2020 EDITION

CALIFORNIA KNOX-KEENE HEALTH CARE SERVICE PLAN ACT AND REGULATIONS

DEPARTMENT OF
Managed
Health Care

2020 EDITION

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Statutes Include Amendments through all 1016 Chapters
of the 2019 Regular Session of the 2018-2019 California Legislature.

DEPARTMENT OF
Managed
Health Care

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PREFACE

LexisNexis is pleased to offer to the health care community the 2019 edition of **California Knox-Keene Health Care Service Plan Act and Regulations**. This volume is a compilation of selected laws and regulations that affect the health care profession. It is fully up to date with statutes enacted up to and including all 1016 Chapters of the 2018 Regular Session of the 2018-2019 California Legislature.

Included herein is a Table of Sections Affected which may be utilized to facilitate research into recently enacted legislation affecting these Codes. Through the use of state-of-the-art computer software, attorney editors have updated the comprehensive descriptive word index with the enactments of the 2018-2019 legislature.

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HISTORY: Added Stats 1975 ch 941 § 2, operative July 1, 1976.

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HISTORY: Added Stats 1975 ch 941 § 2, operative July 1, 1976.

§ 1340. Citation of chapter

This chapter shall be known and may be cited as the Knox-Keene Health Care Service Plan Act of 1975.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976.

§ 1341. Department of Managed Health Care

(a) There is in state government, in the California Health and Human Services Agency, a Department of Managed Health Care that has charge of the execution of the laws of this state relating to health care service plans and the health care service plan business including, but not limited to, those laws directing the department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees.

(b) The chief officer of the Department of Managed Health Care is the Director of the Department of Managed Health Care. The director shall be appointed by the Governor and shall hold office at the pleasure of the Governor. The director shall receive an annual salary as fixed in the Government Code. Within 15 days from the time of the director’s appointment, the director shall

take and subscribe to the constitutional oath of office and file it in the office of the Secretary of State.

(c) The director shall be responsible for the performance of all duties, the exercise of all powers and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the department. The director has and may exercise all powers necessary or convenient for the administration and enforcement of, among other laws, the laws described in subdivision (a).

HISTORY:
Added Stats 1999 ch 525 § 22 (AB 78), operative July 1, 2000. Amended Stats 2000 ch 857 § 19 (AB 2903); Stats 2011 ch 552 § 2 (AB 922), effective January 1, 2012.

§ 1341.1. Principal and branch offices

The director shall have his or her principal office in the City of Sacramento, and may establish branch offices in the City and County of San Francisco, in the City of Los Angeles, and in the City of San Diego. The director shall from time to time obtain the necessary furniture, stationery, fuel, light, and other proper conveniences for the transaction of the business of the Department of Managed Health Care.

HISTORY:
Added Stats 1999 ch 525 § 23 (AB 78), operative July 1, 2000. Amended Stats 2000 ch 857 § 20 (AB 2903).

§ 1341.2. Personnel of Department of Managed Health Care

In accordance with the laws governing the state civil service, the director shall employ and, with the approval of the Department of Finance, fix the compensation of such personnel as the director needs to discharge properly the duties imposed upon the director by law, including, but not limited to, a chief deputy, a public information officer, a chief enforcement counsel, and legal counsel to act as the attorney for the director in actions or proceedings brought by or against the director under or pursuant to any provision of any law under the director's jurisdiction, or in which the director joins or intervenes as to a matter within the director's jurisdiction, as a friend of the court or otherwise, and stenographic reporters to take and transcribe the testimony in any formal hearing or investigation before the director or before a person authorized by the director. The personnel of the Department of Managed Health Care shall perform such duties as the director assigns to them. Such employees as the director designates by rule or order shall, within 15 days after their appointments, take and subscribe to the constitutional oath of office and file it in the office of the Secretary of State.

HISTORY:
Added Stats 1999 ch 525 § 24 (AB 78), operative July 1, 2000. Amended Stats 2000 ch 857 § 21 (AB 2903).

§ 1341.3. Adoption of seal

The director shall adopt a seal bearing the inscription: "Director, Department of Managed Health Care, State of California." The seal shall be affixed to or imprinted on all orders and certificates issued by him or her and such other instruments as he or she directs. All courts shall take judicial notice of this seal.

HISTORY:
Added Stats 1999 ch 525 § 25 (AB 78), operative July 1, 2000. Amended Stats 2000 ch 857 § 22 (AB 2903).

§ 1341.4. Managed Care Fund established

(a) In order to effectively support the Department of Managed Health Care in the administration of this law, there is hereby established in the State Treasury, the Managed Care Fund. The administration of the Department of Managed Health Care shall be supported from the Managed Care Fund.

(b) In any fiscal year, the Managed Care Fund shall maintain not more than a prudent 5 percent reserve unless otherwise determined by the Department of Finance.

HISTORY:
Added Stats 1999 ch 525 § 26 (AB 78), July 1, 2000. Amended Stats 2000 ch 93 § 7 (AB 2877), effective July 7, 2000; Stats 2004 ch 228 § 3 (SB 1103), effective August 16, 2004; Stats 2007 ch 577 § 6 (AB 1750), effective October 13, 2007.

§ 1341.45. Managed Care Administrative Fines and Penalties Fund created; Transfer of monies

(a) There is hereby created in the State Treasury the Managed Care Administrative Fines and Penalties Fund.

(b) The fines and administrative penalties collected pursuant to this chapter, on and after September 30, 2008, shall be deposited into the Managed Care Administrative Fines and Penalties Fund.

(c) The fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department, beginning September 1, 2009, and annually thereafter, as follows:

(1) The first one million dollars ($1,000,000) shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) or Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(2) Any amount over the first one million dollars ($1,000,000), including accrued interest, in the fund shall be transferred to the Health Care Services Plan Fines and Penalties Fund created pursuant to Section 15893 of the Welfare and Institutions Code and, notwithstanding Section 13340 of the Government Code, shall be continuously appropriated for the purposes specified in Section 15894 of the Welfare and Institutions Code.

(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.

(e) The amendments made to this section by the act adding this subdivision shall become operative on July 1, 2014.

(f) The amendments made to this section by the act adding this subdivision shall become operative on July 1, 2017.

HISTORY:
Added Stats 2008 ch 607 § 1 (SB 1379), effective September 30, 2008. Amended Stats 2014 ch 31 § 5 (SB 857), effective June 20, 2014; Stats 2017 ch 52 § 4 (SB 97), effective July 10, 2017.

§ 1341.5. Public information

(a) The director, as a general rule, shall publish or make available for public inspection any information filed with or obtained by the department, unless the director finds that this availability or publication is contrary to law. No provision of this chapter authorizes the director or any of the director's assistants, clerks, or deputies to disclose any information withheld from public inspection except among themselves or when necessary or appropriate in a proceeding or investigation under this chapter or to other federal or state regulatory agencies. No provision of this chapter either creates or derogates from any privilege that exists at common law or otherwise when documentary or other evidence is sought under a subpoena directed to the director or any of his or her assistants, clerks, or deputies.

(b) It is unlawful for the director or any of his or her assistants, clerks, or deputies to use for personal benefit any information that is filed with or obtained by the director and that is not then generally available to the public.

HISTORY:
Added Stats 1999 ch 525 § 27 (AB 78), operative July 1, 2000.

§ 1341.6. Opinions on questions of law

(a) The Attorney General shall render to the director opinions upon all questions of law, relating to the construction or interpretation of any law under the director's jurisdiction or arising in the administration thereof, that may be submitted to the Attorney General by the director and upon the director's request shall act as the attorney for the director in actions and proceedings brought by or against the director under or pursuant to any provision of any law under the director's jurisdiction.

(b) Sections 11041, 11042, and 11043 of the Government Code do not apply to the Director of the Department of Managed Health Care.

HISTORY:
Added Stats 1999 ch 525 § 28 (AB 78), operative July 1, 2000. Amended Stats 2000 ch 857 § 23 (AB 2903).

§ 1341.7. Conflict of interest

(a) Neither the director nor any of the director's assistants, clerks, or deputies shall be interested as a director, officer, shareholder, member other than a member of an organization formed for religious purposes, partner, agent, or employee of any person who, during the period of the official's or employee's association with the Department of Managed Health Care, was licensed or applied for a license as a health care service plan under this chapter.

(b) Nothing contained in subdivision (a) shall prohibit the holdings or purchasing of any securities by the director, an assistant, clerk, or deputy in accordance with rules which shall be adopted for the purpose of protecting the public interest and avoiding conflicts of interest.

(c) Nothing in this section shall prohibit or preclude the director or any of the director's assistants, clerks, or deputies or any employee of the Department of Managed Health Care from obtaining health care services as a subscriber or an enrollee from a plan licensed under this chapter, subject to any rules that may be adopted hereunder or pursuant to proper authority.

HISTORY:
Added Stats 1999 ch 525 § 29 (AB 78), operative July 1, 2000. Amended Stats 2000 ch 857 § 24 (AB 2903).

§ 1341.8. Powers of director

The director shall have the powers of a head of a department pursuant to Chapter 2 (commencing with Section 11150) of Part 1 of Division 3 of Title 2 of the Government Code. The director may make the agreements that he or she deems necessary or appropriate in exercising his or her powers.

HISTORY:
Added Stats 1999 ch 525 § 30 (AB 78), operative July 1, 2000.

§ 1341.9. Succession to powers and responsibilities

The director and department succeed to, and are vested with, all duties, powers, purposes, responsibilities, and jurisdiction of the Commissioner of Corporations and the Department of Corporations as they relate to the Department of Corporations' Health Plan Program, health care service plans, and the health care service plan business, including those powers and duties specified in this chapter. Nothing in this section abrogates, limits, diminishes, or otherwise restricts the duties, powers, purposes, responsibilities, and jurisdictions of the Commissioner of Corporations and the Department of Corporations under the Investment Program, the Financial Services Program, and the other laws in which jurisdiction is vested in the Commissioner of Corporations and the Department of Corporations.

HISTORY:
Added Stats 1999 ch 525 § 31 (AB 78), operative July 1, 2000.

§ 1341.10. Unexpended balance of funds

The department may use the unexpended balance of funds available for use in connection with the performance of the functions of the Department of Corporations to which the department succeeds pursuant to Section 1341.9.

HISTORY:
Added Stats 1999 ch 525 § 32 (AB 78), operative July 1, 2000.

§ 1341.11. Transfer of employees

All officers and employees of the Department of Corporations who, on the operative date of this section, are performing any duty, power, purpose, responsibility, or jurisdiction to which the department succeeds, who are serving in the state civil service, other than as temporary employees, and engaged in the performance of a function vested by the department by Section

1341.9, shall be transferred to the department. The status, positions, and rights of those persons shall not be affected by the transfer and shall be retained by those persons as officers and employees of the department, pursuant to the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code), except as to positions exempted from civil service.

HISTORY:
Added Stats 1999 ch 525 § 33 (AB 78), operative July 1, 2000.

§ 1341.12. Possession of all property

The department shall have possession and control of all records, papers, offices, equipment, supplies, moneys, funds, appropriations, licenses, permits, agreements, contracts, claims, judgments, land, and other property, real or personal, connected with the administration of, or held for the benefit or use of, the Department of Corporations for the performance of the functions transferred to the department by Section 1341.9.

HISTORY:
Added Stats 1999 ch 525 § 34 (AB 78), operative July 1, 2000.

§ 1341.13. Appointment of officers and employees

All officers or employees of the department employed after the operative date of this section shall be appointed by the director.

HISTORY:
Added Stats 1999 ch 525 § 35 (AB 78), operative July 1, 2000.

§ 1341.14. Preexisting regulations, orders, and proceedings

(a) Any regulation, order, or other action, adopted, prescribed, taken, or performed by the Department of Corporations or by an officer of the Department of Corporations in the administration of a program or the performance of a duty, responsibility, or authorization transferred to the department by Section 1341.9 shall remain in effect and shall be deemed to be a regulation, order, or action of the department.

(b) No suit, action, or other proceeding lawfully commenced by or against the Department of Corporations or any other officer of the state, in relation to the administration of any program or the discharge of any duty, responsibility, or authorization transferred to the department by Section 1341.9 shall abate by reason of the transfer of the program, duty, responsibility, or authorization.

HISTORY:
Added Stats 1999 ch 525 § 36 (AB 78), operative July 1, 2000.

