

***LEGISLATIVE  
IMPLEMENTATION  
GUIDELINES***

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# LEGISLATIVE IMPLEMENTATION GUIDELINES

## I. Introduction

1999 produced the most significant California managed care legislation since the passage of the Knox-Keene Health Care Service Plan Act in 1975. The fecundity of the Legislature was checked only by the late-hour intervention of Governor Davis, whose staff presided over weeks of negotiations in search of (undefined) middle grounds on scores of bills already far along in the legislative process.

Since it takes the Governors signature to get a bill on the books, the power of the pen proved the dominant force. As Senator Don Perata explained his openness to gubernatorial influence on his SB 59, I am going to the light! Neither he nor his bill at that point were having a near-death experience, but the imminence of enactment of his bill produced a very powerful and wondrous force on his willingness to amend it and so it came to be passed, and signed.

Whether a natural jump in the evolution of health care delivery or caused by computers, callous health systems, corporate greed, avaricious trial lawyers, providers ill-equipped to be business persons, poor regulation or Helen Hunt 1999 was a very big year. It could have been worse for purveyors or more tilted to users. What the resulting bump in premiums will be remains to be seen. Publicly traded HMO stocks fell sharply upon media reports of the plans of prominent class-action lawyers, inspired by the California outcome, particularly SB 21 (see below).

Managed dentistry did reasonably well in this very big year. It was exempted from two of the major measures, and insulated in several others.

These Legislative Implementation Guidelines address the more significant managed care measures enacted into law in 1999 that affect managed dentistry. A comparison of these guidelines with the previous CADP Legislative Report published in the BUZZ will illustrate the extent of the winnowing process and the relatively reasonable outcome for managed dentistry.

## II. ENACTED Legislation

### A. Health Plan Liability: SB 21 (Figueroa)

For the last several legislative sessions, HMO adversaries, reformers, the Trial Lawyers Association, and several key legislators have attempted to pass legislation that would permit HMO enrollees to sue their plans. This year such legislation passed and was signed by the Governor. Negotiations were intense and prolonged, with the Governor's Office finally taking the reins and virtually prescribing a "compromise" text.

SB 21 establishes for plans a "duty of ordinary care to arrange for the provision of medically necessary health care services to its subscribers and enrollees" where the particular service is a covered benefit. It declares that a plan will be "liable for any and all harm legally caused by its failure to exercise that ordinary care" when two conditions are present: (1) "the failure to exercise ordinary care resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee"; and (2) "the subscriber or enrollee suffered substantial harm." "Substantial harm" is defined as " loss of life, loss or significant

impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss". The measure in one of its more controversial provisions appears to prevent a plan from seeking indemnification from a provider for the liability imposed under the bill.

There are no caps on damages and no "MICRA" limitations available.

There are a number of ambiguities and linguistically awkward provisions in the measure that will require "clean-up" legislation next year. Some of these include the definition of a "managed care entity", what "medically necessary" encompasses, the timing of the provision of the controverted service and by whom, the "boot-strapping" potential of equating "substantial harm" with "significant financial loss", the above-referenced no-indemnification provision and others. It also is not clear whether this measure will survive a challenge of federal preemption under the ERISA statute.

Dental plans should note that SB 21 requires as a pre-condition to filing a liability lawsuit that the person must have exhausted the procedures of any independent review system required by law for the entity being sued. Since dental plans were carved out from the mandatory independent review legislation passed (AB 55 (Migden)), they may be sued directly. It is not clear that a court would even require that the person have exhausted the internal grievance procedure of the plan and the appeal to the Department of Corporations as established under existing law.

Effective Date: January 1, 2001

Implementation: As quoted above, the two triggers permitting litigation are failure to exercise ordinary care that resulted in the denial, delay, or modification of a recommended or furnished service, and the consequent suffering of "substantial harm." "Substantial harm" is defined by very serious outcomes.

