McGeorge Law Review

Volume 35 | Issue 3 Article 18

1-1-2004

# Health and Safety / Chapter 591: Ensuring "Continuity of Care" in a Group-Dominated Health Care Market

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# Chapter 591: Ensuring "Continuity of Care" In a Group-Dominated Health Care Market

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*Code Sections Affected*

Health and Safety Code §§ 1373.65, 1373.95, 1373.96 (amended);
Insurance Code § 10133.56 (amended).
AB 1286 (Frommer); 2003 STAT. Ch. 591.

## I. INTRODUCTION

Unable to reach an agreement on reimbursement rates in the Fall of 2000, the health insurance giant Blue Cross of California terminated its contract with the Sutter Health System.[1] At the time, Blue Cross provided health insurance to about 5.6 million people in the Golden State, and the Sutter Health System owned or was affiliated with twenty-seven hospitals and seven doctor's groups in Northern California. As a result of the contract termination, some 70,000 Northern Californians learned that they would need to find new doctors and health care providers. Otherwise, they would need to switch to health plans that contracted with their providers.[2] Yet, when some members attempted to switch to new plans—especially those who received health insurance through an employer—they discovered that they were locked into their current plans until the next open enrollment period. Blue Cross and Sutter Health eventually ironed out their differences, but only after Blue Cross had shifted 30,000 of its members to new provider groups.[3]

About one year after the Blue Cross-Sutter Health dispute, California's other leading HMO, Health Net of Southern California, announced its intention not to renew its contract with Catholic Healthcare West, a provider network made up of several Catholic hospitals and clinics.[4] After long and tense negotiations, the two parties hammered out an agreement to renew their contract.[5] During this time, the fate of some 100,000 Health Net subscribers who used the Catholic Healthcare

1. Victoria Colliver, *Sutter, Blue Cross OK Deal; Accord Puts End to Dispute on Rates*, S.F. CHRON., Feb. 21, 2001 at A1.

2. *Id.; see also* ASSEMBLY COMMITTEE ON APPROPRIATIONS, COMMITTEE ANALYSIS OF AB 1286, at 3-4 (May 21, 2003).

3. Colliver, *supra* note 1.

4. Lisa Rapaport, *Health Net of California to Terminate Deal with Catholic Hospital System*, SACRAMENTO BEE, Apr. 16, 2003.

5. *Id.*

West system hung in the balance.[6] As one subscriber affected by a contract termination told a newspaper reporter, "It's made me really think long and hard about whom I entrust with our care. I don't think I'll ever feel confident [again]."[7]

Reasons for this loss in confidence are easily identified. At a time when an increasing number of consumers obtain their health insurance from group health plans that contract with groups of providers and system-wide networks like Sutter Health and Catholic Healthcare West, the ramifications of contract termination can be far-reaching.[8] When a large health plan terminates a contract with a provider group, the consumer is denied access to all of the health care providers associated with that group.[9] If the contract terminates an entire network of providers, clinics, and hospitals, it could possibly deny access to a significant portion of the health care providers in a given community or region.[10]

Gone are the days when an individual policy-holder saw the doctor of his or her choice and the insurance company paid for any services, or some portion thereof, which its policy covered.[11] Today's health care market is composed of groups, organizations, and networks whose negotiations with each other can touch the lives of hundreds of thousands, and perhaps millions, of people.[12] One such consequence of the new market, as the cases mentioned above suggest, is that the sudden termination of a contract between an insurance company and a provider group or network can leave thousands suddenly scrambling to find either a new doctor or a new health plan.[13] In an effort to ensure reasonable continuity of health care in such circumstances, the California Legislature enacted Chapter 591. Under specified conditions, Chapter 591 allows a patient to continue with his or her doctor for a reasonable period whenever the relationship between patient, provider, or health plan is disrupted.[14]

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6. Lisa Rapaport, *California HMOs Sign Contract, Let Patients Keep Health Plans*, SACRAMENTO BEE, Apr. 22, 2003.