§ 1342. Legislative intent

It is the intent and purpose of the Legislature to promote the delivery and the quality of health and medical care to the people of the State of California

who enroll in, or subscribe for the services rendered by, a health care service plan or specialized health care service plan by accomplishing all of the following:

(a) Ensuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional.

(b) Ensuring that subscribers and enrollees are educated and informed of the benefits and services available in order to enable a rational consumer choice in the marketplace.

(c) Prosecuting malefactors who make fraudulent solicitations or who use deceptive methods, misrepresentations, or practices which are inimical to the general purpose of enabling a rational choice for the consumer public.

(d) Helping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers.

(e) Promoting effective representation of the interests of subscribers and enrollees.

(f) Ensuring the financial stability thereof by means of proper regulatory procedures.

(g) Ensuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care.

(h) Ensuring that subscribers and enrollees have their grievances expeditiously and thoroughly reviewed by the department.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1980 ch 1031 § 1; Stats 1984 ch 540 § 1; Stats 1999 ch 525 § 37 (AB 78), operative July 1, 2000; Stats 2002 ch 797 § 2 (AB 2179).

§ 1342.1. [Section repealed 2007.]

HISTORY:
Added Stats 1996 ch 815 § 1 (AB 2343). Amended Stats 2001 ch 745 § 125 (SB 1191), effective October 12, 2001. Repealed Stats 2007 ch 577 § 7 (AB 1750), effective October 13, 2007. The repealed section related to legislative findings about health care service plans and convening a task force.

§ 1342.3. [Section repealed 2006.]

HISTORY:
Added Stats 1999 ch 525 § 38 (AB 78), operative July 1, 2000. Amended Stats 2000 ch 857 § 25 (AB 2903). Repealed Stats 2005 ch 77 § 24 (SB 64), effective January 1, 2006. The repealed section related to study of consolidation benefits.

§ 1342.4. Joint working group to ensure clarity for consumers in consistency and enforcement of regulations

(a) The Department of Managed Health Care and the Department of Insurance shall maintain a joint senior level working group to ensure clarity for health care consumers about who enforces their patient rights and consistency in the regulations of these departments.

(b) The joint working group shall undertake a review and examination of the Health and Safety Code, the Insurance Code, and the Welfare and Institutions

Code as they apply to the Department of Managed Health Care and the Department of Insurance to ensure consistency in consumer protection.

(c) The joint working group shall review and examine all of the following processes in each department:

(1) Grievance and consumer complaint processes, including, but not limited to, outreach, standard complaints, including coverage and medical necessity complaints, independent medical review, and information developed for consumer use.

(2) The processes used to ensure enforcement of the law, including, but not limited to, the medical survey and audit process in the Health and Safety Code and market conduct exams in the Insurance Code.

(3) The processes for regulating the timely payment of claims.

(d) The joint working group shall report its findings to the Insurance Commissioner and the Director of the Department of Managed Health Care for review and approval. The commissioner and the director shall submit the approved final report under signature to the Legislature by January 1 of every year for five years.

HISTORY:
Added Stats 2002 ch 793 § 1 (SB 1913).

§ 1342.5. Consultation prior to adopting regulations

The director shall consult with the Insurance Commissioner prior to adopting any regulations applicable to health care service plans subject to this chapter and other entities governed by the Insurance Code for the specific purpose of ensuring, to the extent practical, that there is consistency of regulations applicable to these plans and entities by the Insurance Commissioner and the Director of the Department of Managed Health Care.

HISTORY:
Added Stats 1984 ch 1006 § 1. Amended Stats 1999 ch 525 § 39 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 26 (AB 2903); Stats 2007 ch 577 § 8 (AB 1750), effective October 13, 2007.

§ 1342.6. Effect of antitrust prohibitions on health care services

It is the intent of the Legislature to ensure that the citizens of this state receive high-quality health care coverage in the most efficient and cost-effective manner possible. In furtherance of this intent, the Legislature finds and declares that it is in the public interest to promote various types of contracts between public or private payers of health care coverage, and institutional or professional providers of health care services. This intent has been demonstrated by the recent enactment of Chapters 328, 329, and 1594 of the Statutes of 1982, authorizing various types of contracts to be entered into between public or private payers of health care coverage, and institutional or professional providers of health care services. The Legislature further finds and declares that individual providers, whether institutional or professional, and individual purchasers, have not proven to be efficient-sized bargaining units for these contracts, and that the formation of groups and combinations of institutional and professional providers and combinations of purchasing groups for the purpose of creating efficient-sized contracting units represents a meaningful addition to the health care marketplace. The Legislature further

finds and declares that negotiations between purchasers or payers of health services, and health care service plans governed by the provisions of this chapter, or through a person or entity acting for, or on behalf of, a purchaser or payer of health services, or a health care service plan, are in furtherance of the public's interest in obtaining quality health care services in the most efficient and cost-effective manner possible. It is the intent of the Legislature, therefore, that the formation of groups and combinations of providers and purchasing groups for the purpose of creating efficient-sized contracting units be recognized as the creation of a new product within the health care marketplace, and be subject, therefore, only to those antitrust prohibitions applicable to the conduct of other presumptively legitimate enterprises.

This section does not change existing antitrust law as it relates to any agreement or arrangement to exclude from any of the above-described groups or combinations, any person who is lawfully qualified to perform the services to be performed by the members of the group or combination, where the ground for the exclusion is failure to possess the same license or certification as is possessed by the members of the group or combination.

HISTORY:
Added Stats 1985 ch 1592 § 2.

§ 1342.7. Authority of department to ensure providers of prescription drug coverage comply with Knox-Keene Health Care Service Plan Act of 1975

(a) The Legislature finds that in enacting Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72, it did not intend to limit the department's authority to regulate the provision of medically necessary prescription drug benefits by a health care service plan to the extent that the plan provides coverage for those benefits.

(b)(1) Nothing in this chapter shall preclude a plan from filing relevant information with the department pursuant to Section 1352 to seek the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits. If the department approves an exclusion to a plan's prescription drug benefits, the exclusion shall not be subject to review through the independent medical review process pursuant to Section 1374.30 on the grounds of medical necessity. The department shall retain its role in assessing whether issues are related to coverage or medical necessity pursuant to paragraph (2) of subdivision (d) of Section 1374.30.

(2) A plan seeking approval of a copayment or deductible may file an amendment pursuant to Section 1352.1. A plan seeking approval of a limitation or exclusion shall file a material modification pursuant to subdivision (b) of Section 1352.

(c) Nothing in this chapter shall prohibit a plan from charging a subscriber or enrollee a copayment or deductible for a prescription drug benefit or from setting forth by contract, a limitation or an exclusion from, coverage of prescription drug benefits, if the copayment, deductible, limitation, or exclusion is reported to, and found unobjectionable by, the director and disclosed to the subscriber or enrollee pursuant to the provisions of Section 1363.

(d) The department in developing standards for the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits,

shall consider alternative benefit designs, including, but not limited to, the following:

(1) Different out-of-pocket costs for consumers, including copayments and deductibles.

(2) Different limitations, including caps on benefits.

(3) Use of exclusions from coverage of prescription drugs to treat various conditions, including the effect of the exclusions on the plan's ability to provide basic health care services, the amount of subscriber or enrollee premiums, and the amount of out-of-pocket costs for an enrollee.

(4) Different packages negotiated between purchasers and plans.

(5) Different tiered pharmacy benefits, including the use of generic prescription drugs.

(6) Current and past practices.

(e) The department shall develop a regulation outlining the standards to be used in reviewing a plan's request for approval of its proposed copayment, deductible, limitation, or exclusion on its prescription drug benefits.

(f) Nothing in subdivision (b) or (c) shall permit a plan to limit prescription drug benefits provided in a manner that is inconsistent with Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72.

(g) Nothing in this section shall be construed to require or authorize a plan that contracts with the State Department of Health Services to provide services to Medi-Cal beneficiaries or with the Managed Risk Medical Insurance Board to provide services to enrollees of the Healthy Families Program to provide coverage for prescription drugs that are not required pursuant to those programs or contracts, or to limit or exclude any prescription drugs that are required by those programs or contracts.

(h) Nothing in this section shall be construed as prohibiting or otherwise affecting a plan contract that does not cover outpatient prescription drugs except for coverage for limited classes of prescription drugs because they are integral to treatments covered as basic health care services, including, but not limited to, immunosuppressives, in order to allow for transplants of bodily organs.

(i) The department shall periodically review its regulations developed pursuant to this section.

(j) This section shall become operative on January 2, 2003, and shall only apply to contracts issued, amended, or renewed on or after that date.

HISTORY:
Added Stats 2002 ch 791 § 1 (SB 842), operative January 2, 2003. Amended Stats 2012 ch 728 § 81 (SB 71), effective January 1, 2013.

§ 1342.71. Outpatient prescription drug coverage

(a) The Legislature hereby finds and declares all of the following:

(1) The federal Patient Protection and Affordable Care Act, its implementing regulations and guidance, and related state law prohibit discrimination based on a person's expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions, including benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs.

(2) The Legislature intends to build on the existing state and federal law

to ensure that health coverage benefit designs do not have an unreasonable discriminatory impact on chronically ill individuals, and to ensure affordability of outpatient prescription drugs.

(3) Assignment of all or most prescription medications that treat a specific medical condition to the highest cost tiers of a formulary may effectively discourage enrollment by chronically ill individuals, and may result in lower adherence to a prescription drug treatment regimen.

(b) A nongrandfathered health care service plan contract that is offered, amended, or renewed on or after January 1, 2017, shall comply with this section. The cost-sharing limits established by this section apply only to outpatient prescription drugs covered by the contract that constitute essential health benefits, as defined in Section 1367.005.

(c) A health care service plan contract that provides coverage for outpatient prescription drugs shall cover medically necessary prescription drugs, including nonformulary drugs determined to be medically necessary consistent with this chapter.

(d)(1) Consistent with federal law and guidance, the formulary or formularies for outpatient prescription drugs maintained by the health care service plan shall not discourage the enrollment of individuals with health conditions and shall not reduce the generosity of the benefit for enrollees with a particular condition in a manner that is not based on a clinical indication or reasonable medical management practices. Section 1342.7 and any regulations adopted pursuant to that section shall be interpreted in a manner that is consistent with this section.

(2) For combination antiretroviral drug treatments that are medically necessary for the treatment of AIDS/HIV, a health care service plan contract shall cover a single-tablet drug regimen that is as effective as a multitablet regimen unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multitablet regimen is clinically equally or more effective and more likely to result in adherence to a drug regimen.

(e) A health care service plan contract shall ensure that the placement of prescription drugs on formulary tiers is based on clinically indicated, reasonable medical management practices.

(f)(1) This section shall not be construed to require a health care service plan to impose cost sharing.

(2) This section shall not be construed to require cost sharing for prescription drugs that state or federal law otherwise requires to be provided without cost sharing.

(3) A plan's prescription drug benefit shall provide that if the pharmacy's retail price for a prescription drug is less than the applicable copayment or coinsurance amount, the enrollee shall not be required to pay more than the retail price. The payment rendered shall constitute the applicable cost sharing and shall apply to the deductible, if any, and also to the maximum out-of-pocket limit in the same manner as if the enrollee had purchased the prescription medication by paying the cost-sharing amount.

(g) In the provision of outpatient prescription drug coverage, a health care service plan may utilize formulary, prior authorization, step therapy, or other reasonable medical management practices consistent with this chapter.

(h) This section does not apply to a health care service plan contract with the State Department of Health Care Services.

HISTORY:
Added Stats 2015 ch 619 § 1 (AB 339), effective January 1, 2016, repealed January 1, 2020. Amended Stats 2016 ch 86 § 175 (SB 1171), effective January 1, 2017, repealed January 1, 2020; Stats 2018 ch 787 § 1 (SB 1021), effective January 1, 2019.

§ 1342.72. Drug regimen; Multitablet regimen to be as effective as single [Effective until January 1, 2023; Repealed effective January 1, 2023]

(a) For combination antiretroviral drug treatments that are medically necessary for the prevention of AIDS/HIV, a health care service plan shall not have utilization management policies or procedures, including a standard of care, which rely on a multitablet drug regimen instead of a single-tablet drug regimen unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multitablet regimen is clinically equally or more effective and equally or more likely to result in adherence to a drug regimen.