Nevertheless, plans should review their policies with respect to modification or denials of provider recommendations or referrals over which the plans have approval power. Dental plans would be wise to thoroughly review procedures by which covered services are denied, delayed or modified. SB 59 (Perata), outlined herein, establishes a number of new requirements for utilization review practices of plans and these will be looked to for thresholds for elements of "ordinary care."

Dental plans should also review their complaint and grievance procedures and how enrollees are treated therein. Alacrity, responsiveness, and a caring tone in communications are commonsensical attributes of a grievance procedure that will function to prevent litigation. As a minimum threshold, the statutory time frames and requirements of the Knox-Keene Act need to be carefully honored.

Again, since dental plans were exempted from the independent external review process legislated this year, they are therefore "bare" to lawsuits under SB 21. Minimizing that potential will be a function of how well plans manage the "denial, delay, or modification" of covered recommended

or furnished services. "Ordinary care" is not statutorily defined, and in the case of litigation would likely be left to the determination of the jury, which cannot be expected to be pro-HMO. Thus, to avoid litigation over "ordinary care," dental plans should exercise "extraordinary care" to assure that their procedures do not fail them and result in lawsuits. Enhancing arbitration availability and procedures will likely also help avoid large adverse judgments.

### **B. Independent External Review (AB 55 (Migden))**

The notion that HMOs should be required to utilize an independent external review process as an available sequel to their internal grievance procedures, as supplemented by the statutory DOC review thereof, has been in the legislative pipeline for several years. The trial lawyers have opposed it unless it were linked to the ability of enrollees to sue their plans, while the full service plans came to embrace the idea as a way of insulating themselves from liability. The procedures that have emerged for an acceptable external review process became extremely detailed and oriented towards medical care, as opposed to the managed provision of specialized care by specialized plans (dental, mental, eye, chiropractic, acupuncture).

#### **1. SB 292 (Figueroa)**

During the 1999 session, it became fairly apparent that an external review bill would finally be passed and enacted. The California Dental Association made a stuttering attempt totally rewriting their bill (SB 292) three different times to legislate an external review process that applied exclusively to dental plans. CADP attempted to work with the CDA to craft a streamlined process that made functional sense in the context of managed dentistry, a process that went nowhere at virtually every turn. The CDA was unable to present data that supported even the need for an external review process.

CADP then convened a coalition of representatives of other types of specialized plans, including vision, chiropractic and acupuncture, and the NADP, to simply seek an exemption from the external review legislation then moving rapidly through the Legislature. AB 55 and SB 189 were the two key measures. SB 292 was put on hold by its author. The coalition worked hard, intensely and very well together, and the end result was indeed an exemption of specialty plans from the independent external review process (with certain exceptions, as noted below).

The success was not definitively achieved until some forty-eight hours before the Legislature adjourned. The CDA had striven mightily to include the specialized plans in the external review legislation, conducting a campaign that included seriously misleading full-page newspaper advertisements and communications to legislators that were simply not true. SB 292 remains alive and the CDA has been making sounds to the effect that it may seek to move it along next year.

#### **2. AB 55 (Migden)**

Below are sketched the primary provisions of AB 55, which take effect January 1, 2001, when there is established in the new Department of Managed Care the "Independent Medical Review System."

Specialized health care plans are exempted from these provisions "except to the extent that the service (1) involves the practice of medicine, or (2) is provided pursuant to a contract with the health care service plan." This language emerged from closed door final negotiations from which plans were excluded, on the day before the bill was brought to the floor for final vote. It was not until that moment that the specialized plan coalition knew that indeed our

struggle to achieve an exemption from AB 55 had borne fruit. The quoted language was of course viewed as somewhat problematic and infelicitous.

