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News

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President's Report

by Troy Becker

► The summer is upon us, and even I must say it's been somewhat mild, at least for the time being. The Board has been waiting for the other shoe to drop, yet we have found that the legislative front is pretty much following its preset course - one set by the Governor.

On the other hand, the regulatory front is just heating up. As most of you should know by now, emergency regulations were promulgated regarding the enrollee grievance process. Quite clearly the dental industry was again swept into the discontent of medical issues, although this may be an argued point. In any case, CADP is communicating with the Department to clarify our concerns and will work with Department officials to pre-empt these issues when possible.

I should note that a few members of CADP are experiencing some positive results relative to the Department's new culture. It is far too early to tell, but reports of increased dialogue, logically refined processes and pre-review discussions seem to be goals targeted by the Department in its effort to focus on the right areas. CADP will follow these plans through their audit process and report on results as they become available.

Last, CADP is also refining its processes, as well. The CADP web site is actually functioning out there somewhere. It is not yet in a public domain as Jackie Miller and I are adding much needed functionality and content. Although the site's purpose is mainly informational, CADP will begin to post publications and other important data for members' reference and communication, as well. Once complete, the site will transfer to its host company, which has graciously provided its services free of charge. Our site development company is expecting to publish the site URL in July. CADP will keep you posted.

What's Inside

Potvin v. Metropolitan Life

Page 2

Legislative Report

Page 3

Dots and Dashes

Page 5

In the News

Page 6

DMHC Officials on Board

Page 9



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News

The CADP News is published quarterly. Your suggestions and/or comments are encouraged.

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Potvin v. Metropolitan Life - Supreme Court Decision

By Mary Antoine, Esq., Nossaman, Guthner, Knox & Elliott, LLP

As many of you know, the long awaited California Supreme Court decision in the *Potvin v. Metropolitan Life Insurance Company* case was handed down on May 8, 2000. Although the Supreme Court held in favor of Dr. Potvin – by declaring that the “without cause” termination clause in his PPO contract with Metropolitan Life was unenforceable and that termination could only be done following a “fair procedure” – there are some positives for the managed care industry and some planning opportunities.

This article will not attempt to summarize the full decision. Instead, we will give dental plans our thoughts on what the decision does – and does not – say. These can be summarized as follows:

- In addition to the PPO arrangement in which Dr. Potvin was involved, the decision is, most likely, applicable to all independent contractor relationships with individual providers, provider groups and IPAs.
- While the Supreme Court stated in a footnote that *Potvin* is not applicable to employer-employee contractual relations, dental plans that employ their dentists should nevertheless follow the rules set down by the case.
- A “fair procedure” is required prior to termination of a dentist only when the dental plan contract represents a “substantial economic interest” to the contracted dentist (for terminations based on issues unrelated to professional competence).
- If the contract does represent a “substantial economic interest,” the dentist is entitled to a “fair procedure” prior to termination, but this does not necessarily mean a full evidentiary hearing.
- If a “fair procedure” is required, dental plans have some leeway to decide what that means and what criteria are to be applied in determining whether termination is authorized. It will be up to the dentist to show that these decisions are not “substantively rational.”

- Except for a situation that can be characterized as a “layoff” – e.g., going out of business in a particular region – no guidance is given as to terminations for “economic” reasons.
- The decision does not say whether a fair procedure is required for a non-renewal or a refusal to offer a contract.

Now to elaborate briefly on some of the above points.

Employment Contracts. The *Potvin* decision states in a footnote that it is not applicable to employment contracts with providers. By the same token, the decision does not say how the Court would rule if presented with a case involving a “without cause” termination of an employment agreement *between an HMO and a provider*. The Court spent a great deal of time discussing the concept that the public has a substantial interest in the relationship between HMOs and their preferred providers. This interest is so significant that it enables courts to impose requirements upon that relationship that would not otherwise exist under the contract. One such requirement is the obligation to provide fair procedure prior to terminating a dentist when a dentist’s substantial economic interest is involved. This economic interest will exist whether the arrangement with the dentist is one of employment or independent contractor. We believe that it is reasonably safe to assume, therefore, that “without cause” termination rights in employment agreements between dentists and dental plans are likely to be found unenforceable.

