an independent medical review system whereby requests for reviews are assigned to an independent review organization. An enrollee or insured would be required to pay to the appropriate department a processing fee of \$50, which would be refunded if the enrollee prevails in the review. [*S. Jud*]

AB 136 (Migden). Existing law requires health plans and disability insurers to establish a reasonable external, independent review process to examine coverage decisions regarding experimental treatments or investigational therapies for enrollees who meet prescribed criteria. The criteria include a requirement that the enrollee or insured have a terminal condition that has a high probability of causing death within two years from the date of the request for an independent review. As amended April 15, this bill would revise this criterion to instead require that the enrollee or insured have a life-threatening or seriously debilitating condition. This bill would also require DOC to contract with one or more impartial, independent, accredited entities for purposes of the external, independent review process, rather than the plan or insurer. [*A. Appr*]

AB 12 (Davis), as introduced December 7, would require health plans and certain disability insurers to provide for a medically necessary second opinion by an “appropriately qualified health care professional” if requested by an enrollee and the plan has more than one contracting provider group or independent practice association in a geographic area. Under this bill, an “appropriately qualified health professional” is 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 must authorize a second opinion by an appropriately quali-

fied health professional outside of the plan’s provider network. The bill would also require plans to authorize or deny the second opinion in an expeditious manner; require plans and insurers to file timelines for responding to requests for second opinions by July 1, 2000, with the appropriate state agency; and require that the timelines be made available to the public upon request. This bill would not apply to disability insurers that do not limit second medical opinions or to certain other health insurance. [*A. Appr*]

AB 138 (Gallegos), as introduced January 11, would require the Corporations Commissioner 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. Specified criteria would have to be met in order to receive funding under the program. Every health plan would have to pay annually to DOC its prorated share of fees for the anticipated annual costs associated with carrying out the program. [*A. Appr*]

SB 19 (Figueroa). Existing law prohibits providers of health care—including Knox-Keene health plans—from disclosing confidential medical information, except in specified circumstances. As amended April 20, this bill would make the prohibitions on disclosure of medical information applicable also to contractors of health care providers, including medical groups, medical service organizations, and pharmaceutical benefit managers; and would expressly prohibit the intentional sharing, sale, or use of medical information for commercial purposes without prior specific authorization, except as specified. The bill would make the knowing and willful violation of any of these prohibitions a misdemeanor, without regard to whether the patient suffered any loss or injury, and would additionally provide for specified administrative and civil penalties. The bill would also prohibit a health plan and its contractors from requesting an authorization from an enrollee to disclose medical information for any purpose not directly related to provision of health services to the enrollee or from requesting an enrollee, as a condition to securing health care services, to sign an authorization, waiver, or consent waiving any medical information confidentiality protections authorized by law. [*S. Appr*]

AB 368 (Kuehl), as amended April 27, would require health plans, group disability insurers, and the Medi-Cal program to provide coverage for prosthetic devices for the partially sighted. [*A. Appr*]

AB 549 (Gallegos), as introduced February 18, would require health plans to make available to the public, upon request, the criteria used to determine whether to authorize or deny health care services. This bill would also require every health plan to conduct an annual enrollee disenrollment survey; submit the results to the Corporations Commissioner; and make available a summary of its most recent annual enrollee disenrollment survey results, within three months of completion of the survey, to anyone who requests the summary. [*A. Appr*]

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 April 27, this bill would change the interest rate to 13% per annum on claims that are not contested or denied. 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. *[A. Appr]*

AB 888 (Wayne), as introduced February 25, 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 1124 (Havice), as amended April 15, 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. 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. *[A. Appr]*

AB 1283 (Baugh), as introduced February 26, 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 February 26, would enact additional 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. AB 1285 would also require the Commissioner to review a health plan's compliance with these provisions. *[A. Health]*

SB 217 (Baca). The Knox-Keene Act requires every health plan to establish procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan. As amended April 27, this bill 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. The bill would require DOC, on or before May 1, 2000, to approve a survey format, methodology, and reporting format and to approve an entity to certify survey vendors; and require health plans to utilize the approved survey format, methodology, and reporting format and the entity to certify survey vendors in meeting the requirements of the bill. The bill would also require plans to report the results of the

survey to DOC; require DOC to place a table listing reported ratings for each survey category on its Internet website; and require each plan that has an Internet website to have a link to the table. *[S. Appr]*