The first exception to the exemption is not so difficult to understand. If a specialized plan, for example, were covering the services of an ophthalmologist or a psychiatrist, these would be considered "the practice of medicine." The second exemption exception will apply to specialized plans contracting with other health care service plans. It apparently was the intention of the authors that this refer to contracting with full service health care service plans, the reasoning being that the enrollee being served by a contractual relationship between a specialized plan and a full service plan would already enjoy the benefit of the independent external review process by virtue of membership in the full service plan, and the Legislature did not want to "confuse" the enrollee by denying the enrollee access to independent external review with respect to the specialized benefits.

However, the language is vague enough to arguably extend to contracts between specialized plans. Thus, for example, a dental plan contracting with another dental plan would have to make available an independent external review process, even though the first dental plan did not itself have to offer an independent review process to its own enrollees. This anomaly was not intended by the Legislature, and clean-up language will be pursued next year, sponsored by both CADP and the California Association of Health Plans (the full service plan association) to make clear that this second exemption exception applies only to a contractual relationship between a full-service plan and a specialized plan, rather than to a specialized-plan-to-specialized-plan relationship. Since the effective date of AB 55 is not until January 1, 2001, it is hoped that this ambiguity can be clarified in sufficient time to spare plans with such contracts the burden of preparing to offer independent external review to their members.

Specialized plans contracting with full-service plans should not expect that those relationships will be exempted from the independent external review process, given the reasoning and intent of the Legislature described above. In certain particular instances, it may be feasible for such plans to contract directly with the subscribers of the full service plan, thereby avoiding the need for independent external review. This obviously will need to be done on a case-by-case basis.

The actual text of AB 55 should be analyzed carefully by affected plans and their counsel, since it is quite detailed. Thus, the key elements of AB 55, which will be applicable to specialized plans contracting with full service plans in January 2001 and potentially to specialized plans contracting with specialized plans (see above) will include the following steps in a detailed and complicated process. Plans affected by AB 55 must themselves closely scrutinize each of these steps as they begin to design their required procedures.

- Applies to a covered service "that has been denied, modified, or delayed by decision of the plan, or by one of its contracting providers, in whole or in part due to finding that the service is not medically necessary."
- Does not apply to coverage disputes (not always a clear distinction).

- Employee must have the provider recommending treatment, have received urgent or emergency care from a provider, or be requesting treatment for a condition for which enrollee has been seen by a plan provider, even if the provider is not recommending the treatment.
- The enrollee must file a grievance with the plan and participate until resolution or 30 days (three days if expedited review warranted, and DOC can waive this requirement in certain cases).
- Department determines if enrollee is eligible for independent review, and must create a process to screen grievances to determine eligibility.
- Following internal process, enrollee applies to the Department for independent review.
- Department reviews and notifies enrollee of decision.
- If independent review granted, Department notifies plan and the review organization.
- Within three days plan forwards specified materials to review organization.
- Plan must update information as it emerges and transmit to enrollee and provider.
- Plan must provide enrollee with the documents submitted.
- Enrollee may obtain copies of same.
- Independent External Review Organization (under contract to the Department) conducts its review.
- Reviewer determines medical necessity using specified criteria, review to be completed within thirty days (unless urgent condition, then three days).
- Reviews then provided to Department, plan, enrollee and provider.
- Reviewer's decision binding on plan and issued as a decision by Department.
- When plan receives Department's decision plan contacts enrollee to implement decision.
- Decisions made public after individual information scrubbed.
- Violation of process can result in fines and penalties as specified.
- Plan pays for reviews, at fees set by Department.

Effective Date: January 1, 2001

Implementation: By January 1, 2001 information regarding independent review must be in affected plans' evidences of coverage, plan grievance procedures, letters of denial, written

communications regarding grievances and so forth. One-page application forms, with the specified information, must be prior-approved by the Department.

The plans affected by AB 55 should schedule compliance in a timely fashion, to include amendment of policies and procedures on grievances to incorporate the independent review process, as prescribed in the bill. Plan personnel involved in the process should be thoroughly trained and knowledgeable.

Affected plans should begin to prepare their filings with the Department of Corporations to be approved in a timely fashion to be able to go operational January 1, 2001.