IPA Contracts. Although the *Potvin* case dealt with a “PPO” type of agreement directly between an insurance company and a physician, it is reasonable to conclude that the decision is also applicable to the typical IPA/independent contractor type of relationship in which a dental plan contracts with non-employee dentists. In fact, a recent California Appellate Court case, *Castellanos v. Coastal Providers of San Luis Obispo* (March 10, 2000) holds that termi-

nation of such an agreement requires a “fair procedure” if the agreement represents a “substantial economic interest” to the provider.

Fair Procedure Is Required Only When A Substantial Economic Interest Is Involved. The *Potvin* decision states this as follows:

“The obligation to do so arises only when the insurer possesses power so substantial that the removal significantly impairs the ability of an ordinary, competent physician to practice medicine or a medical specialty in a particular geographic area, thereby affecting an important, substantial economic interest.”

How this standard will be applied remains to be developed in later cases. In any event, it is clear that loss of income is relevant, but not necessarily dispositive. In the *Castellanos* case, the court ruled that termination of an IPA agreement requires a “fair procedure” where the IPA contract in question accounted for about 35% of the physician’s patients. In another case (*Ambrosino*), the Court held that a contract covering 15% of a doctor’s patients represented a “substantial economic interest.” There is also an indication that the “ripple effect” resulting from the removal of the provider from one managed care provider list might be considered relevant.

Keep in mind, however, that the “substantial economic interest” standard is only relevant in determining whether or not a “fair procedure” is required. It is not relevant to whether that fair procedure can result in a valid termination. The *Potvin* decision states that, even when a “fair procedure” is required prior to termination, the termination can be effected “without regard to the financial effect on the [provider], so long as the insurer’s decision is ‘substantively rational and procedurally fair.’”

What Is A Fair Procedure? Assuming that a “fair procedure” is required, the question becomes what type of procedure

continued on page 8

Legislative Report

by John F. Foran, Esq., Nossaman, Guthner, Knox & Elliott, LLP

▶ This is an update of legislative activity during the second half of the current biannual session. A number of bills referred to in the previous report were spot bills and have been deleted, since no substantive amendments were made. Also bills that were never set or abandoned by the author have been removed.

▶ **Arbitration** - In our last report, we identified two bills by Assembly Member Kuehl that would ban arbitration clauses in HMO contracts. These bills were AB 858 and AB 1751. At the time it was unknown as to which specific bill would be pursued. Since that time, AB 1751 was heard and passed out of the Assembly Judiciary Committee. Since it did not have fiscal implications, it was not heard in the Committee on Appropriations and went directly to the Floor where it is currently awaiting action on the Assembly Third Reading file. Because the bill has not yet been taken up, our lobbying efforts against the bill appear to be successful to date. (Update: It appears that Ms. Kuehl does not have the votes to pass this bill off the Assembly Floor; it is currently on the Assembly Inactive File.)

As a defensive mechanism against the passage of AB 1751 (Kuehl), CADP is supporting an alternative bill, SB 1934 (Polanco). SB 1934 provides that where a health care service plan includes terms in its plan contracts requiring binding arbitration for dispute settlement, the plan is prohibited from imposing limits on the damages that may be awarded in an arbitration that differ from the damages that could otherwise be awarded in a similar dispute decided by a court or jury trial. Amendments were adopted to ensure that the legislation, if enacted, would not impact any pending cases; it further provides for corrections to any defect with respect to those issues raised in the cases. The bill has passed the Senate and is currently in the Assembly Judiciary Committee.

▶ **Collusion or Physician Antitrust Exemption** - As reported earlier, SB 2007

(Speier) would have granted physicians immunity from state antitrust laws that prohibit collective negotiation by independent competitors over fees and other contract terms. SB 2007 was amended to totally remove the provisions of the bill as introduced. The bill as amended poses several problems for CADP. It would require the Director of the Department of Managed (Health) Care to establish and maintain a system of reviewing and acting on provider complaints. The Director could then either approve the contract or make findings regarding the need for modification of the contract terms. If the terms of the contract were deemed to compromise patient care, the contract would be unenforceable. In its amended form, the bill passed the Senate Insurance Committee but has stalled in Senate Appropriations. CADP continues to oppose SB 2007.