7. Colliver, *supra* note 1.

8. SENATE COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 1286, at 6-7, 9-11 (July 2, 2003).

9. Colliver, *supra* note 1; Rapaport, *supra* note 4; Rapaport, *supra* note 6.

10. Rapaport, *supra* note 4.

11. *See, e.g.*, DAVID DRANOVE, THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE: FROM MARCUS WELBY TO MANAGED CARE, 3-8 (2000) (discussing the increasing complexity in the contemporary health care market); *see, e.g.* ARNOLD BIRENBAUM, MANAGED CARE: MADE IN AMERICA, vii-x, (1997) (noting that reliance on managed health care plans has accelerated since President Clinton's failure to pass major health care reform).

12. *See* ASSEMBLY FLOOR, ANALYSIS OF AB 1286, at 3 (May 30, 2003); SENATE COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 1286, at 6-7, 9-11 (July 2, 2003); *see also* Eric Wagner, *Types of Managed Care Organizations*, in PETER KONGSTVEDT, ESSENTIALS OF MANAGED HEALTH, 17-30 (4th ed. 2001) (discussing the complex variety of managed care organizations and the development of large "networks" of provider groups, clinics, and hospitals).

13. SENATE COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 1286, at 6-7, 9-11 (July 2, 2003).

14. *Id.* at 1-11.

## II. LEGAL BACKGROUND

The Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act"), as amended in 2002, provides the legal framework for the regulation of California's individual and group health care plans, including Health Maintenance Organizations ("HMO") and other similarly structured managed care organizations ("MCO").[15] While HMOs and MCOs are regulated by the Department of Managed Health Care ("DMHC"), traditional health insurance companies are regulated by the Department of Insurance.[16] The express purpose of the Knox-Keene act is "to promote the delivery of health and medical care" for persons enrolled in health care service plans.[17] Included among its enumerated goals, the Knox-Keene Act seeks to ensure "that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing *continuity of care*."[18] Although the Knox-Keene Act does not expressly define "continuity of care," many of its provisions indicate that "continuity of care" refers to the continuity of health care coverage during a subscriber's transition from one health care plan or provider to another.[19]

Even before the enactment of Chapter 591, the Knox-Keene Act recognized two situations that created "continuity of care" problems and provided limited protections for health care consumers.[20] First were those instances in which an employer unilaterally changed the health care package offered to his or her employees.[21] If the newly proffered plan, or plans, did not cover an employee's doctor or provider group, the employee had little choice but to find a new doctor.[22] When this happened, the Knox-Keene Act required that the health plan cover new enrollees who were undergoing "a current episode of care for an *acute condition* from a non-participating provider."[23] In addition, plans that covered

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15. *See* CAL. HEALTH & SAFETY CODE §§ 1340-1399 (West 1997 & Supp. 2003) (codifying the Knox-Keene Act and its various amendments); *see also* Wagner, *supra* note 12, at 19-30.

16. SENATE COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 1286, at 1 (July 2, 2003).

17. CAL. HEALTH & SAFETY CODE § 1342 (West Supp. 2003). The Knox-Keene Act defines "health care service plan" as one that "undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to 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*." *Id.* § 1345(f)(1) (West 1997) (emphasis added). Although it has less relevance than when the Knox-Keene Act was enacted in 1975, the language of "prepaid" or "periodic" charges for "services" initially distinguished "health care service plans" from traditional "indemnity" plans. *See infra* note 72 (discussing the distinction between "health care service plans" and traditional "health insurers" and the declining relevance of this distinction in the contemporary health care market).

18. CAL. HEALTH & SAFETY CODE § 1342(g) (West 1997) (emphasis added).

19. *See, e.g., id.* §§ 1373.65, 1373.95, 1373.96 (West 1997 & Supp. 2003) (applying the phrase "continuity of care" in cases where a new enrollee may continue to receive services from a non-participating provider for specified periods for specified conditions).

20. *Id.* §§ 1373.95, 1373.96.

21. *Id.* § 1373.95.

22. *Id.*; *see also* Colliver, *supra* note 1; Rapaport, *supra* note 4.