Plans holding specialized-plan-to-specialized-plan contracts should probably be preparing for the worst case scenario that AB 55 will not be amended to clarify that the intent was not to include such contracts, necessitating their timely filing with the Department of Corporations and January 1, 2001 compliance. An amendment to clarify this may not be passed by the Legislature until late summer, although efforts will be made to get it through the Legislature and signed by the Governor prior to that time. It would not need to be "emergency" legislation, which would require a two-thirds vote of both houses, but rules will have to be waived to accelerate the timeline or the amendment will have to be inserted into a bill well along in the legislative process and likely to be signed by the Governor. CADP will be addressing this matter as early as legislative attention can be secured.

Whether plans are affected by AB 55 or not, they must attend to the new requirements of SB 189 (Schiff), outlined below.

### **C. Grievance Procedures (SB 189 (Schiff))**

The companion piece to AB 55 (Migden) is SB 189 by Senator Schiff, which incorporates various changes to the current grievance procedure requirements and coordinates those with the external review process. The provisions of SB 189, however, stand on their own and are applicable to specialized plans, whether a given specialized plan is subject to AB 55 or not. The measure establishes certain requirements and standards effective January 1, 2000, modifying them on January 1, 2001 to coordinate with the then-effective independent external review process requirements.

The key elements of SB 189 are as follows:

- Plan's responses to grievances must contain clear and concise explanations of the reasons behind a decision, including when the issue is clinical, the criteria used and the clinical reasons given. If a dispute involves a contractual provision, it must be explicitly cited.
- Reduces from sixty to thirty days the time in which an enrollee must participate in a plan's grievance process before submitting the grievance to the Department of Corporations for review.
- Adds "severe pain" to criteria for an expedited review by the Department, which could possibly be triggered by a grievance against a dental plan.

- Reduces to thirty days from sixty days the time for the Department to review a grievance and send a written notice of final disposition to the enrollee.
- Reduces to thirty days from sixty days the time the Department must track and then pursue pending and unresolved grievances.
- Eliminates requirement that plans provide enrollees with status report on grievances within thirty days now it will be thirty days and out.
- Reduces to three from the current five days the time to provide the enrollee and the Department with a written statement on the disposition or status of an expedited grievance.
- Eliminates the \$250,000 ceiling on fines for certain violations.
- The measure includes various sections that take effect January 1, 2001 to incorporate references to the independent review process and imposes certain requirements on the Department and grants it certain sanctioning powers. (See Sections Sections 1, 3, 4, 6, and 8 of the measure.).

Effective Date: As noted above, SB 189 has two different effective dates. The provisions outlined above are effective as of January 1, 2000. Dental plans that believe they will be subject to the requirements of AB 55 should consult Sections 1, 2, 5, 7, 9, 10 and 11 for the independent external review process provisions that will become effective on January 1, 2001.

Implementation: Plans should immediately review their grievance systems to ensure that they will be compliant with the identified provisions of SB 189 by January 1, 2000. Internal operations manuals should be modified accordingly, as should materials disseminated to enrollees regarding their grievance procedures.

The precise details of SB 189 should be consulted as the only reliable guidelines for implementation.

**D. Utilization Review: (SB 59 (Perata))**

SB 59 addresses the practices of internal "utilization review" or "utilization management" by health plans ("UR"). Like several other pieces of the major legislation of 1999, it represents the end-point of several years of attempts at legislation and extensive negotiations. And, like the rest of the managed care legislation of 1999, SB 59 reflects significant involvement of the Governor's Office.

SB 59 addresses the prospective, retrospective or concurrent review and approval, modification, delay or denial, based on medical necessity, of requests by providers for the provision of specified health care services to enrollees. It sets forth procedures and timeframes for plans to review a treatment request and it provides for timely provision of information and decisions regarding an enrollee's treatment needs and that enrollees will receive information regarding the processes that are used by the plan when determining whether to deny, modify or approve services. To the extent that a given dental plan does not engage in such activities, the applicability of SB 59 will be accordingly limited.