▶ **Dental Management Service Organizations** - AB 2332 (Mazzoni) would have required a person engaged in business as a dental management service organization to be licensed by the Department as a health care service plan or a specialized health care service plan. The author has dropped the bill.

▶ **Health Care Service Discounts** - SB 173 (Alpert) as amended permits an entity to provide or arrange for services offered to the public under a discount program. The bill exempts these entities from coverage as a health care service plan or as an insurance company, but requires registration of such programs with the Department of Managed (Health) Care, although this provision remains under discussion. Passed the Assembly Health Committee and is currently in Assembly Judiciary.

SB 1181 (Polanco) as amended authorizes health plans to have a written agreement with a provider or organization that contracts with providers to provide services under a discount program. The bill would also permit a full service plan to subcontract with another plan, such as a specialized health care service plan or another

organization, to provide or arrange for the products or services offered under the discount program. This measure also passed the Assembly Health Committee and is currently in Assembly Judiciary.

▶ **Dental Benefits Eligibility** - AB 2299 (Gallegos) increases the number of persons eligible for dental benefits under the Healthy Families program. The measure has passed the Assembly and is currently in the Senate Appropriations Committee.

AB 2415 (Migden) deletes the requirement that eligibility for qualified aliens is dependent upon federal participation. This bill passed the Assembly and awaits hearing in the Senate Appropriations Committee.

▶ **Second Opinion** - As reported previously to CADP members, SB 292 (Figueroa) unanimously passed the Assembly Health Committee on June 27, with CDA amendments removing plan opposition. As amended, the measure clarifies that dentists can request a second opinion. Currently in the Assembly Appropriations Committee.

▶ **Practice of Dentistry** - AB 497 (Gallegos) allows dentists to maintain more than one office. As amended, the measure requires a dentist to assume legal responsibility and liability for the services rendered in each office. Awaits action by the full Senate.

▶ **Privacy** - SB 129 (Peace) continues to be the subject of Conference Committee hearings but no action has been taken on the bill. The other principal bills dealing with the privacy issue, AB 1707 (Kuehl), SB 1337 (Speier), and SB 1372 (Leslie), have all been defeated.

▶ **Small Employer Health Coverage - Medical Savings Accounts** - AB 1388 (Aanestad) which would set-up medical savings accounts in connection with high deductible health plans or insurance coverage was introduced in 1999. The bill failed in the Senate Insurance Committee and has not been reset for hearing.

continued on page 4

Selected Bills Followed by HMOs -

AB 1734 (Thomson) authorizes tax credits to employers who provide health care to employees. Held under submission in Assembly Appropriations.

AB 1735 (Thomson) requires school districts to provide parents with information on the Healthy Families Program. Passed the Assembly and is in Senate Education.

AB 1887 (Cedillo) creates the Healthy Californians Program to assist employers who cannot afford to provide health insurance coverage for their employees. Passed the Assembly and is currently in Senate Appropriations.

AB 1915 (Corbett) as amended requires the Department of Health Services to biannually review Medi-Cal reimbursements. The results are to be reported to the Legislature as a basis for its rate setting responsibilities. Currently in the Assembly Appropriations Committee.

AB 1974 (Migden) as amended requires the Managed Risk Medical Insurance Board (MRMIB) to develop a document to be made available to employers regarding the Healthy Families Program. Passed the Assembly and awaits action in the Senate Appropriations Committee.

AB 2039 (Kuehl) represents a commitment made by the author of SB 21 of the 1999 session establishing the HMO liability law. The bill provides that a person who has established significant financial loss must exhaust the applicable independent review system prior to filing a lawsuit unless a judge, as a matter of law, finds that exhaustion of the review would be futile. AB 2039 was heard in Assembly Judiciary Committee and failed passage.

AB 2225 (Kuehl) requires the Department of Health Services to revise forms for predetermination of eligibility benefits under the Medi-Cal program. Assigned to the Assembly Health Committee and was not set for hearing.