SB 292 (Figueroa), as amended April 5, would require every dental plan and disability insurer that issues policies providing dental benefits to provide an enrollee or insured with the opportunity to seek independent review whenever dental care services have been denied, significantly delayed, terminated, or otherwise limited by the plan or by one of its contracting providers. Beginning January 1, 2001, this bill would establish a Dental

Independent Review System in DOC and in DOI, whereby enrollee or insured grievances involving disputed dental care services or other adverse decisions may be resolved by independent review organizations. The bill would set forth the duties and responsibilities of the departments, dental plans, disability insurers, and enrollees and insureds with respect to the system. Medi-Cal and Medicare beneficiaries would not be excluded from the system, to the extent that their participation is not preempted by federal law. SB 292 would also require the Corporations Commissioner and the Insurance Commissioner to contract with a private, non-profit accrediting organization to accredit the independent review organizations, and would further require the adoption of related regulations. This bill would require the departments to contract with independent expert entities to undertake evaluations of the dental independent review systems; and require the evaluators to provide their evaluation to the departments on or before January 1, 2003, a copy of which would be required to be made available to the public. This bill would require reviews to be conducted by an individual California dentist, subject to strict conflict of interest provisions, and whose decision would be binding upon the dental plan or insurer. The costs of such review would be borne by the dental plans. *[S. Jud]*

SB 337 (Figueroa), as introduced, 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. The Corporations Commissioner would annually report to the legislature and the public regarding the administrative costs of every health plan. *[S. Ins]*

SB 349 (Figueroa), as amended April 14, would clarify that when emergency psychiatric care is provided, it shall be a covered benefit and shall be reimbursed by health plans. *[S. Appr]*

AB 215 (Soto), as amended April 6, would require health plans to approve or deny a request from a health care provider that a subscriber or enrollee be referred to a specialist and notify the health care provider of the decision within a timeframe appropriate for the condition of the patient, but no later than 72 hours after receiving the request. Health plans would be required to approve or deny referral requests addressing urgent or emergency medical conditions within 24 hours of receiving the request, and—upon denial of a referral

request—to notify the subscriber or enrollee of his/her right to appeal the plan's decision. [*S. Ins*]

SB 362 (Alpert), as amended April 27, would require every individual or group health plan contract to provide coverage for the screening and diagnosis 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. [*A. Appr*]

SB 1053 (Poochigian), as introduced February 26, would require health plans to allow a patient to obtain covered services from any participating physician outside of the patient's service area for conditions which threaten the loss of life, limb, or bodily function. [*S. Appr*]

SB 1177 (Perata), as amended April 14, 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*]

AB 351 (Steinberg), as introduced February 11, would establish various requirements, including notice to the Attorney General, in case of certain transactions that concern the merger, acquisition, or change in control of a nonprofit health plan doing business in California. The bill would require the Attorney General to conduct public meetings to solicit comments or issue a public notice soliciting written comments regarding the proposed transaction, and authorize the Attorney General to consent to, give conditional consent to, or not consent to the transaction. [*A. Appr*]

LITIGATION

On January 20, a San Bernardino jury returned a record verdict against a health plan in *Goodrich v. Aetna Health Plans of California, Inc.*, No. RCV020499. The jury awarded \$4.5 million in compensatory damages and \$116 million in punitive damages to the family of David Goodrich, who died in 1995 after a three-year struggle with a rare type of stomach cancer. On behalf of Goodrich's family, attorney Michael J. Bidart alleged that Aetna denied and delayed medically necessary treatment for over two years; when Goodrich finally received treatment, Aetna refused to pay for it. Goodrich was a former San Bernardino County Assistant District Attorney whose health care coverage was paid by his government employer, thus qualifying his survivors to sue Aetna for full damages. Other consumers who suffer identical harm but secure their health coverage through private employers are barred from suing for full damages under the federal Employee Retirement Income Security Act (ERISA); their remedy for harm due to denied or delayed treatment is the cost of the denied service. Consumer advocates hope the verdict prompts policymakers

to correct this inequity and enable patients to hold health plans accountable for refusal to provide medically necessary treatment. Texas has already passed a statute closing the so-called "ERISA loophole" [16:1 CRLR 25-26, 33-34]; SB 21 (Figueroa) (see LEGISLATION)—now moving through the California legislature—would do the same in California.