Every dental plan that engages in utilization review shall have a "clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan." This should be a dentist. Moreover, only certain licensed health care professionals may deny or modify requests for authorization of services for an enrollee for reasons of medical necessity. "Medical necessity" is not differentiated between medical necessity and dental or other types of specialized necessities.

The measure establishes several new requirements regarding clinical criteria or guidelines used in a plan's utilization review and how those are to be disclosed. These include:

- Disclosing UR processes to contracting provider groups and any entities that perform UR for the plan.
- Applies plan criteria and guidelines to those used by contracting providers that do UR.
- Criteria and guidelines must be consistent with sound clinical principles and processes.
- When criteria or guidelines are used for denial or modification of a treatment request, they must be disclosed to the provider and the enrollee automatically without need for a specific request.
- Criteria or guidelines for specific procedures or conditions must be made available to the public upon request and a fee may be charged for copying and postage expenses. Electronic means may also be utilized.
- A specific disclaimer is required when such information is disclosed to the public.

SB 59 also establishes a variety of UR process standards.

- They apply both to plans and to contracted entities performing UR functions for the plan.
- There must be written policies and procedures regarding UR processes and procedures, with specified elements thereof.
- The "clinical director" is required to ensure that the UR procedures comply with the requirements of SB 59.
- Approvals for treatment may be made by unlicensed personnel as noted above but only California licensed health care professionals competent to evaluate the clinical issues of a given request may deny or modify such a request on the basis of medical necessity.
- The plan is restricted to requesting from providers, to determine medical necessity, only information which is reasonably necessary to make the determination.

- If a decision will affect routine care it must be made no later than five business days from the plan's receipt of the information needed to make the decision. If the decision affects care where the enrollee faces an "imminent and serious threat" to his/her health, or when the five-day standard would be detrimental thereto, the decision must be made within 72 hours or less of the receipt of the information necessary. Emergency services of course must be rendered to enrollees without any prior authorization up to the point of stabilization.
- Provision is made for extension of the above time frames when the plan is unable to receive all the information requested or for other reasons stated. There are notice requirements involved in such an extension.
- Communication of plan decisions must be made within specified time frames applicable respectively to prospective, retrospective or concurrent review.
- All communications regarding UR decisions must be specific, clear and concise, giving reasons for the decision, a description of any criteria or guidelines used relating to medical necessity and so forth. If there is a denial, delay or modification, the name and phone number of the health care professional responsible must be included, as well as information about the filing of grievances. If a plan uses UR, it must provide telephone access to permit providers to secure authorization. Compliance with these requirements must be part of the plan's quality assurance program and will be an element of the Department's periodic on-site medical survey of the plan.
- The Department has the power to assess administrative penalties for non-compliance with the requirements of SB 59.

Effective Date: January 1, 2000

Implementation: Plans that do utilization review, as defined, should review their policies and procedures to ensure that they are in compliance with SB 59. The "medical necessity" language should not be considered an "out" for dental plans, since they are clearly intended to be covered by SB 59. The definition of "medical necessity" is obviously one that should be of "dental necessity", which must be developed and consistent with sound clinical principles and processes. This is a requirement of existing law. The very specific time frames suggest that plans should develop reliable internal tracking systems for affected requests. Plans should develop information packets regarding the policies and procedures used in their utilization review, for dissemination to providers and to enrollees and the public, as specified.

- Dental plans should make sure that their Dental Directors hold a California license and that any plan personnel involved in denying or modifying treatment requests are themselves "appropriately licensed" to be making such decisions. Although this is a gray area in the bill, plans should be conservative in their procedures for permitting various categories of personnel to make such negative UR decisions.
- Dental plans should review their standard letters regarding denials or approvals of requested procedures to ensure that they comply with SB 59, and that they are courteous and "caring".