23. CAL. HEALTH & SAFETY CODE § 1373.95(a)(1) (emphasis added).

mental health care services were required to permit new enrollees to continue seeing non-participating mental health care providers for a "reasonable transition period," so as "to effect a safe transfer on a case-by-case basis."[24] New enrollees who did not suffer from mental illness or an acute medical condition, on the other hand, had no choice but to switch to one of the plan's participating providers.[25]

The Knox-Keene Act also required health plans to submit to DMHC a written policy describing continuity of care policies, including any procedures for notifying new enrollees of their right to continue seeing a non-participating provider for an acute condition.[26] Overall, the Knox-Keene Act required health plans to give "reasonable consideration" to the potential clinical effect of an involuntary change of provider,[27] but the force of these requirements was limited by at least three factors. First, the law applied only where the new enrollee suffered from a "current episode" of an "acute" medical condition or a covered mental condition.[28] Second, the law placed the burden on the new enrollee to "request" continued coverage with a non-participating provider, rather than granting continued coverage as a matter of course.[29] Third, the law could not compel the former provider to continue services on the new plan's terms.[30] Thus, if the new enrollee's former doctor did not like the terms offered by the patient's new health plan, the doctor was not compelled to continue providing medical services.[31]

A second "continuity of care" problem arose when a health plan unilaterally terminated a provider or provider group.[32] A health plan may terminate providers for a variety of reasons, but the two most likely reasons are that the plan and the provider can no longer agree on contract terms or the plan is unhappy with the provider's performance.[33] When a patient lost the services of a health care provider due to the actions of the health plan, as opposed to the actions of an employer, the Knox-Keene Act offered more protection to the affected patient.[34] While a patient who lost his health insurance due to an employer's decision could only receive continued coverage for an acute condition, the patient who had his

24. *Id.* § 1373.95(a)(2).
25. *Id.*
26. *Id.* § 1373.95(a).
27. *Id.* § 1373.95(b).
28. *Id.* § 1373.95(a)(1)-(2).
29. *Id.* § 1373.95(b).
30. *Id.* § 1373.95(c).
31. *Id.*
32. *Id.* § 1373.96 (West 1997).
33. *See* Interview with Ann Vuletich, Health Plan Analyst, California Department of Managed Health Care (Sept. 2, 2003) [hereinafter Vuletich Interview] (notes on file with the *McGeorge Law Review*) (explaining that health plans are most likely to terminate relations with a provider group or provider network due to disagreements on contractual or payment terms, whereas termination of an individual provider will most likely be for reasons related to performance—such as a failure to meet quality of care requirements or a history of medical malpractice).
34. CAL. HEALTH & SAFETY CODE § 1373.96.

provider terminated by the health plan was entitled to continued coverage for acute conditions, serious chronic conditions, and certain pregnancies.[35] In cases of acute or serious chronic conditions, the law required the plan to provide coverage with a terminated provider for up to ninety days "or a longer period if necessary for a safe transfer to another provider."[36] The precise duration of the covered service was "determined by the plan in consultation with the terminated provider" and "consistent with good professional practice."[37] In the case of pregnancy, the Knox-Keene Act required plans to cover the services of a terminated provider for high-risk pregnancies and pregnancies that had reached the second or third trimester.[38] However, none of the requirements pertaining to terminated providers applied where the plan had terminated the provider for quality of care issues or "for reasons relating to a medical disciplinary cause or action."[39]

Perhaps the most difficult problem created by the "continuity of care" provisions in the Knox-Keene Act concerned the nature of the contractual relationship between the health plan and the terminated provider during the transition period.[40] The Knox-Keene Act stipulated that a plan was not obligated to provide coverage unless the terminated provider agreed to be subject "to the same contractual terms and conditions that were imposed upon the provider prior to termination."[41] Similarly, the plan had no duty to cover post-contractual services unless the terminated provider accepted the same payment rates as those offered to participating providers in the same geographic area as the terminated provider.[42] However, the terminated provider was free to accept or reject these terms.[43] Given that the relationship between the plan and the provider most often fractured over payment rates and other contractual terms, a patient who met the

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35. *Id.* § 1373.96(c)(1)-(3).

36. *Id.* § 1373.96(b).

37. *Id.* The statute does not say what would happen if the plan and the terminated provider did not agree on what constituted a reasonable period of time to ensure "safe transfer," but the language of the statute strongly suggests that the period is "determined by the plan," requiring only "consultation" with the terminated provider with the rather ill-defined condition that period of time be "consistent with good professional practice." *Id.*

38. *Id.* The plan was also required to cover services beyond the postpartum treatment, but only "if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice." *Id.* § 1373.96(a)(6).

39. *Id.* § 1373.96(i); *see also* CAL. BUS & PROF. CODE § 805(a) (identifying the grounds for a medical disciplinary action).