(b) This section does not apply to a health care service plan contract with the State Department of Health Care Services.

(c) This section shall remain in effect only until January 1, 2023, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2023, deletes or extends that date.

HISTORY:
Added Stats 2018 ch 787 § 3 (SB 1021), effective January 1, 2019, repealed January 1, 2023.

§ 1342.73. Drug formulary [Effective until January 1, 2024; Repealed effective January 1, 2024]

(a)(1) With respect to an individual or group health care service plan contract subject to Section 1367.006, the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription for a supply of up to 30 days shall not exceed two hundred fifty dollars ($250), except as provided in paragraphs (2) and (3).

(2) With respect to products with actuarial value at, or equivalent to, the bronze level, cost sharing for a covered outpatient prescription drug for an individual prescription for a supply of up to 30 days shall not exceed five hundred dollars ($500), except as provided in paragraph (3).

(3) For a health care service plan contract that is a "high deductible health plan" under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, paragraphs (1) and (2) of this subdivision shall apply only once an enrollee's deductible has been satisfied for the year.

(4) For a nongrandfathered individual or small group health care service plan contract, the annual deductible for outpatient drugs, if any, shall not exceed twice the amount specified in paragraph (1) or (2), respectively.

(5) For purposes of paragraphs (1) and (2), "any other form of cost sharing" shall not include a deductible.

(b)(1) If a health care service plan contract for a nongrandfathered individual or small group product maintains a drug formulary grouped into tiers that includes a fourth tier, a health care service plan contract shall use the following definitions for each tier of the drug formulary:

(A) Tier one shall consist of most generic drugs and low-cost preferred brand name drugs.

(B) Tier two shall consist of nonpreferred generic drugs, preferred brand name drugs, and any other drugs recommended by the health care service plan's pharmacy and therapeutics committee based on safety, efficacy, and cost.

(C) Tier three shall consist of nonpreferred brand name drugs or drugs that are recommended by the health care service plan's pharmacy and therapeutics committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.

(D) Tier four shall consist of drugs that are biologics, drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost the health plan more than six hundred dollars ($600) net of rebates for a one-month supply.

(2) In placing specific drugs on specific tiers, or choosing to place a drug on the formulary, the health care service plan shall take into account the other provisions of this section and this chapter.

(3) A health care service plan contract may maintain a drug formulary with fewer than four tiers. A health care service plan contract shall not maintain a drug formulary with more than four tiers.

(4) This section shall not be construed to limit a health care service plan from placing any drug in a lower tier.

(c) This section does not apply to a health care service plan contract with the State Department of Health Care Services.

(d) This section shall remain in effect only until January 1, 2024, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2024, deletes or extends that date.

HISTORY:
Added Stats 2018 ch 787 § 4 (SB 1021), effective January 1, 2019, repealed January 1, 2024.

§ 1342.74. Preexposure and postexposure HIV prophylaxis [Effective January 1, 2020]

(a)(1) Notwithstanding Section 1342.71, a health care service plan shall not subject antiretroviral drugs that are medically necessary for the prevention of AIDS/HIV, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy, except as provided in paragraph (2).

(2) If the United States Food and Drug Administration has approved one or more therapeutic equivalents of a drug, device, or product for the prevention of AIDS/HIV, this section does not require a health care service plan to cover all of the therapeutically equivalent versions without prior authorization or step therapy, if at least one therapeutically equivalent version is covered without prior authorization or step therapy.

(b) Notwithstanding any other law, a health care service plan shall not prohibit, or permit a delegated pharmacy benefit manager to prohibit, a pharmacy provider from dispensing preexposure prophylaxis or postexposure prophylaxis.

(c) A health care service plan shall not cover preexposure prophylaxis that has been furnished by a pharmacist, as authorized in Section 4052.02 of the Business and Professions Code, in excess of a 60-day supply to a single patient once every two years, unless the pharmacist has been directed otherwise by a prescriber.

(d) This section does not require a health care service plan to cover preexposure prophylaxis or postexposure prophylaxis by a pharmacist at an out-of-network pharmacy, unless the health care service plan has an out-of-network pharmacy benefit.

HISTORY:
Added Stats 2019 ch 532 § 4 (SB 159), effective January 1, 2020.

§ 1342.8. Audits or surveys

The State Department of Health Services and the department shall coordinate, to the extent feasible, audits or surveys of physician offices required by this chapter and by the managed care program under the Medi-Cal Act (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code) and for any physician office auditing required by this chapter.

HISTORY:
Added Stats 1998 ch 647 § 2 (AB 162).

§ 1343. Application of chapter; Exemptions

(a) This chapter shall apply to health care service plans and specialized health care service plan contracts as defined in subdivisions (f) and (o) of Section 1345.

(b) The director may by the adoption of rules or the issuance of orders deemed necessary and appropriate, either unconditionally or upon specified terms and conditions or for specified periods, exempt from this chapter any class of persons or plan contracts if the director finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under this chapter, and that the regulation of the persons or plan contracts is not essential to the purposes of this chapter.

(c) The director, upon request of the Director of Health Care Services, shall exempt from this chapter any county-operated pilot program contracting with the State Department of Health Care Services pursuant to Article 7 (commencing with Section 14490) of Chapter 8 of Part 3 of Division 9 of the Welfare and Institutions Code. The director may exempt noncounty-operated pilot programs upon request of the Director of Health Care Services. Those exemptions may be subject to conditions the Director of Health Care Services deems appropriate.

(d) Upon the request of the Director of Health Care Services, the director may exempt from this chapter any mental health plan contractor or any capitated rate contract under Chapter 8.9 (commencing with Section 14700) of Part 3 of Division 9 of the Welfare and Institutions Code. Those exemptions may be subject to conditions the Director of Health Care Services deems appropriate.

(e) This chapter shall not apply to:

(1) A person organized and operating pursuant to a certificate issued by the Insurance Commissioner unless the entity is directly providing the health care service through those entity-owned or contracting health facilities and providers, in which case this chapter shall apply to the insurer's plan and to the insurer.

(2) A plan directly operated by a bona fide public or private institution of higher learning which directly provides health care services only to its students, faculty, staff, administration, and their respective dependents.

(3) A person who does all of the following:

(A) Promises to provide care for life or for more than one year in return for a transfer of consideration from, or on behalf of, a person 60 years of age or older.

(B) Has obtained a written license pursuant to Chapter 2 (commencing with Section 1250) or Chapter 3.2 (commencing with Section 1569).

(C) Has obtained a certificate of authority from the State Department of Social Services.

(4) The Major Risk Medical Insurance Board when engaging in activities under Chapter 8 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code, and Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code.

(5) The California Small Group Reinsurance Fund.

HISTORY:
Added Stats 1990 ch 1043 § 2 (SB 785), operative April 1, 1993. Amended Stats 1992 ch 722 § 3 (SB 485), effective September 14, 1992, operative April 1, 1993, ch 1128 § 4 (AB 1672), operative April 1, 1993; Stats 1994 ch 633 § 1 (AB 757), effective September 20, 1994; Stats 1999 ch 525 § 40 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 27 (AB 2903); Stats 2007 ch 577 § 9 (AB 1750), effective October 13, 2007; Stats 2012 ch 34 § 13 (SB 1009), effective June 27, 2012, operative July 1, 2012.

§ 1343.1. Exception to application of chapter

This chapter shall not apply to any program developed under the authority of Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

HISTORY:
Added Stats 1992 ch 1024 § 2 (SB 1708). Amended Stats 2011 ch 367 § 2 (AB 574), effective January 1, 2012.

§ 1343.5. Burden of proof

In any proceeding under this chapter, the burden of proving an exemption or an exception from a definition is upon the person claiming it.

HISTORY:
Added Stats 1978 ch 778 § 9.

§ 1344. Rules; Interpretive opinions; Good faith acts

(a) The director may from time to time adopt, amend, and rescind any rules, forms, and orders that are necessary to carry out the provisions of this chapter, including rules governing applications and reports, and defining any terms, whether or not used in this chapter, insofar as the definitions are not

inconsistent with the provisions of this chapter. For the purpose of rules and forms, the director may classify persons and matters within the director's jurisdiction, and may prescribe different requirements for different classes. The director may waive any requirement of any rule or form in situations where in the director's discretion that requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to this chapter. The director may adopt rules consistent with federal regulations and statutes to regulate health care coverage supplementing Medicare.

(b) The director may, by regulation, modify the wording of any notice required by this chapter for purposes of clarity, readability, and accuracy, except that a modification shall not change the substantive meaning of the notice.

(c) The director may honor requests from interested parties for interpretive opinions.

(d) No provision of this chapter imposing any liability applies to any act done or omitted in good faith in conformity with any rule, form, order, or written interpretive opinion of the director, or any opinion of the Attorney General, notwithstanding that the rule, form, order, or written interpretive opinion may later be amended or rescinded or be determined by judicial or other authority to be invalid for any reason.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1992 ch 287 § 2 (SB 925), effective July 21, 1992; Stats 1999 ch 525 § 41 (AB 78), operative July 1, 2000; Stats 2009 ch 298 § 3 (AB 1540), effective January 1, 2010.

§ 1345. Definitions

As used in this chapter:

(a) "Advertisement" means any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or similar communications media, published in connection with the offer or sale of plan contracts.

(b) "Basic health care services" means all of the following:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. "Basic health care services" includes ambulance and ambulance transport services provided through the "911" emergency response system.

(7) Hospice care pursuant to Section 1368.2.

(c) "Enrollee" means a person who is enrolled in a plan and who is a recipient of services from the plan.

(d) "Evidence of coverage" means any certificate, agreement, contract, brochure, or letter of entitlement issued to a subscriber or enrollee setting forth the coverage to which the subscriber or enrollee is entitled.

(e) "Group contract" means a contract which by its terms limits the eligibility of subscribers and enrollees to a specified group.

(f) "Health care service plan" or "specialized health care service plan" means either of the following:

(1) Any person who 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.

(2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(g) "License" means, and "licensed" refers to, a license as a plan pursuant to Section 1353.

(h) "Out-of-area coverage," for purposes of paragraph (6) of subdivision (b), means coverage while an enrollee is anywhere outside the service area of the plan, and shall also include coverage for urgently needed services to prevent serious deterioration of an enrollee's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to the plan's service area.

(i) "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(j) "Person" means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the state.

(k) "Service area" means a geographical area designated by the plan within which a plan shall provide health care services.

(*l*) "Solicitation" means any presentation or advertising conducted by, or on behalf of, a plan, where information regarding the plan, or services offered and charges therefor, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan.

(m) "Solicitor" means any person who engages in the acts defined in subdivision (*l*).

(n) "Solicitor firm" means any person, other than a plan, who through one or more solicitors engages in the acts defined in subdivision (*l*).

(o) "Specialized health care service plan contract" means a contract for health care services in a single specialized area of health care, including dental care, for subscribers or enrollees, or which pays for or which reimburses 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.

(p) "Subscriber" means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

(q) Unless the context indicates otherwise, "plan" refers to health care service plans and specialized health care service plans.

(r) "Plan contract" means a contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health

care services, including basic health care services, are furnished; and unless the context otherwise indicates it includes specialized health care service plan contracts; and unless the context otherwise indicates it includes group contracts.

(s) All references in this chapter to financial statements, assets, liabilities, and other accounting items mean those financial statements and accounting items prepared or determined in accordance with generally accepted accounting principles, and fairly presenting the matters which they purport to present, subject to any specific requirement imposed by this chapter or by the director.

HISTORY:
Added Stats 1990 ch 1043 § 4 (SB 785), operative April 1, 1993. Amended Stats 1994 ch 1010 § 154 (SB 2053); Stats 1995 ch 515 § 1 (SB 1151); Stats 1998 ch 979 § 1 (AB 984), ch 1025 § 1 (SB 658), ch 1026 § 2 (AB 1899); Stats 1999 ch 525 § 42 (AB 78), ch 528 § 1 (AB 892); Stats 2002 ch 760 § 1 (AB 3048).

§ 1345.5. "Minimum essential coverage"

(a) "Minimum essential coverage" means any of the following:

(1) Coverage under any of the following government-sponsored programs:

(A) The Medicare program under Part A or Part C of Title XVIII of the federal Social Security Act.

(B) Full scope coverage under the Medi-Cal program, including the Medi-Cal Access Program and Medi-Cal for Pregnant Women, and other full scope health coverage programs administered and determined to be minimum essential coverage by the State Department of Health Care Services.