AB 2500 (Ashburn) established an income reduction of 150 percent of the United States Department of Health and Human Services Poverty Guidelines for Medi-Cal eligibility. Heard in the Assembly Health Committee and failed passage.

AB 2547 (Hertzberg) authorizes the Department of Health Services to publicize specific information on licensing and certification on the Internet. Passed the Assembly and is pending in Senate Appropriations.

SB 1471 (Schiff) provides that no lien for recovery of money paid to an enrollee for medical services under a health care service plan may exceed the amount paid pursuant to the contract to the treating medical provider. Passed the Senate and currently awaits action on the Assembly Floor.

SB 1738 (Hayden) creates the Insurance Policyholder and Patient Protection Association as a nonprofit consumer-based association to protect and advocate the interests of policyholders and patients with respect to insurance and health care issues. Passed the Senate Insurance Committee. Held under submission in the Senate Appropriations Committee.

SB 1746 (Figueroa) requires a notice to provide instructions to health plan enrollees to choose a new "gatekeeper" and permits an enrollee to self-refer under specified conditions. This bill passed the Senate and is currently in the Assembly Appropriations Committee.

SB 1780 (Chesbro) establishes a Medicare Payment Area Task Force which would be required to develop recommendations on Medicare payment areas. Passed the Senate and is currently awaiting action in the Assembly Appropriations Committee.

SB 1821 (Sher) applies to dental services and would deem children who are eligible for certain social services programs to be eligible for the purposes of the Medi-Cal and Healthy Families programs. Passed the Senate and is currently in Assembly Appropriations.

SB 1903 (Speier) prohibits health care providers from sharing or selling medical information of patients without providing a written notice of their request to the patient. Passed the Senate and is currently in the Assembly Appropriations Committee.

SB 1993 (Johnston) permits more than one health plan in a geographic area to be a community provider plan under the Healthy Families Program. Further requires in those geographic areas in which

no health plan meets the threshold standard, that the Managed Risk Medical Insurance Board designate a health plan as the community provider plan. Passed the Senate Insurance Committee. Currently on the Senate Inactive File.

SB 2020 (Speier) requires both public and private schools to assist parents of public school pupils if they wish information on the Medi-Cal and Healthy Families programs. The bill has passed the Senate and awaits action in Assembly Appropriations.

SB 2069 (Perata) permits health care service plans that require utilization review to communicate such by fax. Assigned to the Senate Insurance Committee and has not had a hearing.

SB 2136 (Dunn) establishes a Quality Advisory Group in the Department of Managed Care to assist in providing a uniform quality audit process for the health delivery system of each health care plan. Passed the Senate and is currently in the Assembly Appropriations Committee.

Department to Change Name

The Department of Managed Care is changing its name to the Department of Managed Health Care (DMHC). A legislative vehicle is needed to change the name, which is set by statute. In a discussion with Executive Director Jackie Miller, Joy Higa, Assistant Director for Plan and Provider Relations, reiterated that to the extent plans have already made changes in documents relative to the new department (DOC to DMC), materials won't have to be reprinted until supplies are exhausted. However, she also indicated that the Department requests that plans reference the new name in correspondence with enrollees and begin doing so immediately.

According to Ms. Higa, the name change is taking place because it clarifies the Department's mission, especially for consumers.

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Dots and Dashes

D.E. FitzGerald, DDS, Chair, Quality Assurance Committee

The Annual Quality Assurance Conference in Indian Wells was an unqualified success. Once again the dedication, commitment and enthusiasm of the attendees was infectious. National interest in the Auditor Credentialing course is evident in the increasing number of participants from other states. We are very close to "taking it on the road." Subsequent to the May conference, we presented an interim course in the Bay Area, where 19 interested parties successfully passed the case studies and didactic test. A current list of certified auditors will soon be available at the CADP website.

I can only report mixed reviews on the progress of audit sharing. First Choice, the primary clearinghouse vendor, had an exhibit booth at the Annual Conference and their representatives indicated there was serious interest in the project. However, in the following weeks First Choice has failed to provide a schedule of offices which might be of interest to the plans to share audit data. I remain hopeful that we might have at least 30 offices audited this year where data and/or reports will be shared by multiple plans.