40. SENATE COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 1286, at 7-8 (July 2, 2003).

41. CAL. HEALTH & SAFETY CODE § 1373.96(c).

42. *Id.* § 1373.96(d).

43. *Id.* § 1373.96(c)-(d). Earlier versions of AB 1286 attempted to force doctors and hospitals to accept the terms. AB 1286 (2003) (as introduced on Feb. 21, 2003, but not enacted). However, this provision was dropped when the bill reached the Senate. AB 1286 (2003) (as amended July 15, 2003, but not enacted). In part this may be because California case law apparently holds that doctors cannot be compelled to provide services beyond what is minimally necessary "to secure the presence of other medical attendance." *See, e.g.*, 36 CAL. JUR. 3D, *Healing Arts and Institutions* § 282 (1997) (noting that there "is little direct authority in [California] concerning the extent of a physician's duty, if any, to continue a physician-patient relationship").

conditions for continuity of care might still find that his or her doctor refused the terms offered by the health plan.[44]

Although the Knox-Keene Act protected certain individuals temporarily suspended between health plans or providers, critics claimed that these protections were inadequate in the modern health care market.[45] Most importantly, existing law did not anticipate the large "block transfer of enrollees" that resulted when a large health plan terminated a contract with an entire "network" of provider groups.[46] Indeed, the continuity of care provisions of the Knox-Keene Act spoke in the singular language of a terminated or nonparticipating *provider*.[47] Only the Act's notice requirements spoke directly to contract termination with *provider groups*.[48] As amended in 1994 and 2000, the Knox-Keene Act required a health plan to notify affected enrollees at least thirty days prior to terminating a contract with an "entire medical group" or an "individual practice association."[49] Critics of the existing law argued that thirty days was not enough time to find a new doctor, especially if the health plan had terminated relations with a larger "provider network" that included a significant portion of the medical providers, hospitals, and clinics in a given community.[50] Responding to these concerns, in 2003 the California legislature enacted Chapter 591.

## III. CHAPTER 591

According to its sponsors and authors, Chapter 591 ensures greater continuity of care for persons whose relationships with their usual health care provider has been disrupted by a contract dispute between a health plan and a provider group.[51] It does so first by expanding notice requirements.[52] Whereas prior law required that a health plan notify enrollees at least thirty days prior to terminating a

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44. *See* Vuletich Interview, *supra* note 33 (pointing out that contract termination most often resulted from failure to reach agreement on rates and methods of payment).

45. SENATE COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 1286, at 1-2, 7-8 (July 2, 2003).

46. *Id.* at 6-7; *see also* SENATE APPROPRIATIONS COMMITTEE, COMMITTEE ANALYSIS OF AB 1286, at 1 (Aug. 18, 2003) (discussing the problem of "block transfers" created by contract terminations between health plans and provider groups or networks); SENATE RULES COMMITTEE, FLOOR ANALYSIS OF AB 1286, at 2-3 (Sept. 5, 2003) (same).

47. CAL. HEALTH & SAFETY CODE §§ 1373.95, 1373.96 (West 1997 & Supp. 2003). Although section 1373.96(a) states that an enrollee suffering from specified medical conditions is entitled to continued coverage with a terminated "provider," it does not follow that the provision applies *only* to instances where the plan terminated an individual provider and not an entire group. Whether the plan terminates a contract with an individual provider or a group of providers, the enrollee has lost access to a single "provider." If the requisite conditions are met, the enrollee is entitled to continued coverage. *Id* § 1373.96(a) (West 1997).

48. CAL. HEALTH & SAFETY CODE § 1373.65 (West 1997 & Supp. 2003).

49. *Id.* § 1373.65(a) (West 1997). In 2000, the thirty-day notice requirement was extended to include termination with an individual primary care provider. *Id.* § 1373.65(a)(1) (West Supp. 2003).

50. SENATE COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 1286, at 6-7 (July 2, 2003).

51. *Id.* at 6.