(C) The Medicaid program under Title XIX of the federal Social Security Act.

(D) The CHIP program under Title XXI of the federal Social Security Act or under a qualified CHIP look-alike program, as defined in Section 2107(g) of the federal Social Security Act.

(E) Medical coverage under Chapter 55 of Title 10 of the United States Code, including coverage under the TRICARE program.

(F) A health care program under Chapter 17 or Chapter 18 of Title 38 of the United States Code.

(G) A health plan under Section 2504(e) of Title 22 of the United States Code, relating to Peace Corps volunteers.

(H) The Nonappropriated Fund health benefits program of the Department of Defense, established under Section 349 of the National Defense Authorization Act for Fiscal Year 1995.

(I) Refugee Medical Assistance, supported by the Administration for Children and Families, which is authorized under Section 412(e)(7)(A) of The Immigration and Nationality Act.

(J) A successor program to one of the above programs, as determined by the department or, pursuant to subparagraph (B), by the State Department of Health Care Services.

(2) The University of California Student Health Insurance Plan and the University of California Voluntary Dependent Plan.

(3) Coverage under an eligible employer-sponsored plan, including grandfathered plans and policies. "Eligible employer-sponsored plan" means a

group health plan offered in connection with employment to an employee or related individuals, including a governmental plan within the meaning of Section 2791(d)(8) of the federal Public Health Service Act (42 U.S.C. Sec. 201 et seq.) or any other plan, group health care service plan contract, or group health insurance policy offered in the small or large group market within the state.

(4) Coverage under an individual health care service plan contract or individual health insurance policy, including grandfathered contracts and policies, or student health coverage that substantially meets all the requirements of Title I of the Affordable Care Act pertaining to nongrandfathered, individual health insurance coverage.

(5) Any other health benefits coverage similar in form and substance to the benefits described in this subdivision that is determined by the department to constitute minimum essential coverage pursuant to this section.

(b) "Minimum essential coverage" does not include health coverage as follows:

(1) Coverage of the following excepted benefits:

(A) Coverage only for accident or disability income insurance, or a combination of the two.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for onsite medical clinics.

(H) Other similar health coverage, under which benefits for medical care are secondary or incidental to other health benefits.

(2) Coverage of the following excepted benefits, if offered separately:

(A) Limited scope dental or vision benefits, or benefits limited to any other single specialized area of health care.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Other similar, limited benefits.

(3) Coverage of the following excepted benefits if offered as independent, noncoordinated benefits.

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) Coverage of the following excepted benefits if offered as a separate contract for health care coverage:

(A) Medicare supplemental health insurance, as defined under Section 1395ss(g)(1) of Title 42 of the United States Code.

(B) Coverage supplemental to the coverage provided under Chapter 55 (commencing with Section 1071) of Title 10 of the United States Code.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, or the State Department of Health Care Services, may implement, interpret, or make specific this section by means of guidance or instructions, without taking regulatory action.

HISTORY:
Added Stats 2019 ch 38 § 14 (SB 78), effective June 27, 2019.

ARTICLE 2
Administration

Section
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1348.95. Annual report to department [Effective January 1, 2020].
1348.96. Submission of data for risk adjustment program.

HISTORY: Added Stats 1975 ch 941 § 2, operative July 1, 1976.

§ 1346. Powers of administration

(a) The director shall administer and enforce this chapter and shall have the following powers:

(1) Recommend and propose the enactment of any legislation necessary to protect and promote the interests of the public, subscribers, enrollees, and providers of health care services in health care service plans in the State of California.

(2) Provide information to federal and state legislative committees and executive agencies concerning plans.

(3) Assist, advise, and cooperate with federal, state, and local agencies and officials to protect and promote the interests of plans, subscribers, enrollees, and the public.

(4) Study, investigate, research, and analyze matters affecting the interests of plans, subscribers, enrollees, and the public.

(5) Hold public hearings, subpoena witnesses, take testimony, compel the production of books, papers, documents, and other evidence, and call upon other state agencies for information to implement the purposes, and enforce this chapter.

(6) Conduct audits and examinations of the books and records of plans and other persons subject to this chapter, and may prescribe by rule or order, but is not limited to, the following:

(A) The form and contents of financial statements required under this chapter.

(B) The circumstances under which consolidated statements shall be filed.

(C) The circumstances under which financial statements shall be audited by independent certified public accountants or public accountants.

(7) Conduct necessary onsite medical surveys of the health delivery system of each plan.

(8) Propose, develop, conduct, and assist in educational programs for the public, subscribers, enrollees, and licensees.

(9) Promote and establish standards of ethical conduct for the administration of plans and undertake activities to encourage responsibility in the promotion and sale of plan contracts and the enrollment of subscribers or enrollees in the plans.

(10) Advise the Governor on all matters affecting the interests of plans, subscribers, enrollees, and the public.

(11) Determine that investments of a plan's assets necessary to meet the requirements of Section 1376 are acceptable. For those purposes, reinvestment in the plan and investment in any obligations set forth in Article 3 (commencing with Section 1170) of, and Article 4 (commencing with Section 1190) of, Chapter 2 of Part 2 of Division 1 of the Insurance Code shall be considered acceptable. All other assets shall be invested in a prudent manner.

(b) The powers enumerated in subdivision (a) shall not limit, diminish, or otherwise restrict the other powers of the director specifically set forth in this chapter and other laws.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1991 ch 898 § 1 (SB 118); Stats 1999 ch 525 § 43 (AB 78), operative July 1, 2000.

§ 1346.1. Database of health care service plans

The department shall maintain a database indicating for each county, the names of the health care service plans that operate in that particular county.

HISTORY:
Added Stats 2003 ch 80 § 1 (AB 362).

§ 1346.2. Coordination with Insurance Commissioner to review specified Internet portal and enhancements; Development and maintenance of electronic clearinghouse

The director shall, in coordination with the Insurance Commissioner, review the Internet portal developed by the United States Secretary of Health and Human Services under subdivision (a) of Section 1103 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and paragraph (5) of subdivision (c) of Section 1311 of that act, and any enhancements to that portal expected to be implemented by the secretary on or before January 1, 2015. The review shall examine whether the Internet portal provides sufficient information regarding all health benefit products offered by health care service plans and health insurers in the individual and small employer markets in California to facilitate fair and affirmative marketing of all individual and small employer products, particularly outside the California Health Benefit Ex-

change created under Title 22 (commencing with Section 100500) of the Government Code. If the director and the Insurance Commissioner jointly determine that the Internet portal does not adequately achieve those purposes, they shall jointly develop and maintain an electronic clearinghouse to achieve those purposes. In performing this function, the director and the Insurance Commissioner shall routinely monitor individual and small employer benefit filings with, and complaints submitted by individuals and small employers to, their respective departments, and shall use any other available means to maintain the clearinghouse.

HISTORY:
Added Stats 2010 ch 659 § 3 (SB 900), effective January 1, 2011.

§ 1346.4. Legislative findings; Publication of code provisions

(a) The Legislature finds and declares all of the following:

(1) That millions of Californians are insured under health care service plans regulated by the Knox-Keene Health Care Service Plan Act of 1975, and that more Californians each year are insuring themselves under these health plans.

(2) That greater awareness of the rights and protections afforded by the Knox-Keene Health Care Service Plan Act of 1975 will further the act's goal of providing access to quality health care.

(3) That the public, Knox-Keene providers, and those seeking to form health care service plans under the act will benefit from having the text of the act available to them, affording a greater understanding of what the act does and making it easier for providers to comply with its provisions.

(b) The director shall annually publish this chapter and make it available for sale to the public.

HISTORY:
Added Stats 1991 ch 102 § 1 (SB 361). Amended Stats 1999 ch 525 § 44 (AB 78), operative July 1, 2000.

§ 1346.5. Entity purporting to be exempt health care service plan

If the director determines that an entity purporting to be a health care service plan exempt from the provisions of Section 740 of the Insurance Code is not a health care service plan, the director shall inform the Department of Insurance of that finding. However, if the director determines that an entity is a health care service plan, the director shall prepare and maintain for public inspection a list of those persons or entities described in subdivision (a) of Section 740 of the Insurance Code, which are not subject to the jurisdiction of another agency of this or another state or the federal government and which the director knows to be operating in the state. There shall be no liability of any kind on the part of the state, the director, and employees of the Department of Managed Health Care for the accuracy of the list or for any comments made with respect to it. Additionally, any solicitor or solicitor firm who advertises or solicits health care service plan coverage in this state described in subdivision (a) of Section 740 of the Insurance Code, which is provided by any person or entity described in subdivision (c) of that section, and where such coverage does not meet all pertinent requirements specified in

the Insurance Code, and which is not provided or completely underwritten, insured or otherwise fully covered by a health care service plan, shall advise and disclose to any purchaser, prospective purchaser, covered person or entity, all financial and operational information relative to the content and scope of the plan and, specifically, as to the lack of plan coverage.

HISTORY:
Added Stats 1983 ch 830 § 1, effective September 14, 1983. Amended Stats 1984 ch 582 § 1, effective July 19, 1984, ch 947 § 1, effective September 10, 1984; Stats 1999 ch 525 § 45 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 28 (AB 2903).

§ 1347. [Section repealed 2006.]

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1977 ch 1252 § 250, operative July 1, 1978; Stats 1979 ch 1083 § 3; Stats 1984 ch 947 § 2, effective September 10, 1984; Stats 1988 ch 848 § 1; Stats 1991 ch 722 § 1 (AB 1669); Stats 1999 ch 525 § 46 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 29 (AB 2903); Repealed Stats 2005 ch 77 § 25 (SB 64), effective January 1, 2006. The repealed section related to Advisory Committee on Managed Health Care.

§ 1347.1. [Section repealed 2005.]

HISTORY:
Added Stats 1999 ch 525 § 47 (AB 78), operative July 1, 2000. Repealed Stats 2005 ch 77 § 26 (SB 64), effective January 1, 2006. The repealed section related to clinical advisory panel.

§ 1347.15. Establishment of Financial Solvency Standards Board; Members; Purpose, Meetings

(a) There is hereby established in the Department of Managed Health Care the Financial Solvency Standards Board composed of eight members. The members shall consist of the director, or the director's designee, and seven members appointed by the director. The seven members appointed by the director may be, but are not necessarily limited to, individuals with training and experience in the following subject areas or fields: medical and health care economics; accountancy, with experience in integrated or affiliated health care delivery systems; excess loss insurance underwriting in the medical, hospital, and health plan business; actuarial studies in the area of health care delivery systems; management and administration in integrated or affiliated health care delivery systems; investment banking; and information technology in integrated or affiliated health care delivery systems. The members appointed by the director shall be appointed for a term of three years, but may be removed or reappointed by the director before the expiration of the term.

(b) The purpose of the board is to do all of the following:

(1) Advise the director on matters of financial solvency affecting the delivery of health care services.

(2) Develop and recommend to the director financial solvency requirements and standards relating to plan operations, plan-affiliate operations and transactions, plan-provider contractual relationships, and provider-affiliate operations and transactions.

(3) Periodically monitor and report on the implementation and results of the financial solvency requirements and standards.

(c) Financial solvency requirements and standards recommended to the director by the board may, after a period of review and comment not to exceed

45 days, be noticed for adoption as regulations as proposed or modified under the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). During the director's 45-day review and comment period, the director, in consultation with the board, may postpone the adoption of the requirements and standards pending further review and comment. Nothing in this subdivision prohibits the director from adopting regulations, including emergency regulations, under the rulemaking provisions of the Administrative Procedure Act.

(d) The board shall meet at least quarterly and at the call of the chair. In order to preserve the independence of the board, the director shall not serve as chair. The members of the board may establish their own rules and procedures. All members shall serve without compensation, but shall be reimbursed from department funds for expenses actually and necessarily incurred in the performance of their duties.

(e) For purposes of this section, "board" means the Financial Solvency Standards Board.

HISTORY:
Added Stats 1999 ch 529 § 1 (SB 260). Amended Stats 2000 ch 1067 § 5 (SB 2094); Stats 2005 ch 77 § 27 (SB 64), effective January 1, 2006; Stats 2007 ch 577 § 10 (AB 1750), effective October 13, 2007.