- Plans engaging in UR should ensure that their providers have adequate telephone access to seek authorizations.
- Plans should ensure that their internal personnel are aware of these new requirements and be prepared to respond to requests, whether from requesting providers, enrollees or simply members of the public, for the decisions and or materials to which they have a right under SB 59.
- Plans should ensure that their providers are aware of the new requirements of AB 59, so their treatment requests are properly handled, whether through prior, concurrent or retrospective review.

**E. Second Opinions: (AB 12 (Davis))**

Second opinion legislation has also been before the Legislature for several years, finally making it in 1999. AB 12 gives enrollees access to a second opinion under specified but non-exclusive conditions. The open-endedness of this "conditions" section suggests that the enumerated conditions will be viewed merely as examples rather than as the exclusive portals to a second opinion. The Department of Corporations is likely to interpret this access quite liberally. Thus although the conditions include any of: the presence of surgical procedures; a condition threatening loss of life, limb or bodily function; unclear or complex and confusing clinical indications or conflicting test results or inability to diagnose conditions; a treatment plan in progress not improving the condition of the enrollee within an appropriate period of time; or the enrollee's "serious concerns" about the diagnosis" it is likely that a request for a second opinion, unless patently frivolous, ought to be provided.

A second opinion must be provided by "an appropriately qualified health care professional, acting within his or her scope of practice", and possessing "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 authorization or denial must be provided in an expeditious manner, and if there is indeed an imminent and serious threat to health, life or limb the second opinion must be rendered in a timely fashion appropriate to the condition but not to exceed 72 hours after the plan's receipt of the request, whenever possible. The second opinion is to be rendered by an in-plan provider, unless there is no appropriately qualified provider within the plan's network. Certain sub-distinctions are made with respect to provider organizations within the plan network.

If the second opinion is rendered the provider must give the enrollee and the initial health professional a consultation report, including any recommended procedures or tests. If a request for a second opinion is denied the plan must give the reasons for the denial in writing to the enrollee and notify the enrollee of the right to dispute the denial or file a grievance.

Plans should note that the timeframes of SB 59 will apply to the authorization or denial of a request for a second opinion.

Note: The enrollee requesting a second opinion is responsible only for the costs of applicable co-payments which the plan requires for similar referrals, the plan picking up any other expenses of the second opinion.

Effective Date: January 1, 2000; by July 1, 2000 plans must file with the Department of Corporations their timelines for responding to requests for second opinions.

Implementation: Plans should be prepared to respond to requests for second opinions through the screens of AB 12. Providers should be notified of this new opportunity open to enrollees.

Plans will need to modify their own internal policies and procedures regarding second opinions in light of AB 12. They may conclude that more generous policies will in the long run prove the most functional. The open-endedness of AB 12 suggests that an external adjudicator of a denial, whether the Department of Corporations or a judge or a jury, may construe the text, in all but the most clearly frivolous requests, to find the right to a second opinion. The statute sets out some standards of need for a second opinion, and while some of them are high, some of them ooze considerably lower. The threshold for the obligation to grant a second opinion is not clear. Plans may, in the end, find that the best policy is a liberal policy.

**F. Telephone Advice Services: AB 285 (Corbett)**

AB 285 imposes requirements on entities engaged in "the business of providing telephone medical advice services to a patient at a California address"

Such an entity, whether in-state or out-of-state, must be registered with the Department of Consumer Affairs. It does not apply to California professional licensees who provide telephone medical advice as part of their practice.

The bill is a timing nightmare. It restricts operation of such services after January 1, 2000 but requires the Department of Consumer Affairs to make application forms available by July 1, 2000, leaving an apparent *de facto* moratorium in place. If such a business entity is accredited by certain enumerated national accrediting groups, then they will be deemed provisionally registered until the end of the year 2000 or until a denial or grant of an application registration is made by the Department of Consumer Affairs. Clearly this is a bill that will require emergency clean-up legislation in 2000.