52. CAL. HEALTH & SAFETY CODE § 1373.65(a)-(b) (amended by Chapter 591).

contract with a health care provider or provider group, the new law expands the notice requirement to sixty days.[53] In addition, the health plan must notify DMHC at least seventy-five days before terminating a contract, or fifteen days before notifying the enrollees.[54] The health plan may not send letters to enrollees until the notice letters have been "reviewed and approved" by the DMHC.[55] Whenever a plan notifies an enrollee of a contract termination, the notice letter must include the following statement in at least eight-point type: "If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period."[56] All communications with enrollees must also include the toll-free number of DMHC's help-line so that consumers may be fully apprised of their rights to continuation of covered services.[57]

In addition to strengthening notice requirements, Chapter 591 imposes a series of filing requirements on health plans.[58] On or before March 31, 2004, all health plans doing business in California must submit to DMHC written policy statements describing how the plan intends to facilitate continuity of care.[59] These policy statements must include each of the following: a description of the plan's process for transferring large numbers of enrollees to new providers;[60] a template of the notice that the plan intends to send to enrollees in the event of provider termination;[61] a description of the plan's process for reviewing enrollee requests for continuation of covered services;[62] and a general statement of how the plan will ensure "that reasonable consideration is given to the potential clinical effect on an enrollee's treatment caused by a change of provider [sic]."[63] Although DMHC must approve the provisions of such policy statements, the new law does not expressly state what those provisions should include or the ramifications of failure to meet DMHC approval.[64]

Beyond the notice and filing requirements, the most substantive section of Chapter 591 eliminates the distinction between non-participating and terminated providers and increases the number of conditions that entitle an enrollee to continuation of covered services.[65] For "acute" conditions, coverage shall

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53. *Id.* § 1373.65(b).

54. *Id.* § 1373.65(a)-(b).

55. *Id.* § 1373.65(a).

56. *Id.* § 1373.65(f).

57. *Id.* § 1373.65(c)-(f); *see also* ASSEMBLY FLOOR, ANALYSIS OF AB 1286, at 3 (May 30, 2003) (discussing complaints handled by DMHC).

58. CAL. HEALTH & SAFETY CODE § 1373.95(a) (amended by Chapter 591).

59. *Id.* § 1373.95(a)(1)-(a)(2).

60. *Id.* § 1373.95(a)(2)(A)-(B).

61. *Id.* § 1373.95(a)(2)(C).

62. *Id.* § 1373.95(a)(2)(D); ASSEMBLY FLOOR, ANALYSIS OF AB 1286, at 1-3 (Sept. 10, 2003).

63. CAL. HEALTH & SAFETY CODE § 1373.95(a)(2)(E) (amended by Chapter 591).

64. *Id.* § 1373.95(a)(3). Apparently, the filing requirements are intended to force plans to give more thought to continuity of care issues and enhance the oversight role of DMHC. *See* ASSEMBLY FLOOR, ANALYSIS OF AB 1286, at 3 (May 30, 2003) (discussing the role of DMHC).

65. CAL. HEALTH & SAFETY CODE § 1373.96 (amended by Chapter 591).

continue "for the duration of the acute condition."[66] For "serious chronic" conditions, coverage shall continue "for a period of time necessary to complete a course of treatment and to arrange for a safe transfer" from one provider to another.[67] The new law expands provisions for pregnancy by providing continued coverage for all three trimesters and for postpartum treatment.[68] While prior law also provided coverage for these categories under certain conditions,[69] Chapter 591 expands the list of "qualifying conditions" still further by extending continuity of care provisions to persons suffering from terminal illnesses, children up to three years of age, and persons already scheduled for nonelective surgery.[70]

Lastly, Chapter 591 amends the California Insurance Code by extending the new requirements for "health care service plans" regulated by the DMHC to "traditional" health insurers regulated by the Department of Insurance.[71] In the last two decades, even "traditional" health insurers have adopted contracting and payment methods similar to those used by the health care service plans regulated by the DMHC.[72] Chapter 591 takes account of these changes by transporting the relevant portions of the Health and Safety Code into the Insurance Code.[73] To the

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66. *Id.* § 1373.96(c)(1) (amended by Chapter 591).

67. *Id.* § 1373.96(c)(2). What constitutes a "necessary" period of time for a "safe transfer" is determined by the plan in "consultation" with the terminated or nonparticipating provider in accordance with "good professional practice." *Id.*

68. *Id.* § 1373.96(c)(3).

69. *Id.* §§ 1373.95(a)(1), 1373.96(a)-(b) (West 1997 & Supp. 2003).