§ 1347.5. Implementation of Medi-Cal program's premium and cost-sharing payments by health care service plan

(a) A health care service plan providing individual coverage in the Exchange shall cooperate with requests from the Exchange to collaborate in the development of, and participate in the implementation of, the Medi-Cal program's premium and cost-sharing payments under Sections 14102 and 14148.65 of the Welfare and Institutions Code for eligible Exchange enrollees.

(b) A health care service plan providing individual coverage in the Exchange shall not charge, bill, ask, or require an enrollee receiving benefits under Section 14102 or 14148.65 of the Welfare and Institutions Code to make any premium or cost-sharing payments for any services that are subject to premium or cost-sharing payments by the State Department of Health Care Services under Section 14102 or 14148.65 of the Welfare and Institutions Code.

(c) For purposes of this section, "Exchange" means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

HISTORY:
Added Stats 2014 ch 31 § 6 (SB 857), effective June 20, 2014. Amended Stats 2015 ch 303 § 249 (AB 731), effective January 1, 2016.

§ 1348. Antifraud plan

(a) Every health care service plan licensed to do business in this state shall establish an antifraud plan. The purpose of the antifraud plan shall be to organize and implement an antifraud strategy to identify and reduce costs to the plans, providers, subscribers, enrollees, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. The antifraud plan elements shall include, but not be limited to, all of

the following: the designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations; training of plan personnel and contractors concerning the detection of health care fraud; the plan's procedure for managing incidents of suspected fraud; and the internal procedure for referring suspected fraud to the appropriate government agency.

(b) Every plan shall submit its antifraud plan to the department no later than July 1, 1999. Any changes shall be filed with the department pursuant to Section 1352. The submission shall describe the manner in which the plan is complying with subdivision (a), and the name and telephone number of the contact person to whom inquiries concerning the antifraud plan may be directed.

(c) Every health care service plan that establishes an antifraud plan pursuant to subdivision (a) shall provide to the director an annual written report describing the plan's efforts to deter, detect, and investigate fraud, and to report cases of fraud to a law enforcement agency. For those cases that are reported to law enforcement agencies by the plan, this report shall include the number of cases prosecuted to the extent known by the plan. This report may also include recommendations by the plan to improve efforts to combat health care fraud.

(d) Nothing in this section shall be construed to limit the director's authority to implement this section in accordance with Section 1344.

(e) For purposes of this section, "fraud" includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit.

(f) Nothing in this section shall be construed to limit any civil, criminal, or administrative liability under any other provision of law.

HISTORY:
Added Stats 1998 ch 837 § 1 (SB 956). Amended Stats 1999 ch 525 § 48 (AB 78), operative July 1, 2000.

§ 1348.5. Compliance with other law

A health care service plan shall comply with the provisions of Section 56.107 of the Civil Code to the extent required by that section. To the extent this chapter conflicts with Section 56.107 of the Civil Code, the provisions of Section 56.107 of the Civil Code shall control.

HISTORY:
Added Stats 2013 ch 444 § 10 (SB 138), effective January 1, 2014.

§ 1348.6. Proscription on payment to health care practitioner to deny, limit, or delay services

(a) No contract between a health care service plan and a physician, physician group, or other licensed health care practitioner shall contain any incentive plan that includes specific payment made directly, in any type or form, to a physician, physician group, or other licensed health care practitioner as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services provided with respect to a specific enrollee or groups of enrollees with similar medical conditions.

(b) Nothing in this section shall be construed to prohibit contracts that contain incentive plans that involve general payments, such as capitation payments, or shared-risk arrangements that are not tied to specific medical decisions involving specific enrollees or groups of enrollees with similar medical conditions. The payments rendered or to be rendered to physicians, physician groups, or other licensed health care practitioners under these arrangements shall be deemed confidential information in accordance with subdivision (d) of Section 1351.

HISTORY:
Added Stats 1996 ch 1014 § 2 (AB 2649).

§ 1348.8. Requirements for telephone medical advice services; Forwarding of data to Department of Consumer Affairs

(a) A health care service plan that provides, operates, or contracts for telephone medical advice services to its enrollees and subscribers shall do all of the following:

(1) Ensure that the in-state or out-of-state telephone medical advice service complies with the requirements of Chapter 15 (commencing with Section 4999) of Division 2 of the Business and Professions Code.

(2) Ensure that the staff providing telephone medical advice services for the in-state or out-of-state telephone medical advice service are licensed as follows:

(A) For full service health care service plans, the staff hold a valid California license as a registered nurse or a valid license in the state within which they provide telephone medical advice services as a physician and surgeon or physician assistant, and are operating in compliance with the laws governing their respective scopes of practice.

(B)(i) For specialized health care service plans providing, operating, or contracting with a telephone medical advice service in California, the staff shall be appropriately licensed, registered, or certified as a dentist pursuant to Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code, as a dental hygienist pursuant to Article 7 (commencing with Section 1740) of Chapter 4 of Division 2 of the Business and Professions Code, as a physician and surgeon pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act, as a registered nurse pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, as a psychologist pursuant to Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code, as an optometrist pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code, as a marriage and family therapist pursuant to Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, as a licensed clinical social worker pursuant to Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code, as a professional clinical counselor pursuant to Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, or as a chiropractor pursuant to

the Chiropractic Initiative Act, and operating in compliance with the laws governing their respective scopes of practice.

(ii) For specialized health care service plans providing, operating, or contracting with an out-of-state telephone medical advice service, the staff shall be health care professionals, as identified in clause (i), who are licensed, registered, or certified in the state within which they are providing the telephone medical advice services and are operating in compliance with the laws governing their respective scopes of practice. All registered nurses providing telephone medical advice services to both in-state and out-of-state business entities registered pursuant to this chapter shall be licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

(3) Ensure that every full service health care service plan provides for a physician and surgeon who is available on an on-call basis at all times the service is advertised to be available to enrollees and subscribers.

(4) Ensure that staff members handling enrollee or subscriber calls, who are not licensed, certified, or registered as required by paragraph (2), do not provide telephone medical advice. Those staff members may ask questions on behalf of a staff member who is licensed, certified, or registered as required by paragraph (2), in order to help ascertain the condition of an enrollee or subscriber so that the enrollee or subscriber can be referred to licensed staff. However, under no circumstances shall those staff members use the answers to those questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of an enrollee or subscriber or determine when an enrollee or subscriber needs to be seen by a licensed medical professional.

(5) Ensure that no staff member uses a title or designation when speaking to an enrollee or subscriber that may cause a reasonable person to believe that the staff member is a licensed, certified, or registered professional described in Section 4999.2 of the Business and Professions Code unless the staff member is a licensed, certified, or registered professional.

(6) Ensure that the in-state or out-of-state telephone medical advice service designates an agent for service of process in California and files this designation with the director.

(7) Require that the in-state or out-of-state telephone medical advice service makes and maintains records for a period of five years after the telephone medical advice services are provided, including, but not limited to, oral or written transcripts of all medical advice conversations with the health care service plan's enrollees or subscribers in California and copies of all complaints. If the records of telephone medical advice services are kept out of state, the health care service plan shall, upon the request of the director, provide the records to the director within 10 days of the request.

(8) Ensure that the telephone medical advice services are provided consistent with good professional practice.

(b) The director shall forward to the Department of Consumer Affairs, within 30 days of the end of each calendar quarter, data regarding complaints filed with the department concerning telephone medical advice services.

(c) For purposes of this section, "telephone medical advice" means a telephonic communication between a patient and a health care professional in

which the health care professional's primary function is to provide to the patient a telephonic response to the patient's questions regarding his or her or a family member's medical care or treatment. "Telephone medical advice" includes assessment, evaluation, or advice provided to patients or their family members.

HISTORY:
Added Stats 1999 ch 535 § 2 (AB 285). Amended Stats 2002 ch 1013 § 83 (SB 2026); Stats 2003 ch 885 § 3 (SB 969); Stats 2008 ch 31 § 51 (SB 853), effective January 1, 2009, operative July 1, 2009 (ch 31 prevails), ch 179 § 137, effective January 1, 2008; Stats 2010 ch 328 § 113 (SB 1330), effective January 1, 2011; Stats 2011 ch 381 § 28 (SB 146), effective January 1, 2012; Stats 2016 ch 799 § 42 (SB 1039), effective January 1, 2017.

§ 1348.9. Adoption of regulations establishing Consumer Participation Program; Award of advocacy and witness fees [Repealed effective January 1, 2024]

(a) On or before July 1, 2003, the director shall adopt regulations to establish the Consumer Participation Program, which shall allow for the director to award reasonable advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of any regulation or to an order or decision made by the director if the order or decision has the potential to impact a significant number of enrollees.

(b) The regulations adopted by the director shall include specifications for eligibility of participation, rates of compensation, and procedures for seeking compensation. The regulations shall require that the person or organization demonstrate a record of advocacy on behalf of health care consumers in administrative or legislative proceedings in order to determine whether the person or organization represents the interests of consumers.

(c) This section shall apply to all proceedings of the department, but shall not apply to resolution of individual grievances, complaints, or cases.

(d) Fees awarded pursuant to this section may not exceed three hundred fifty thousand dollars ($350,000) each fiscal year.

(e) The fees awarded pursuant to this section shall be considered costs and expenses pursuant to Section 1356 and shall be paid from the assessment made under that section. Notwithstanding the provisions of this subdivision, the amount of the assessment shall not be increased to pay the fees awarded under this section.

(f) The department shall report to the appropriate policy and fiscal committees of the Legislature before March 1, 2004, and annually thereafter, the following information:

(1) The amount of reasonable advocacy and witness fees awarded each fiscal year.

(2) The individuals or organization to whom advocacy and witness fees were awarded pursuant to this section.

(3) The orders, decisions, and regulations pursuant to which the advocacy and witness fees were awarded.

(g) This section shall remain in effect only until January 1, 2024, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2024, deletes or extends that date.

HISTORY:
Added Stats 2002 ch 792 § 2 (SB 1092). Amended Stats 2006 ch 69 § 20 (AB 1806), effective July 12, 2006, repealed January 1, 2012. Stats 2011 ch 31 § 14 (AB 119), effective June 29, 2011, repealed January 1, 2018. Amended Stats 2017 ch 52 § 5 (SB 97), effective July 10, 2017.

§ 1348.95. Annual report to department [Effective until January 1, 2020]

Commencing March 1, 2013, and at least annually thereafter, every health care service plan, not including a health care service plan offering specialized health care service plan contracts, shall provide to the department, in a form and manner determined by the department in consultation with the Department of Insurance, the number of enrollees, by product type, as of December 31 of the prior year, that receive health care coverage under a health care service plan contract that covers individuals, small groups, large groups, or administrative services only business lines. Health care service plans shall include the enrollment data in specific product types as determined by the department, including, but not limited to, HMO, point-of-service, PPO, grandfathered, and Medi-Cal managed care. The department shall publicly report the data provided by each health care service plan pursuant to this section, including, but not limited to, posting the data on the department's Internet Web site. The department shall consult with the Department of Insurance to ensure that the data reported is comparable and consistent, does not duplicate existing reporting requirements, and utilizes existing reporting formats.

HISTORY:
Added Stats 2012 ch 852 § 1 (AB 1083), effective January 1, 2013.

§ 1348.95. Annual report to department [Effective January 1, 2020]

(a) Commencing March 1, 2013, and at least annually thereafter, a health care service plan, not including a health care service plan offering specialized health care service plan contracts, shall provide to the department, in a form and manner determined by the department in consultation with the Department of Insurance, the number of enrollees, by product type, as of December 31 of the prior year, that receive health care coverage under a health care service plan contract that covers individuals and small groups inside and outside of the California Health Benefit Exchange, large groups, administrative services only business lines, and any other business lines. Health care service plans shall include the enrollment data in specific product types as determined by the department, including, but not limited to, HMO, point-of-service, PPO, grandfathered, and Medi-Cal managed care. Data reported pursuant to this subdivision shall specify the covered persons that are being reported pursuant to subdivision (b).

(b) Commencing March 1, 2020, and at least annually thereafter, a health care service plan that provides coverage through a multiple employee welfare arrangement (MEWA) that is not subject to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 of the Insurance Code shall provide to the department, in a form and manner determined by the department in consultation with the Department of Insurance, the name of each MEWA and the number of covered persons in each MEWA as of December 31

of the prior year, divided by market segment and product type. Data reported pursuant to this subdivision shall be identified and separately reported under subdivision (a).