We are on schedule to meet with principal staff and possibly Mr. Zingale himself in September to discuss items of concern to dental, which are under Department of Managed (Health) Care authority. All indications are that the Department will remain open to hearing our positions. There are several items of immediate concern, not the least of which is interpretation and implementation of the requirements surrounding the grievance process since enactment of emergency regulations. This particular issue once again provides a rallying point for our association to represent the member plans.

Scheduling conflicts have resulted in an off-cycle meeting of the Dental Directors. Instead of the usual September meeting, we will be meeting at MDC/The Guardian in Woodland Hills on July 18. The agenda appears to be building an interesting texture.



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In the News

▶ **Productive Meeting with DMHC**— Executive Director Jackie Miller had an introductory meeting in early June with newly-appointed DMHC executives Joy Higa, Assistant Director of Plan and Provider Relations, and Herb Schultz, Deputy Director of External Affairs. During the discussion, Ms. Higa noted that her initial efforts will focus on improving communications between the Department and plans as well as operational changes in medical surveys, while Mr. Schultz indicated that he would be responsible for legislation as well as serving as the Department liaison to the advisory committees, members of which will be named in the near future. (It should be noted that of the 22-member Advisory Committee on Managed Care, only one is a dental plan appointment, appointed by the Governor. Vision and mental health plans also have an appointment. There are ten public members.)

Issues of interest to the Association were discussed in general terms, including (1) legislation/regulation focused on medical applied inappropriately to specialized plans; (2) assessment fees; (3) lack of consistency by the Department of Corporations; and (4) regular, ongoing input by specialized plans.

▶ **Once Again, Report Shows Few Dental Plan Complaints**— The May 2000 DOC report of enrollee complaints for 1999 shows once again that dental plans had few complaints. The "Summary of Enrollee Requests for Assistance" reports that of more than 17 million enrollees, a total of 321 RFAs were received, or 0.1871 per 10,000 enrollees. The Department categorizes complaints into four categories: (1) accessibility; (2) benefits/coverage; (3) claims; and (4) quality of care. The number of complaints involving dental plans has remained consistently low since the Department began issuing the reports in 1996.

Copies of reports are available on the Department's website: www.corp.ca.gov (note that this website is linked to the Department of Managed Health Care's site: www.dmhc.ca.gov).

▶ **PacifiCare Dental Expands PPO**— Anaheim-based PacifiCare Dental has ex-

panded its PPO statewide; the PPO had previously been limited to Southern California. The expanded network now includes more than 6,000 dentists throughout the state.

▶ **SafeGuard Reports Fourth Quarter Loss**— SafeGuard Health Plans, based in Aliso Viejo, reported a net loss of \$2.46 million for the fourth quarter 1999. Revenues for the quarter were \$24.46 million, up from \$23.86 million during the same period in 1998. In March, John Cox, who had been president, left the company; Dr. Steven Baileys resigned his CEO position but retained his position as chairman of the board; and James Buncher was named president and CEO.

▶ **CMA Files Class Action Lawsuit**— The California Medical Association (CMA) has filed a federal lawsuit against the three largest for-profit national health plans in California for imposing unfair contract terms, unnecessarily denying and delaying payments for procedures patients need, and reimbursing physicians at rates that are insufficient to cover costs. The suit against WellPoint/Blue Cross of California, HealthNet and PacifiCare was filed in U.S. District Court in San Francisco under the civil RICO (Racketeer Influenced and Corruption Act) laws. The suit, *California Medical Association v. Blue Cross of California et. al.*, claims that racketeering activity by those three plans has damaged the businesses of and victimized the patients of California physicians. CMA alleges that the health plans used coercive, unfair and fraudulent means to dominate and control physician-patient relationships for their own financial gain to the detriment of both patients and physicians. CMA seeks injunctive relief.