70. *Id.* § 1373.96(c)(3)-(6) (amended by Chapter 591). For terminal illnesses, coverage shall continue for the duration of the illness. For children, from the age of birth to three years, continuation of coverage is not to exceed twelve months. For surgery already scheduled, coverage is guaranteed for surgery scheduled to occur within the next 180 days. *Id.*

71. CAL. INS. CODE § 10133.56 (amended by Chapter 591).

72. Although California law still recognizes the distinction between "health care service plans" regulated by the Department of Managed Health Care and "health insurers" regulated by the Department of Insurance, the distinction is of less practical significance than it once was. The original distinction rested upon method of payment. Health care service plans used some form of prepayment method, where the subscriber made a fixed payment to the health service plan, and the plan paid its member doctors either on a fee-for-service or "capitated" (i.e., per enrollee) basis. Under "traditional" health insurance, the insurer used an "indemnity" plan, whereby the subscriber paid a premium to the health insurer and was then reimbursed (or paid an indemnity) for any payments made to the doctor. In short, under the indemnity plan, the insurer never paid money directly to the provider; the subscriber paid the doctor and then received reimbursement from the insurance company. However, this distinction has been rendered less meaningful in the past few decades, as the line between "traditional" insurers and various health service plans and HMOs has become less distinct. *See, e.g.*, Vuletich Interview, *supra* note 33 (explaining that the distinction between "health care service plan" and "health insurer," while still useful in some respects, is not nearly as significant as it once was); Wagner, *supra* note 12, at 20 (noting that many traditional indemnity insurance companies have virtually transformed themselves into MCOs, often by acquiring smaller HMOs and PPOs); ROBERT SHOULDICE, INTRODUCTION TO MANAGED CARE 1-18 (1991) (describing the differences between indemnity plans and service plans, on the one hand, and "fee-for-service" payment and capitation, on the other hand); People *ex. rel.* Roddis v. Cal. Mut. Ass'n, 441 P.2d 97, 68 Cal. 2d 677 (1968) (holding that the extent to which a health care service plan is regulated by the Department of Insurance is contingent upon the extent to which its "indemnity" features outbalance its "service" or pre-payment function).

73. CAL. INS. CODE § 10133.56. (amended by Chapter 591). The provisions in the Insurance Code are taken almost word-for-word from the Heath and Safety Code. *Compare* CAL. HEALTH & SAFETY CODE § 1373.96 (amended by Chapter 591), *with* CAL. INS. CODE § 10133.56 (amended by Chapter 591).

extent that "health insurers" engage in activities once exclusively practiced by service plans, they will be regulated as service plans and subject to the Knox-Keene Act.[74]

## IV. ANALYSIS OF CHAPTER 591

Chapter 591 began as an ambitious effort to protect all health plan enrollees, regardless of their medical condition, from the perils of contract disputes in the modern health care market.[75] As enacted, however, Chapter 591 makes only modest efforts to extend notice requirements and expand the list of conditions that entitle enrollees to continuation of covered services.[76] In order to understand its limitations, however, it is instructive to compare Chapter 591 with earlier versions of AB 1286, introduced by Assemblyman Dario Frommer and sponsored by the DMHC.[77] When the Assembly sent AB 1286 to the Senate, it contained what was supposed to become section 1373.66 of the Health and Safety Code.[78] This section proposed that, in the event of contract termination between a health plan and a provider group, all affected enrollees, regardless of their medical condition, were entitled to continuation of covered services.[79] If covered by a group health plan or by the California Healthy Families Program, the enrollee could continue seeing a terminated provider until his next enrollment period, for a period of up to twelve months.[80] When receiving coverage on an individual basis or through the Medi-Cal program, the enrollee could continue to see a terminated provider for up to 180 days from the expiration of the contract.[81] These provisions took cognizance of the fact that health plan subscribers, most of whom receive health coverage through employers, are often locked into a particular health plan until the next enrollment period, which typically occurs

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74. CAL. INS. CODE § 10133.56 (amended by Chapter 591). *See also* Vuletich Interview, *supra* note 33 (explaining that even traditional, fee-for-service "health insurers" contract for alternative rates with groups of "preferred providers"); SHOULDICE, *supra* note 72, at 57-59 (describing such preferred provider arrangements, whether called PPAs or PPOs, as a hybrid of the traditional fee-for-service payment structure with the cost control features of managed care organizations).