(c) The department shall publicly report the data provided by each health care service plan pursuant to this section, including, but not limited to, posting the data on the department's internet website. The department shall consult with the Department of Insurance to ensure that the data reported is comparable and consistent, does not duplicate existing reporting requirements, and utilizes existing reporting formats. The data for the previous calendar year shall be made available no later than April 15 of each calendar year.

HISTORY:
Added Stats 2012 ch 852 § 1 (AB 1083), effective January 1, 2013. Amended Stats 2019 ch 241 § 1 (SB 129), effective January 1, 2020.

§ 1348.96. Submission of data for risk adjustment program

Any data submitted by a health care service plan to the United States Secretary of Health and Human Services, or his or her designee, for purposes of the risk adjustment program described in Section 1343 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18063) shall be concurrently submitted to the department in the same format. The department shall use the information to monitor federal implementation of risk adjustment in the state and to ensure that health care service plans are in compliance with federal requirements related to risk adjustment.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 2 § 1 (SBX1 2), effective September 30, 2013.

ARTICLE 3

Licensing and Fees

Section
1349. License requirement.
1349.1. Exemptions.
1349.2. Exemption of certain plans.
1349.3. [Section repealed 2002.]
1350. License requirement for sponsor of prescription drug plan.
1350.1. [Section repealed 1984.]
1351. Applications for licensure.
1351.1. Authorization for disclosure.
1351.2. Mexican prepaid health plans; Application for licensure in California; Requirements; Fees; Actions to be taken when plan ceases to operate legally in Mexico.
1351.3. Effect of noncompliance.
1352. Amendment for change in information.
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1353. Applicants to satisfy provisions of chapter.
1354. Denials of applications or disapprovals.
1355. Duration of license.
1356. Fees and reimbursements.
1356.1. Excess charges or assessments.
1356.2. Imposition of additional assessment.

HISTORY: Added Stats 1975 ch 941 § 2, operative July 1, 1976.

§ 1349. License requirement

It is unlawful for any person to engage in business as a plan in this state or to receive advance or periodic consideration in connection with a plan from or on behalf of persons in this state unless such person has first secured from the director a license, then in effect, as a plan or unless such person is exempted by the provisions of Section 1343 or a rule adopted thereunder. A person licensed pursuant to this chapter need not be licensed pursuant to the Insurance Code to operate a health care service plan or specialized health care service plan unless the plan is operated by an insurer, in which case the insurer shall also be licensed by the Insurance Commissioner.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1999 ch 525 § 49 (AB 78), operative July 1, 2000.

§ 1349.1. Exemptions

A health care service plan which satisfies both of the following criteria is exempt from Section 1349:

(a) Provides only emergency ambulance services or advanced life support services, as defined by Section 1797.52, or both.

(b) Is operated by the State of California, any city, county, city and county, public district, or public authority.

HISTORY:
Added Stats 1986 ch 502 § 1.

§ 1349.2. Exemption of certain plans

(a) A health care service plan, including a self-insured reimbursement plan that pays for or reimburses any part of the cost of health care services, operated by any city, county, city and county, public entity, political subdivision, or public joint labor management trust that satisfies all of the following criteria is exempt from this chapter:

(1) Provides services or reimbursement only to employees, retirees, and the dependents of those employees and retirees, of any participating city, county, city and county, public entity, or political subdivision, but not to the general public.

(2) Provides funding for the program.

(3) Provides that providers are reimbursed solely on a fee-for-service basis, so that providers are not at risk in contracting arrangements.

(4) Complies with Section 1378 and, to the extent that a plan contracts directly with providers for health care services, complies with Section 1379.

(5) Does not reduce or change current benefits except in accordance with collective bargaining agreements, or as otherwise authorized by the governing body in the case of unrepresented employees, and provides, pays for, or reimburses at least part of the cost of all basic health care services as defined in subdivision (b) of Section 1345. Plans covering only a single specialized health care service, including dental, vision, or mental health services, shall not be required to cover all basic health care services.

(6) Refrains from any conduct that constitutes fraud or dishonest dealing

or unfair competition, as defined by Section 17200 of the Business and Professions Code, and notifies enrollees of their right to file complaints with the director regarding any violation of this exemption.

(7) Maintains a fiscally sound operation and makes adequate provision against the risk of insolvency so that enrollees are not at risk, individually or collectively, as evidenced by audited financial statements submitted to the director as of the end of the plan's fiscal year, within 180 days after the close of that fiscal year. The financial statements shall be accompanied by a report, certificate, or opinion of an independent certified public accountant. The financial statements shall be prepared in accordance with generally accepted accounting principles. The audit shall be conducted in accordance with generally accepted auditing standards. However, audits of public entities or political subdivisions shall be conducted in accordance with governmental auditing standards. Upon request, the governing body of the plan shall provide copies thereof, without charge, to any enrollee or recognized and participating employee organization.

(8) Submits with the annual financial statements required under paragraph (7), a declaration, which shall conform to Section 2015.5 of the Code of Civil Procedure, executed by a plan official authorized by the governing body of the plan, that the plan complies with this subdivision.

(b) The director's responsibilities under this section shall be limited to enforcing compliance with this section. Nothing in this section shall impair or impede the director's enforcement authority or the remedies available under this chapter, including, but not limited to, the termination of the plan's exemption under this section.

(c) A public joint labor management trust is a trust maintained by one or more participating cities, counties, cities and counties, public entities, or political subdivisions that appoint management representatives, and one or more recognized and participating employee organizations representing the employees of one or more of the cities, counties, cities and counties, public entities, or political subdivisions that appoint labor representatives, in which the management representatives and the labor representatives have equal voting power in the operation of the trust.

(d) A public joint labor management trust shall not be deemed to provide services or reimbursement to the general public if, in addition to providing services or reimbursement to the persons described in paragraph (1) of subdivision (a), it provides services or reimbursement only to employees, retirees, and dependents of those employees and retirees, of the recognized and participating employee organizations or of the trust.

(e) Nothing in this section shall be construed to prohibit a recognized and participating employee organization from filing a complaint with the director regarding a violation of this section.

HISTORY:

Added Stats 1989 ch 1152 § 1, operative until December 31, 1992. Amended Stats 1990 ch 216 § 51 (SB 2510), operative until December 30, 1992; Stats 1992 ch 458 § 1 (SB 1664), effective August 7, 1992, operative until January 1, 1994; Stats 1993 ch 760 § 1 (SB 902), operative until January 1, 1996; Stats 1995 ch 756 § 1 (AB 1272), ch 757 § 1 (SB 957); Stats 1999 ch 525 § 50 (AB 78), operative July 1, 2000.

§ 1349.3. [Section repealed 2002.]

HISTORY:
Added Stats 1999 ch 529 § 2 (SB 260). Repealed, operative January 1, 2002, by its own terms. The repealed section related to ban on issuance of licenses with waivers and limited licenses relating to services to enrollees of another plan.

§ 1350. License requirement for sponsor of prescription drug plan

(a) Consistent with federal law, a sponsor of a prescription drug plan authorized by the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) shall hold a valid license as a health care service plan issued by the department or as a life and disability insurer by the Department of Insurance.

(b) An entity that is licensed as a health care service plan and that operates a prescription drug plan shall be subject to the provisions of this chapter, unless preempted by federal law.

HISTORY:
Added Stats 2005 ch 230 § 1 (AB 1359), effective September 6, 2005.

§ 1350.1. [Section repealed 1984.]

HISTORY:
Added Stats 1977 ch 818 § 4, effective September 16, 1977. Repealed Stats 1984 ch 844 § 3. The repealed section related to application of chapter to transitionally licensed plans.

§ 1351. Applications for licensure

Each application for licensure as a health care service plan or specialized health care service plan under this chapter shall be verified by an authorized representative of the applicant, and shall be in a form prescribed by the department. This application shall be accompanied by the fee prescribed by subdivision (a) of Section 1356 and shall set forth or be accompanied by each and all of the following:

(a) The basic organizational documents of the applicant; such as, the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments thereto.

(b) A copy of the bylaws, rules and regulations, or similar documents regulating the conduct of the internal affairs of the applicant.

(c) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, which shall include among others, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, each shareholder with over 5-percent interest in the case of a corporation, and all partners or members in the case of a partnership or association, and each person who has loaned funds to the applicant for the operation of its business.

(d) A copy of any contract made, or to be made, between the applicant and any provider of health care services, or persons listed in subdivision (c), or any other person or organization agreeing to perform an administrative

function or service for the plan. The director by rule may identify contracts excluded from this requirement and make provision for the submission of form contracts. The payment rendered or to be rendered to such provider of health care services shall be deemed confidential information that shall not be divulged by the director, except that such payment may be disclosed and become a public record in any legislative, administrative, or judicial proceeding or inquiry. The plan shall also submit the name and address of each physician employed by or contracting with the plan, together with his or her license number.

(e) A statement describing the plan, its method of providing for health care services and its physical facilities. If applicable, this statement shall include the health care delivery capabilities of the plan including the number of full-time and part-time primary physicians, the number of full-time and part-time and specialties of all nonprimary physicians; the numbers and types of licensed or state-certified health care support staff, the number of hospital beds contracted for, and the arrangements and the methods by which health care services will be provided. For purposes of this subdivision, primary physicians include general and family practitioners, internists, pediatricians, obstetricians, and gynecologists.

(f) A copy of the forms of evidence of coverage and of the disclosure forms or material which are to be issued to subscribers or enrollees of the plan.

(g) A copy of the form of the individual contract which is to be issued to individual subscribers and the form of group contract which is to be issued to any employers, unions, trustees, or other organizations.

(h) Financial statements accompanied by a report, certificate, or opinion of an independent certified public accountant. However, financial statements from public entities or political subdivisions of the state need not include a report, certificate, or opinion by an independent certified public accountant if the financial statement complies with such requirements as may be established by regulation of the director.

(i) A description of the proposed method of marketing the plan and a copy of any contract made with any person to solicit on behalf of the plan or a copy of the form of agreement used and a list of the contracting parties.

(j) A power of attorney duly executed by any applicant, not domiciled in this state, appointing the director the true and lawful attorney in fact of such applicant in this state for the purposes of service of all lawful process in any legal action or proceeding against the plan on a cause of action arising in this state.

(k) A statement describing the service area or areas to be served, including the service location for each provider rendering professional services on behalf of the plan and the location of any other plan facilities where required by the director.

(*l*) A description of enrollee-subscriber grievance procedures to be utilized as required by this chapter, and a copy of the form specified by subdivision (c) of Section 1368.

(m) A description of the procedures and programs for internal review of the quality of health care pursuant to the requirements set forth in this chapter.

(n) A description of the mechanism by which enrollees and subscribers

will be afforded an opportunity to express their views on matters relating to the policy and operation of the plan.

(o) Evidence of adequate insurance coverage or self-insurance to respond to claims for damages arising out of the furnishing of health care services.

(p) Evidence of adequate insurance coverage or self-insurance to protect against losses of facilities where required by the director.

(q) If required by the director by rule pursuant to Section 1376, a fidelity bond or a surety bond in the amount prescribed.

(r) Evidence of adequate workmen's compensation insurance coverage to protect against claims arising out of work-related injuries that might be brought by the employees and staff of a plan against the plan.

(s) All relevant information known to the applicant concerning whether the plan, its management company, or any other affiliate of the plan, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in the plan, management company, or other affiliate, has any of the following:

(1) Any history of noncompliance with applicable state or federal laws, regulations, or requirements related to providing, or arranging to provide for, health care services or benefits in this state or any other state.

(2) Any history of noncompliance with applicable state or federal laws, regulations, or requirements related to providing, or arranging to provide for, health care services or benefits authorized for reimbursement under the federal Medicare or Medicaid Program.

(3) Any history of noncompliance with applicable state or federal laws, regulations, or requirements related to providing, or arranging for the provision of, health care services as a licensed health professional or an individual or entity contracting with a health care service plan or insurer in this state or any other state.

(t) Such other information as the director may reasonably require.

HISTORY:

Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1976 ch 652 § 1.5, effective August 28, 1976, operative July 1, 1976; Stats 1977 ch 818 § 5, effective September 16, 1977; Stats 1978 ch 285 § 2, effective June 23, 1978; Stats 1980 ch 1031 § 2; Stats 1999 ch 525 § 51 (AB 78), operative July 1, 2000; Stats 2006 ch 758 § 2 (AB 2667), effective January 1, 2007.