"Medical advice" is very broadly defined in the measure, as "any activity that would require licensure under this division", which includes dentistry. Any dental plans contracting with a separate entity providing such telephone medical advice should ensure that the staff employed are properly licensed in accordance with AB 285. If it is an in-state advice service, the staff must be appropriately California-licensed, certified or registered. If it is an out-of-state advice service, the employed professionals must be licensed, registered or certified in the state within which they are operating. Plans will be obligated to ensure that the advice provided by a contracting telephonic advice service is consistent with good professional practice, that it maintains records of the services provided to California patients and that it provides quarterly data relating to complaints filed against the service itself.

It would not appear that the requirements of AB 285 apply to telephone advice given by a plan itself. Clarification on this may emerge when the Department of Consumer Affairs issues regulations to implement the measure, although it is not required to do so. Dental plans would, however, be wise to ensure that their staff telephonically providing "medical advice" as defined, be appropriately licensed, certified or registered and in good standing with the appropriate

professional licensing board in the Department of Consumer Affairs, particularly their dentists and dental hygienists. The truly conservative path would be to limit telephonic communication of "medical advice" entirely. This may not be difficult, since most plans are cautious about providing over the telephone the sorts of advice that would require licensure.

Effective Date: January 1, 2000/July 1, 2000

Implementation: See above suggestions, although the best implementation may likely have to await clean-up legislation and regulations.

**G. New Department of Managed Care: (AB 78 (Gallegos))**

The notion of establishing a new department dedicated exclusively to regulating HMOs has been around the Legislature for the last several sessions. Last year such a bill made it to Governor Wilson's desk, only to be vetoed, although he had earlier in the year introduced a "Governor's Reorganization Proposal" to create a new department. This year several bills were introduced to achieve this objective. AB 78 by Assembly Member Dr. Martin Gallegos, Chair of the Assembly Health Committee, became the vehicle for the ultimate text.

The Davis administration released its health care reform package only in mid-August and the actual text of the reorganization bill was not released until the morning of the floor vote on the bill during the last week of the session. It was never heard in committee.

AB 78 establishes a new Department of Managed Care within the Business, Transportation and Housing Agency, where the Department of Corporations is currently housed. It will be headed by a Director appointed by the Governor. The new department will be very much the same as the old department and the three hundred and twenty-six page measure is largely an exercise in re-naming.

Some changes are, however, worth noting and reviewing.

- The Director of the new Department is mandated to work with the new Advisory Committee on Managed Care to study the feasibility and advisability of transferring to the new Department the regulation of health insurance from the Department of Insurance. The result of this study is due December 31, 2001.
- Section 1342 of the Knox-Keene Act is amended to elevate to a "purpose" of the Act that enrollees have their grievances reviewed by the new Department expeditiously and thoroughly.
- The composition of the Health Care Service Plan Advisory Committee is reconstituted and it is renamed the Advisory Committee on Managed Care and given a more pro-active charter.
- The Office of Patient Advocate is established, to help enrollees obtain covered services from their plans, to give assistance in using the new independent external review process and to educate enrollees. The Patient Advocate is to develop educational guides for consumers on health care rights and do public "outreach" and education on same; the Advocate is to issue an annual quality of care report card on HMOs, which will be placed on the new Department's Internet website; and the Advocate is to make recommendations to the new Department on

enforcement actions to protect patients. It is semi-independent of the Department and reports to the BT&H Agency.

- A new Clinical Advisory Panel is established, to help monitor the new independent external review process and do other clinical reviews related to reducing clinical errors and promoting patient safety.
- The new bill also includes disclosure provisions relating to other of the new legislation passed this year, including the new internal utilization review processes, second opinion rights, and the independent external review process.
- Authorizes the Director of the new Department to order the discontinuance of an unsafe or injurious practice if the Director has reasonable grounds to believe that irreparable loss and injury will occur to a given plan enrollee. Certain expedited procedural steps are included.
- Authorizes the new Director to levy an additional assessment, over and beyond the current assessment powers of the DOC, to provide sufficient revenue to support the incremental costs of the new Department in fiscal year 2000-2001. (This despite the Department of Corporations' current \$10 million fund balance, the unexpended balance of which will be transferred from the DOC to the new Department.)