75. AB 1286 (2003) (as introduced on Feb. 21, 2003, but not enacted); *see also* ASSEMBLY COMMITTEE ON HEALTH, COMMITTEE ANALYSIS OF AB 1286, at 1-5 (Apr. 22, 2003) (analyzing AB 1286 as originally introduced).

76. *Compare* AB 1286 (2003) (as introduced on February 21, 2003, but not enacted), *with* CAL. HEALTH & SAFETY CODE §§ 1373.65, 1373.95, 1373.96 (amended by Chapter 591).

77. AB 1286 (2003) (as introduced on Feb. 21, 2003, but not enacted); *see also* ASSEMBLY COMMITTEE ON HEALTH, COMMITTEE ANALYSIS OF AB 1286, at 1-5 (Apr. 22, 2003) (analyzing AB 1286 as originally introduced).

78. ASSEMBLY FLOOR, ANALYSIS OF AB 1286, at 1-3 (May 30, 2003); AB 1286 (as amended on June, 30, 2003, but not enacted).

79. AB 1286 (as amended on June, 30, 2003, but not enacted) (purporting to add section 1373.66 to the Health and Safety Code).

80. *Id.* (purporting to add section 1373.66(b)(1) to the Health and Safety Code).

81. *Id.* (purporting to add section 1373.66(b)(2)-(3) to the Health and Safety Code).

annually.[82] Even with sixty days notice, therefore, the enrollee was not always free to select a new health plan that covered a chosen provider.[83]

The proposal to offer continuity of care to all affected enrollees for a period of up to twelve months, however, encountered opposition from both providers and health plans.[84] While the opponents of this provision supported the general goal of "continuity of care," they pointed to the profound technical problems of implementing such a policy.[85] First and foremost, opponents pointed to the extreme difficulty of determining methods and rates of payment during a transition period that could last up to twelve months.[86] Opponents found it highly unlikely that plans and providers would reach an agreement on payment rates during the transition period, especially given that disagreements on such issues caused contract termination in the first place.[87] Early versions of AB 1286 attempted to deal with this problem by requiring that all contracts entered into as of January 1, 2004, contain a provision stipulating rates during any possible transition period.[88] But opponents pointed out that this would only add another source of contention to already difficult contract negotiations.[89] Blue Cross of California hoped that the problem of negotiating the transition rates could be mitigated by using a standard medical inflation index.[90] However, this proposal apparently failed to assuage opponents, and the Senate eventually deleted the most far-reaching proposal of AB 1286.[91] Even as amended, Chapter 591 does not eliminate the problem of negotiating payment rates during the transition period, since providers are still free to accept or reject the plan's terms.[92] However, because Chapter 591 limits continued coverage to those suffering from specified conditions and for shorter periods of times, the new law presents less of a problem.[93]

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82. SENATE COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 1286, at 8-11 (July 2, 2003).

83. *Id.* at 7-12.

84. *Id.* at 7-9, 11-12; *see also* ASSEMBLY COMMITTEE ON APPROPRIATIONS, COMMITTEE ANALYSIS OF AB 1286, at 4 (May 21, 2003) (explaining that a 2002 bill, quite similar to AB 1286, passed in both houses only to die in conference committee due to disagreements over payment rates in the post-contract termination period).

85. SENATE COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 1286, at 7-9 (July 2, 2003).

86. *Id.*; ASSEMBLY COMMITTEE ON APPROPRIATIONS, COMMITTEE ANALYSIS OF AB 1286, at 4 (May 21, 2003).

87. SENATE COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 1286, at 7-9 (July 2, 2003); ASSEMBLY COMMITTEE ON APPROPRIATIONS, COMMITTEE ANALYSIS OF AB 1286, at 4 (May 21, 2003).

88. SENATE COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 1286, at 7-9 (July 2, 2003); ASSEMBLY COMMITTEE ON APPROPRIATIONS, COMMITTEE ANALYSIS OF AB 1286, at 4 (May 21, 2003).

89. SENATE COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 1286, at 7-8 (July 2, 2003).

90. *Id.* at 8.

91. AB 1286 (as amended by Senate on Aug. 18, 2003 and Sept. 2, 2003) (eliminating the proposed California Health & Safety Code section 1373.66); *see also* ASSEMBLY FLOOR, ANALYSIS OF AB 1286, at 2 (Sept. 10, 2003) (noting that the Senate amendments narrowed the provisions in the Assembly version).