§ 1351.1. Authorization for disclosure

In addition to the requirements of Section 1351 and upon request of the director, each application shall be accompanied by authorization for disclosure to the director of financial records of each health care service plan or specialized health care service plan licensed under this chapter pursuant to Section 7473 of the Government Code. For the purpose of this chapter, the authorization for disclosure shall also include the financial records of any association, partnership or corporation controlling, controlled by or otherwise affiliated with a health care service plan or specialized health care service plan.

HISTORY:

Added Stats 1976 ch 1320 § 7. Amended Stats 1978 ch 812 § 1; Stats 1999 ch 525 § 52 (AB 78), operative July 1, 2000.

§ 1351.2. Mexican prepaid health plans; Application for licensure in California; Requirements; Fees; Actions to be taken when plan ceases to operate legally in Mexico

(a) If a prepaid health plan operating lawfully under the laws of Mexico elects to operate a health care service plan in this state, the prepaid health plan shall apply for licensure as a health care service plan under this chapter by filing an application for licensure in the form prescribed by the department and verified by an authorized representative of the applicant. The prepaid health plan shall be subject to the provisions of this chapter, and the rules adopted by the director thereunder, as determined by the director to be applicable. The application shall be accompanied by the fee prescribed by subdivision (a) of Section 1356 and shall demonstrate compliance with the following requirements:

(1) The prepaid health plan is constituted and operating lawfully under the laws of Mexico and, if required by Mexican law, is authorized as an Insurance Institution Specializing in Health by the Mexican Insurance Commission. If the Mexican Insurance Commission determines that the prepaid health plan is not required to be authorized as an Insurance Institution Specializing in Health under the laws of Mexico, the applicant shall obtain written verification from the Mexican Insurance Commission stating that the applicant is not required to be authorized as an Insurance Institution Specializing in Health in Mexico. A Mexican prepaid health plan that is not required to be an Insurance Institution Specializing in Health shall obtain written verification from the Mexican Ministry of Health that the prepaid health plan and its provider network are operating in full compliance of Mexican law.

(2) The prepaid health plan offers and sells in this state only employer-sponsored group plan contracts exclusively for the benefit of Mexican nationals legally employed in the County of San Diego or the County of Imperial, and for the benefit of their dependents regardless of nationality, that pay for, reimburse the cost of, or arrange for the provision or delivery of health care services that are to be provided or delivered wholly in Mexico, except for the provision or delivery of those health care services set forth in paragraph (4).

(3) Solicitation of plan contracts in this state is made only through insurance brokers and agents licensed in this state or a third-party administrator licensed in this state, each of which is authorized to offer and sell plan group contracts.

(4) Group contracts provide, through a contract of insurance between the prepaid health plan and an insurer admitted in this state, for the reimbursement of emergency and urgent care services provided out of area as required by subdivision (h) of Section 1345.

(5) All advertising, solicitation material, disclosure statements, evidences of coverage, and contracts are in compliance with the appropriate provisions of this chapter and the rules or orders of the director. The director shall require that each of these documents contain a legend in 10-point type, in both English and Spanish, declaring that the health care service plan contract provided by the prepaid health plan may be limited as to benefits, rights, and remedies under state and federal law.

(6) All funds received by the prepaid health plan from a subscriber are deposited in an account of a bank organized under the laws of this state or in an account of a national bank located in this state.

(7) The prepaid health plan maintains a tangible net equity as required by this chapter and the rules of the director, as calculated under United States generally accepted accounting principles, in the amount of a least one million dollars ($1,000,000). In lieu of an amount in excess of the minimum tangible net equity of one million dollars ($1,000,000), the prepaid health plan may demonstrate a reasonable acceptable alternative reimbursement arrangement that the director may in his or her discretion accept. The prepaid health plan shall also maintain a fidelity bond and a surety bond as required by Section 1376 and the rules of the director.

(8) The prepaid health plan agrees to make all of its books and records, including the books and records of health care providers in Mexico, available to the director in the form and at the time and place requested by the director. Books and records shall be made available to the director no later than 24 hours from the date of the request.

(9) The prepaid health plan files a consent to service of process with the director and agrees to be subject to the laws of this state and the United States in any investigation, examination, dispute, or other matter arising from the advertising, solicitation, or offer and sale of a plan contract, or the management or provision of health care services in this state or throughout the United States. The prepaid health plan shall agree to notify the director, immediately and in no case later than one business day, if it is subject to any investigation, examination, or administrative or legal action relating to the prepaid health plan or the operations of the prepaid health plan initiated by the government of Mexico or the government of any state of Mexico against the prepaid health plan or any officer, director, security holder, or contractor owning 10 percent or more of the securities of the prepaid health plan. The prepaid health plan shall agree that in the event of conflict of laws in any action arising out of the license, the laws of California and the United States shall apply.

(10) The prepaid health plan agrees that disputes arising from the group contracts involving group contractholders and providers of health care services in the United States shall be subject to the jurisdiction of the courts of this state and the United States.

(11) The prepaid health plan shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act for health care services set forth in paragraph (4). For health care services that are to be provided or delivered wholly in Mexico, the prepaid health plan may employ or designate a medical director operating under the laws of Mexico.

(b) The prepaid health plan shall pay the application processing fee and other fees and assessments set forth in Section 1356. The director, by order, may designate provisions of this chapter and rules adopted thereunder that need not be applied to a prepaid health plan licensed under the laws of Mexico when consistent with the intent and purpose of this chapter, and in the public interest.

(c) If the plan ceases to operate legally in Mexico, the director shall immediately deliver written notice to the health care service plan that it is not in compliance with the provisions of this section. If this occurs, a health care service plan shall do all of the following:

(1) Provide the director with written proof that the prepaid health plan has complied with the laws of Mexico not later than 45 days after the date the written notice is received by the health care service plan.

(2) If, by the 45th day, the health care service plan is unable to provide written confirmation that it is in full compliance with Mexican law, the director shall notify the health care service plan in writing that it is prohibited from accepting any new enrollees or subscribers. The health care service plan shall be given an additional 180 days to comply with Mexican law or to become a licensed health care service plan.

(3) If, at the end of the 180-day notice period in paragraph (2), the health care service plan has not complied with the laws of Mexico or California, the director shall issue an order that the health care service plan cease and desist operations in California.

HISTORY:
Added Stats 1998 ch 1025 § 2 (SB 1658). Amended Stats 1999 ch 83 § 96 (SB 966), ch 525 § 53 (AB 78), operative July 1, 2000; Stats 2003 ch 417 § 1 (SB 798); Stats 2004 ch 491 § 1 (SB 1347); Stats 2007 ch 196 § 1 (SB 192), effective January 1, 2008.

§ 1351.3. Effect of noncompliance

On and after January 1, 2007, the department, in considering an application for an initial license for any entity under this chapter, shall consider any information provided concerning whether the plan, its management company, or any other affiliate of the plan, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in the plan, management company, or affiliate has any history of noncompliance, as described in subdivision (s) of Section 1351, and any other relevant information concerning misconduct.

HISTORY:
Added Stats 2006 ch 758 § 3 (AB 2667), effective January 1, 2007.

§ 1352. Amendment for change in information

(a) A licensed plan shall, within 30 days after any change in the information contained in its application, other than financial or statistical information, file an amendment thereto in the manner the director may by rule prescribe setting forth the changed information. However, the addition of any association, partnership, or corporation in a controlling, controlled, or affiliated status relative to the plan shall necessitate filing, within a 30-day period of an authorization for disclosure to the director of financial records of the person pursuant to Section 7473 of the Government Code.

(b) Prior to a material modification of its plan or operations, a plan shall give notice thereof to the director, who shall, within 20 business days or such additional time as the plan may specify, by order approve, disapprove, suspend, or postpone the effectiveness of the change, subject to Section 1354.

(c) A plan shall, within five days, give written notice to the director in the form as by rule may be prescribed, of a change in the officers, directors, partners, controlling shareholders, principal creditors, or persons occupying similar positions or performing similar functions, of the plan and of a management company of the plan, and of a parent company of the plan or management company. The director may by rule define the positions, duties, and relationships which are referred to in this subdivision.

(d) The fee for filing a notice of material modification pursuant to subdivision (b) shall be the actual cost to the director of processing the notice, including overhead, but shall not exceed seven hundred fifty dollars ($750).

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1976 ch 1320 § 7.1; Stats 1989 ch 845 § 1; Stats 1999 ch 525 § 54 (AB 78), operative July 1, 2000; Stats 2007 ch 577 § 11 (AB 1750), effective October 13, 2007.

§ 1352.1. Filings and findings prior to specified acts

(a) Except as provided in subdivision (b), no plan shall enter into any new or modified plan contract or publish or distribute, or allow to be published or distributed on its behalf, any disclosure form or evidence of coverage, unless (1) a true copy thereof has first been filed with the director, at least 30 days prior to any such use, or any shorter period as the director by rule or order may allow, and (2) the director by notice has not found the plan contract, disclosure form, or evidence of coverage, wholly or in part, to be untrue, misleading, deceptive, or otherwise not in compliance with this chapter or the rules thereunder, and specified the deficiencies, within at least 30 days or any shorter time as the director by rule or order may allow.

(b) Except as provided in subdivision (c), a licensed plan which has been continuously licensed under this chapter for the preceding 18 months and which has had group contracts in effect at all times during that period may enter a new or modified group contract or may publish or distribute, or allow to be published or distributed on its behalf, any group disclosure form or evidence of coverage without having filed the same for the director's prior approval, if the plan and the materials comply with each of the following conditions:

(1) The contract, disclosure form, or evidence of coverage, or any material provision thereof, has not been previously disapproved by the director by written notice to the plan and the plan reasonably believes that the contract, disclosure form, and evidence of coverage do not violate any requirements of this chapter or the rules thereunder.

(2) The plan files the contract and any related disclosure form and evidence of coverage with the director not later than 10 business days after entering the contract, or within any additional period as the director by rule or order may provide.

(3) If the person or group entering into the contract with the plan is not an employee welfare benefit plan, as defined in the Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001 et seq.), the person or group is not organized solely or principally for the purpose of providing health benefits to members of the group.

(c) The director by order may require a plan which has entered any group contract or published or distributed, or allowed to be published or distributed

on its behalf, any disclosure form or evidence of coverage in violation of this chapter or the rules thereunder to comply with subdivision (a) prior to entering group contracts, or a specified class of group contracts, and prior to publishing or distributing, or allowing to be published or distributed on its behalf, related disclosure forms and evidences of coverage. An order issued pursuant to this subdivision shall be effective for 12 months from its issuance, and may be renewed by order if the contracts, disclosure forms, or evidences of coverage submitted under this subdivision indicate difficulties of voluntary compliance with the applicable provisions of this chapter and the rules thereunder.

(d) A licensed plan or other person regulated under this chapter may, within 30 days after receipt of any notice or order under this section, file a written request for a hearing with the director.

HISTORY:
Added Stats 1981 ch 662 § 2. Amended Stats 1986 ch 718 § 1; Stats 1999 ch 525 § 55 (AB 78), operative July 1, 2000.

§ 1353. Applicants to satisfy provisions of chapter

The director shall issue a license to any person filing an application pursuant to this article, if the director, upon due consideration of the application and of the information obtained in any investigation, including, if necessary, an onsite inspection, determines that the applicant has satisfied the provisions of this chapter and that, in the judgment of the director, a disciplinary action pursuant to Section 1386 would not be warranted against such applicant. Otherwise, the director shall deny the application.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1999 ch 525 § 56 (AB 78), operative July 1, 2000.

§ 1354. Denials of applications or disapprovals

Upon denial of application for licensure, or the issuance of an order pursuant to Section 1352 disapproving, suspending, or postponing a material modification, the director shall notify the applicant in writing, stating the reason for the denial and that the applicant has the right to a hearing if the applicant makes written request within 30 days after the date of mailing of the notice of denial. Service of the notice required by this subdivision may be made by certified mail addressed to the applicant at the latest address filed by the applicant in writing with the department.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1999 ch 525 § 57 (AB 78), operative July 1, 2000.

§ 1355. Duration of license

Every plan's license issued under this chapter shall remain in effect until revoked or suspended by the director, except that every transitional license shall expire on September 30, 1978, unless such expiration date is extended by the director.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1977 ch 818 § 7, effective September 16, 1977; Stats 1999 ch 525 § 58

(AB 78), operative July 1, 2000.