Effective Dates: January 1, 2000, but not operative until the Governor by administrative action establishes the new Department or July 1, 2000, whichever occurs first.

Implementation: There are no explicit new requirements imposed on plans by AB 78, although as plans update their enrollee, provider, vendor and other documents they should systematically change references to the "Department of Corporations" to the "Department of Managed Care." The measure is silent on the timing of this but plans would be well advised to address this as soon as possible.

#### **H. "Silent PPO's": (SB 559 (Brulte))**

SB 559 relates to the selling, leasing, transferring or conveying the availability of providers in a network by a health care plan. However, the language is somewhat muddled and so it pertains to all plans that develop networks. The following are the key provisions of the bill:

- A plan must disclose to a provider whether its provider network will be sold, leased, transferred or conveyed to other entities as defined, with various other disclosure requirements included.
- A plan must disclose the practices of the payors to whom the network will be sold or leased that encourage the payors or subscribers to use the provider network.
- The plan must disclose to the provider whether any payors so acquiring the network are permitted to pay a discounted rate and must disclose within specified timeframes to the provider a summary of all the payors eligible to pay the provider the contracted rate under the contract.

· The plan must permit providers to decline to be included in any network that is so transacted if the payors do not actively encourage their subscribers to use the provider network, and not be penalized for so declining.

Effective Date: July 1, 2000

Implementation: Plans that have or develop provider networks and then sell, lease, transfer or convey the availability of these providers and the discounts granted pursuant to the provider contract should examine this statute very carefully. If a given dental plan is engaged in such transactions, on either side of the transaction, this statute pertains.

### **I. Miscellaneous**

A number of other managed care measures were enacted in 1999, but dental plans were either exempted from them or their subject matter did not pertain to dental plans.

Perhaps the most significant of these was SB 260 (Speier), dealing with the increasingly serious problem of the solvency of capitated medical groups. Several large ones have gone bankrupt or are in serious financial straits, a significant threat to the stability of the overall health care delivery system. Dental plans were exempted from this legislation, which establishes certain group financial solvency criteria and also establishes a new Financial Solvency Standards Board within the new Department of Managed Care to study certain specified issues in greater detail.

While specialized plans were exempted from this legislation, they nevertheless should consult its provisions for tailored emulation in their monitoring the fiscal and administrative stability and solvency of provider entities with which they contract, whether on a capitated basis or otherwise. The stability of provider groups in health plan networks is a top issue of concern with legislators and health policy makers. If provider group fiscal instability is perceived within specialized plan networks, it is certainly conceivable that specialized plans could come to be included in the statutory provisions enacted by SB 260. Therefore they should be consulted at least by way of guidance and reference for managing provider groupings in specialized plan networks.

### **III. CAUTION**

The measures outlined in these Implementation Guidelines must be carefully read and analyzed by plan management and plan counsel. There are a myriad of details and nuances in each and plans will be held accountable for knowing and implementing them. These are complicated measures, not only dealing with large issues, but quite explicit and detailed in their requirements reflecting the several years of legislative attempts and negotiations that preceded their ultimate passage. Moreover, after Governor Davis decided to intervene in the managed care reform legislative process in early July, with conceptual proposals released only in mid-August, and some text only revealed on the day of the floor votes various bills were consolidated into these consequently large bills.

The output of the 1999 legislative session obviously creates a new era of regulation of managed care. Smart plans will study, absorb and implement the new legislation conscientiously and deliberately. Plans who neglect these measures will surely be visited by the Enforcement Division of either the Department of Corporations or the new Department of Managed Care.