92. CAL. HEALTH & SAFETY CODE §§ 1373.96(d)(1)-(2), 1373.96(e)(1)-(2) (amended by Chapter 591).

93. *Id.* §§ 1373.95, 1373.96.

Despite being weakened by Senate amendments, Chapter 591 still provides important protections to a greater number of health care consumers.[94] At the very least, supporters contend, extending notice requirements from thirty to sixty days will give consumers more time to search for a suitable replacement when and if enrollees lose access to their old provider.[95] Moreover, because the notice provisions require plans to inform enrollees about the plan's continuity of care polices and the scope of the enrollee's rights, Chapter 591 should encourage people to request continued services who might otherwise have been unaware that they possessed such rights.[96] Finally, by requiring that plans file policy statements and notify DMHC at least seventy-five days prior to an anticipated contract termination, the new law will foster earlier and more informed intervention on the part of DMHC, thereby increasing the opportunities for DMHC to encourage settlement of contract disputes.[97]

However the specific details of Chapter 591 work themselves out, a still larger issue concerns how Chapter 591, or any other piece of health care legislation, fits into the plethora of health care proposals either pending or recently enacted.[98] The 2003 legislative session produced, as one reporter noted, "[a] stack of competing bills to reform health insurance in California."[99] Even though most commentators and legislators complain about the growing number of people without any health insurance, only a handful of bills address this problem.[100] Instead, most health care proposals, including Chapter 591, offer piecemeal reforms to the existing system and do nothing about the problem of the uninsured.[101] Allowing enrollees to remain with their doctor in the event of a contract dispute between health plan and provider does nothing for those who have neither a plan nor a provider.

## V. CONCLUSION

Chapter 591 began as an ambitious proposal to counteract the disruptive effects of contract termination between large health plans and health care provider groups.[102] As originally conceived, Assemblyman Frommer's

94. *Id.* § 1373.96(a)-(c).

95. SENATE COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 1286, at 6 (July 2, 2003).

96. CAL. HEALTH & SAFETY CODE § 1373.65(f) (amended by Chapter 591).

97. *Id.* §§ 1373.65(a), 1373.95(a)(1)-(a)(2).

98. Lisa Rapaport, *Health Care Is Hot Again in Capital; Hard Time Fuel a Long List of Bills*, SACRAMENTO BEE, Aug. 4, 2003, at A3.

99. Laura Kurtzman, *California Health Insurance Reform Advances*, SAN JOSE MERCURY NEWS, May 1, 2003.

100. Rapaport, *supra* note 98.

101. *See* Rapaport, *supra* note 98 (stating that, with "the number of uninsured Californians on the rise again, covering the uninsured is a refrain running through many of the pending bills").

102. *Compare* AB 1286 (2003) (as introduced on Feb. 21, 2003, but not enacted), *with* CAL. HEALTH & SAFETY CODE §§ 1373.65, 1373.95, 1373.96 (amended by Chapter 591).

"Continuity of Care" bill promised uninterrupted health care services to all Californians affected by contract termination, regardless of their medical condition.[103] As finally enacted, however, Chapter 591 makes two substantive but modest changes to existing law. First, while prior law required health plans to provide thirty days notice to any enrollee affected by contract termination, Chapter 591 extends the notice requirements to sixty days.[104] Second, Chapter 591 recognizes a greater number of conditions that will permit an enrollee to continue receiving health care services from a nonparticipating or terminated provider.[105] Although significantly weakened by amendments, Chapter 591 will nevertheless lessen the disruptions of contract termination for some Californians and provide more time for others to find new providers or health plans.

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103. AB 1286 (2003) (as introduced on Feb. 21, 2003, but not enacted); *see also* ASSEMBLY COMMITTEE ON HEALTH, COMMITTEE ANALYSIS OF AB 1286, at 1-5 (Apr. 22, 2003) (analyzing AB 1286 as originally introduced).

104. CAL. HEALTH & SAFETY CODE § 1373.65(a)-(b) (amended by Chapter 591).

105. *Compare id.* § 1373.96, *with* CAL. HEALTH & SAFETY CODE §§ 1373.95(a)(1), 1373.96(a)-(b) (West 1997 & Supp. 2003).