▶ **Surgeon General's Report on Oral Health Released**— The first-ever Surgeon General's Report on Oral Health in America has found that despite the advances in oral health made over the last half century, there is still much work to be done, highlighting the oral health problems of disadvantaged populations and the effects on their well-being that result from lack of access to care. The report concludes with a framework to enable further progress, emphasizing the

importance of building partnerships to enhance education, service, and research and eliminate barriers to care. Copies of the report are available at www.surgeongeneral.gov.

▶ **Dr. Steve Bull Appointed to Advisory Committee on Managed Health Care**— Dr. Steve Bull, Senior Vice President, Delta Dental Plan of California, and member of CADP's Board of Directors, has been appointed by Governor Davis as the dental plan representative to the Advisory Committee on Managed Health Care. The 22-member committee, the categories of which are determined by statute, was established as part of the HMO reform legislation creating the new Department of Managed Health Care. In addition to the Director, the Governor has 15 appointments, while the Speaker of the Assembly and Senate Rules Committee each have three appointments.

Other appointees named by the Governor include John F. Alksne, vice chancellor of health services, University of California San Diego; Thomas Davies, regional health care manager, GTE Service Corporation; Morton Field, director, High Complexity Physicians Office Laboratory; Alfred Forrest, associate medical director, Martin Luther King/Charles R. Drew Medical Center, Los Angeles County Department of Health Services; Jay Gellert, president and CEO, Foundation Health Systems, Inc.; Jose Gonzalez, president and CEO, Latino Health Care; Rosetta Hassan, assistant professor, Department of Obstetrics/Gynecology, Martin Luther King/Charles R. Drew Medical Center; Irene Ibarra, CEO, Alameda Alliance for Health; Elizabeth Imholz, director, West Coast Regional Office, Consumers Union; Stuart Needleman, president and CEO, Vision Plan of America; Pratibha Patel, medical director, Harriman Jones Medical Group; Naomi Strom, director of development, University of California, San Francisco/Fresno Medical Education Program; Arthur Torres, chairman, California Democratic Party; and Susan Urbanski, president and executive director, CIGNA Behavioral Health of California, Inc.

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must be followed. One clear message is that, regardless of the type of procedure, the dental plan must have a reason for the termination and this reason must be given to the provider. Of course, if the reason is based upon quality of dental practice issues, this may give a powerful incentive to the dental plan not to require that the process be instituted. As you know, once a formal statement is made, there is a likelihood that a report to the Dental Board under Section 805 of the Business and Professions Code will be required. This, in turn, will usually require a formal hearing under Section 809 of that code.

As indicated above, a "fair procedure" does not necessarily mean a formal hearing similar to a credentialing hearing. The reason for the proposed termination will dictate what type of procedure is required. To take an extreme example, assume that a dentist's license to practice dentistry has been revoked. Here, a simple written notification of termination would suffice, subject only to giving the dentist the opportunity to advise you if you are incorrect about the license revocation. At the other end of the scale would be a termination for a "dental practice" issue. Here, even if Business and Professions Code Section 809 does not apply for some reason, you may need to conduct a formal hearing before a peer review committee.

What is required is to provide the dentist with a reasonable opportunity to address and, if appropriate, attack the validity and accuracy of the reasons given for the termination. If the reason for the termination is based upon demonstrable facts, all that is required is an opportunity to contest those facts, which can often be accomplished through written communications.

This, of course, results in your favorite type of advice from attorneys – i.e., the answer to the question "What type of procedure is required?" is "It depends." This is all the more reason for you to keep your attorneys' phone numbers on your speed dial.

Economic Terminations. There may be "substantively rational" reasons for terminating provider contracts for economic reasons. Of course, the bad news is that dental plans will need to state the economic reasons and allow the dentist an opportunity to tell the plan if he or she thinks the plan's facts are incorrect and to attack the "rationality" of the decision. As indicated above, it is at least defensible that providing such notice and opportunity through written communications is a "fair procedure" for this type of termination. Unfortunately, the exchange of information could potentially provide an opportunity for the dentist to make arguments regarding the legality of the economic termination.