Also on January 20, Attorney General Bill Lockyer issued *Attorney General's Opinion No. 98-611* in response to a question posed by Senator Liz Figueroa. Lockyer addressed the issue of whether a corporate entity licensed as a health plan under the Knox-Keene Act may enter into an agreement with a network of providers of cosmetic medical services, a specialty not covered by any of the entity's health benefit plans, and then (1) refer its enrollees to a participating provider for medical services at a discount rate; and (2) deduct an "administrative fee" from the fee it pays to the provider.

The entity at issue has proposed establishing a directory of participating physicians, plastic surgeons, dermatologists, ophthalmologists, and other licensed health care providers who would perform cosmetic surgery procedures at discounted rates. The entity would refer an enrollee to a participating physician and serve as a third-party intermediary by collecting the fee from the enrollee-patient and forwarding it to the physician provider, minus an administrative fee for organizing and administering the program. Because these proposed services are not covered by any of the entity's existing health benefit plans, the services would be offered as a "supplemental personal purchasing program," not a plan benefit.

Lockyer first concluded that because payment on a fee-for-service basis would be entirely the responsibility of the enrollee and the entity would be assuming no financial risk, the proposed arrangement violates 1375.1 of the Health and Safety Code, which requires that "every health care service plan assume full financial risk on a prospective basis for the provision of covered health care services...." Thus, the proposed arrangement is not authorized by the Knox-Keene Act.

Next, the AG concluded that the arrangement would violate Business and Professions Code section 650, which prohibits physicians (among others) from offering a discount as an inducement for the referral of patients. Although here the discount would be offered to the patient (not the entity), Lockyer concluded that it would be impermissible because the discount to the enrollee of the entity would constitute consideration to the referring entity: "[T]he discount conferred upon an enrollee of the entity would enhance the entity's economically advantageous relationship with the enrollee. The program would be a marketing tool for the entity to use in soliciting new enrollees. The partnership between the physicians and the entity would thus not only benefit the physicians in obtaining new patients, but also the entity in promoting its health care service plans vis-a-vis its competition. In sum, the referrals would be induced by considerations other than the best interests of the patient."

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. Plaintiffs Keya 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 violation of the Act, based on allegations that Cigna deceptively and misleadingly advertised 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 Caesarean 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." The Supreme Court granted review on October 1, 1998.

On March 24, the Supreme Court narrowed the issues under consideration in *Broughton* to "(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."

The Second District Court of Appeal's decision in *Potvin v. Metropolitan Life Insurance Co.*, 54 Cal. App. 4th 936 (1997), is also pending review by the California Supreme Court. 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. [16:1 CRLR 33]

At this writing, the U.S. Supreme Court is still considering the federal government's petition for certiorari in *Grijalva v. Shalala*, 152 F.3d 1115 (9th Cir. 1998). In that 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, 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.

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, health maintenance organization, or other

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.

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. [16:1 CRLR 33-34]

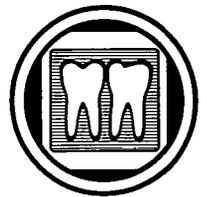
Plaintiff insurance companies challenged the statute, arguing primarily that it is preempted by section 514(a) of the federal Employee Retirement Income Security Act (ERISA), which provides that ERISA "shall supersede any and all State laws insofar as they...relate to any employee benefit plan." 29 U.S.C. § 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." Aetna Liability Casualty Company is appealing this portion of the holding.

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. Texas Attorney General Dan Morales has appealed this portion of Judge Gilmore's ruling.

Board of Dental Examiners

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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 (RDHEF), 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.

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