No Ruling On Non-Renewals And Refusals To Contract. The *Potvin* decision does not comment on these issues. The reasoning used by the Court could probably be used to require a "fair procedure" in either of these situations. In fact, our guess is that it is likely that a fair procedure would be required for an affirmative notice of non-renewal. Furthermore, dental plans must comply with Health and Safety Code Section 1373.65 regarding informing a provider of the reasons for termination of a

contract when the termination occurs during the contract year. On the other hand, if a contract simply expires and there is no provision for renewal and the relationship continues only if an entirely new contract is entered into, the result may be different. Of course, this is highly impractical, and if automatic renewals are common and are the expectation of the parties, it may well be treated the same as the "notice of non-renewal" situation.

In summary, the "good news" for dental plans is that (1) plans get to make the initial decision of whether a fair procedure is required and, if so, what type of procedure should be followed; (2) even if a "fair procedure" is required prior to termination, that procedure is potentially more damaging, expensive and disruptive for the dentist than it will be for the dental plan; and (3) if a fair procedure is conducted, the dental plan is still entitled to decide whether termination is permitted and that decision can only be attacked on the basis that the procedure was not fair or that the termination decision is not "substantively rational." In most situations, this will be a difficult standard for the dentist to meet.

If you would like a copy of either the *Potvin* or the *Castellanos* decision, please feel free to contact Mary Antoine, Nossaman, Guthner, Knox & Elliott, phone: (916) 442-8888, e-mail: mantoine@nossaman.com

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DMHC Officials on Board

The Department of Managed Health Care's leadership team is now in place. In addition to Daniel Zingale, Director, whom many of you met at CADP's Annual Conference in May, the following are new appointments:

Herb K. Schultz, Deputy Director for External Affairs— Mr. Schultz will lead the Department's legislative affairs effort and serve as liaison to the Advisory Committee on Managed Care. He has extensive experience in health care and insurance policy at the federal, state and local levels. From 1994-1998, he served as vice president of state affairs for the American Association of Health Plans in Washington, DC, where he directed state legislative, regulatory policy, and political activities. He has also held positions at Principal Health Care, Inc., and FHP, Inc. He comes to the Department from the AIDS Project Los Angeles, where he served as director of government affairs.

Steven Fisher, Deputy Director for Communications and Planning— Mr. Fisher will lead the Department's communications work and strategic planning. Prior to joining the Department, Mr. Fisher headed the advocacy group AIDS Action in Washington, DC. He also served as deputy chief of staff to U.S. Senator Robert Torricelli (D-NJ), and was also his top aide for seven years when Senator Torricelli served in the House of Representatives.

Joy Higa, Assistant Director for Plan and Provider Relations— Ms. Higa has been appointed to the first-ever office of plan and provider relations, where her efforts will be focused on opening the lines of communications between the Department and health plans and providers. The Department's preventive regulation efforts will be another of her responsibilities. She came to the Department from UCLA, where she was director of Health Sciences Government Relations. From 1996-1998, Ms. Higa was manager of governmental relations for PacifiCare Health Systems. She also worked in other health care venues from 1993-1996. Ms. Higa will be the plans' primary contact in the Department.



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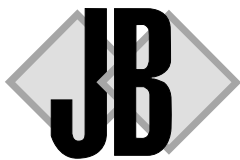
For more information, please contact:
Dale S. Miller, Esq., Henry A. Holguin, Esq.
or Michael A. Dowell, Esq.

CADP Protests Last-Minute DOC Regulations

CADP Executive Director Jackie Miller has sent a strongly-worded letter to the Department of Managed Health Care regarding the Department of Corporations' recent emergency regulations relative to the enrollee grievance process.

In her letter, Ms. Miller noted that the regulations were promulgated on an emergency basis without any apparent compelling need and that dental plans will be forced to comply within a very limited period. She also protested the fact that no public hearing had been scheduled, and formally requested that the Department schedule a public comment period and hearing. She also requested that the Department reconsider the implementation of the regulations until the industry has had an adequate opportunity to comment.

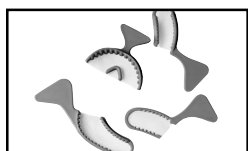
The Department took over the DOC's authority to regulate managed care plans on July 1.



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