§ 1356. Fees and reimbursements

(a) Each plan applying for licensure under this chapter shall reimburse the director for the actual cost of processing the application, including overhead, up to an amount not to exceed twenty-five thousand dollars ($25,000). The cost shall be billed not more frequently than monthly and shall be remitted by the applicant to the director within 30 days of the date of billing. The director shall not issue a license to an applicant prior to receiving payment in full from that applicant for all amounts charged pursuant to this subdivision.

(b)(1) In addition to other fees and reimbursements required to be paid under this chapter, each licensed plan shall pay to the director an amount as estimated by the director for the ensuing fiscal year, as a reimbursement of its share of all costs and expenses, including, but not limited to, costs and expenses associated with routine financial examinations, grievances, and complaints including maintaining a toll-free telephone number for consumer grievances and complaints, investigation and enforcement, medical surveys and reports, and overhead reasonably incurred in the administration of this chapter and not otherwise recovered by the director under this chapter or from the Managed Care Fund. The amount may be paid in two equal installments. The first installment shall be paid on or before August 1 of each year, and the second installment shall be paid on or before December 15 of each year.

(2) The amount paid by each plan shall be ten thousand dollars ($10,000) plus an amount up to, but not exceeding, an amount computed in accordance with paragraph (3).

(3)(A) In addition to the amount specified in paragraph (2), all plans, except specialized plans, shall pay 65 percent of the total amount of the department's costs and expenses for the ensuing fiscal year as estimated by the director. The amount per plan shall be calculated on a per enrollee basis as specified in paragraph (4).

(B) In addition to the amount specified in paragraph (2), all specialized plans shall pay 35 percent of the total amount of the department's costs and expenses for the ensuing fiscal year as estimated by the director. The amount per plan shall be calculated on a per enrollee basis as specified in paragraph (4).

(4) The amount paid by each plan shall be for each enrollee enrolled in its plan in this state as of the preceding March 31, and shall be fixed by the director by notice to all licensed plans on or before June 15 of each year. A plan that is unable to report the number of enrollees enrolled in the plan because it does not collect that data, shall provide the director with an estimate of the number of enrollees enrolled in the plan and the method used for determining the estimate. The director may, upon giving written notice to the plan, revise the estimate if the director determines that the method used for determining the estimate was not reasonable.

(5) In determining the amount assessed, the director shall consider all appropriations from the Managed Care Fund for the support of this chapter and all reimbursements provided for in this chapter.

(c) Each licensed plan shall also pay two thousand dollars ($2,000), plus an amount up to, but not exceeding, forty-eight hundredths of one cent ($0.0048), for each enrollee for the purpose of reimbursing its share of all costs and expenses, including overhead, reasonably anticipated to be incurred by the department in administering Sections 1394.7 and 1394.8 during the current fiscal year. The amount charged shall be remitted within 30 days of the date of billing.

(d) In no case shall the reimbursement, payment, or other fee authorized by this section exceed the cost, including overhead, reasonably incurred in the administration of this chapter.

(e) For the purpose of calculating the assessment under this section, an enrollee who is enrolled in one plan and who receives health care services under arrangements made by another plan or plans, whether pursuant to a contract, agreement, or otherwise, shall be considered to be enrolled in each of the plans.

(f) On and after January 1, 2009, no refunds or reductions of the amounts assessed shall be allowed if any miscalculated assessment is based on a plan's overestimate of enrollment.

HISTORY:
Added Stats 2003 ch 12 § 2 (SB 580), effective May 28, 2003, operative July 1, 2003. Amended Stats 2008 ch 607 § 2 (SB 1379), effective September 30, 2008.

§ 1356.1. Excess charges or assessments

Notwithstanding subdivision (f) of Section 1356, as amended by Section 2.5 of Chapter 722 of the Statutes of 1991, and subdivision (d) of Section 1356, as amended by Section 3 of Chapter 722 of the Statutes of 1991, if the director determines that the charges and assessments set forth in this chapter for any year are in excess of the amount necessary, or are insufficient, to meet the expenses of administration of this chapter, for that year, the assessments and charges for the following year shall be adjusted on a pro rata basis in accordance with the percentage of the excess or insufficiency as related to the actual charges and assessments for the year for which the excess or insufficiency occurred, in order to recover the actual costs of administration.

HISTORY:
Added Stats 1991 ch 722 § 4 (AB 1669). Amended Stats 1992 ch 427 § 84 (AB 3355); Stats 1999 ch 525 § 60 (AB 78), operative July 1, 2000.

§ 1356.2. Imposition of additional assessment

The director, by notice to all licensed health care service plans on or before October 15, 2010, may require health care service plans to pay an additional assessment to provide the department with sufficient revenues to support costs and expenses of the department as set forth in subdivision (b) of Section 1341.4 and Section 1356 for the 2010-11 fiscal year. The assessment paid pursuant to this section shall be separate and independent of the assessment imposed pursuant to subdivision (b) of Section 1356 and shall not be aggregated with the assessment imposed pursuant to subdivision (b) of Section 1356 for the purposes of limitation or otherwise. The assessment paid pursuant to this section shall not be subject to the limitations imposed on assessments

pursuant to Section 1356.1. In imposing an assessment pursuant to this section, the director shall levy on each health care service plan an amount determined by the director using the categories of plans in the schedules set forth in subdivision (b) of Section 1356. The assessments imposed pursuant to this section shall be paid in full by December 1, 2010. On and after July 1, 2011, and until August 31, 2015, the director may raise the assessment limit described in subdivision (b) of Section 1356 to incorporate the annual expenditure levels set forth in this section.

HISTORY:
Added Stats 2010 ch 717 § 11 (SB 853), effective October 19, 2010.

ARTICLE 3.1

Small Employer Group Access to Contracts for Health Care Services

Section
1357. Definitions.
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1357.12. Requirements for premiums.
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1357.16. Provision of administrative services by qualified associations.
1357.17. Regulations.
1357.18. [Section repealed 2007.]
1357.19. Applicability.

HISTORY: Added Stats 1992 ch 1128 § 5, operative July 1, 1993.

§ 1357. Definitions

As used in this article:

(a) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health care plan contract covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (o).

(b) "Eligible employee" means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal

workweek of at least 30 hours, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term does not include sole proprietors or the spouses of those sole proprietors, partners of a partnership or the spouses of those partners, or employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association are eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are eligible employees if all four of the following apply:

(A) They otherwise meet the definition of an eligible employee except for the number of hours worked.

(B) The employer offers the employees health coverage under a health benefit plan.

(C) All similarly situated individuals are offered coverage under the health benefit plan.

(D) The employee shall have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The health care service plan may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

(2) Any member of a guaranteed association as defined in subdivision (o).

(c) "In force business" means an existing health benefit plan contract issued by the plan to a small employer.

(d) "Late enrollee" means an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's plan contract and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, any other person eligible for coverage through a guaranteed association pursuant to subdivision (o), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) He or she was covered under another employer health benefit plan, the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or the Medi-Cal program at the time the individual was eligible to enroll.

(B) He or she certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy

Families Program, the AIM Program, or the Medi-Cal program was the reason for declining enrollment, provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) He or she has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, or divorce; or he or she has lost or will lose coverage under the Healthy Families Program, the AIM Program, or the Medi-Cal program.

(D) He or she requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within 60 days after termination of Medi-Cal program coverage, AIM Program coverage, or Healthy Families Program coverage.

(2) The employer offers multiple health benefit plans and the employee elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan.

(4)(A) In the case of an eligible employee, as defined in paragraph (1) of subdivision (b), the plan cannot produce a written statement from the employer stating that the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed, acknowledgment of an explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion, unless the individual meets the criteria specified in paragraph (1), (2), or (3).

(B) In the case of an association member who did not purchase coverage through a guaranteed association, the plan cannot produce a written statement from the association stating that the association sent a written notice in boldface type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the member can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or meets the requirements of paragraph (2) or (3).

(C) In the case of an employer or person who is not a member of an association, was eligible to purchase coverage through a guaranteed

association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association, the employer or person can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1), or meets the requirements of paragraph (2) or (3), or that he or she recently had a change in status that would make him or her eligible and that application for enrollment was made within 30 days of the change.

(5) The individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision and the coverage under that provision has been exhausted. For purposes of this section, the definition of "COBRA" set forth in subdivision (e) of Section 1373.621 shall apply.

(6) The individual is a dependent of an enrolled eligible employee who has lost or will lose his or her coverage under the Healthy Families Program, the AIM Program, or the Medi-Cal program and requests enrollment within 60 days after termination of that coverage.

(7) The individual is an eligible employee who previously declined coverage under an employer health benefit plan and who has subsequently acquired a dependent who would be eligible for coverage as a dependent of the employee through marriage, birth, adoption, or placement for adoption, and who enrolls for coverage under that employer health benefit plan on his or her behalf and on behalf of his or her dependent within 30 days following the date of marriage, birth, adoption, or placement for adoption, in which case the effective date of coverage shall be the first day of the month following the date the completed request for enrollment is received in the case of marriage, or the date of birth, or the date of adoption or placement for adoption, whichever applies. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(8) The individual is an eligible employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan at the time of the previous enrollment period. That individual may enroll himself or herself or his or her dependents for plan coverage during a special open enrollment opportunity if his or her dependents have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the employee not more than 30 days after the date that the other health coverage is exhausted or terminated. Upon enrollment, coverage shall be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(e) "New business" means a health care service plan contract issued to a small employer that is not the plan's in force business.

(f) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period

following the employee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(g) "Creditable coverage" means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(3) The Medicaid program pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) Chapter 55 (commencing with Section 1071) of Title 10 of the United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under Chapter 89 (commencing with Section 8901) of Title 5 of the United States Code (Federal Employees Health Benefits Program (FEHBP)).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the federal Public Health Service Act, as amended by Public Law 104-191, the federal Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the federal Peace Corps Act (22 U.S.C. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(c)).

(h) "Rating period" means the period for which premium rates established by a plan are in effect and shall be no less than six months.

(i) "Risk adjusted employee risk rate" means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.

(j) "Risk adjustment factor" means the percentage adjustment to be applied equally to each standard employee risk rate for a particular small

employer, based upon any expected deviations from standard cost of services. The factor may not be more than 110 percent or less than 90 percent.

(k) "Risk category" means the following characteristics of an eligible employee: age, geographic region, and family composition of the employee, plus the health benefit plan selected by the small employer.

(1) No more than the following age categories may be used in determining premium rates:

Under 30
30-39
40-49
50-54
55-59
60-64
65 and over.

However, for the 65 years of age and over category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided by the Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(2) Small employer health care service plans shall base rates to small employers using no more than the following family size categories:

(A) Single.
(B) Married couple.
(C) One adult and child or children.
(D) Married couple and child or children.

(3)(A) In determining rates for small employers, a plan that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and divide no county into more than two regions. Plans shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state's population. Geographic regions established pursuant to this section shall, as a group, cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

(B)(i) In determining rates for small employers, a plan that does not operate statewide shall use no more than the number of geographic regions in the state that is determined by the following formula: the population, as determined in the last federal census, of all counties that are included in their entirety in a plan's service area divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. No region may be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. A plan shall not have less than one geographic area.

(ii) If the formula in clause (i) results in a plan that operates in more than one county having only one geographic region, then the formula in clause (i) shall not apply and the plan may have two geographic regions, provided that no county is divided into more than one region.

This section does not require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan's existing service area.

(*l*) "Small employer" means either of the following:

(1) Any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least two, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a health care service plan shall use the test that ensures eligibility if only one test would establish eligibility. However, for purposes of subdivisions (a), (b), and (c) of Section 1357.03, the definition shall include employers with at least two eligible employees. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, any employer purchasing coverage for employees through a guaranteed association, and any small employer as defined in this paragraph who purchases coverage through any arrangement.

(2) Any guaranteed association, as defined in subdivision (n), that purchases health coverage for members of the association.

(m) "Standard employee risk rate" means the rate applicable to an eligible employee in a particular risk category in a small employer group.

(n) "Guaranteed association" means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that (1) includes one or more small employers as defined in paragraph (1) of subdivision (*l*), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered to the association, (4) is organized and

maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has included health insurance as a membership benefit for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any plan contract that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the plan contracts offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the health care service plan with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

This subdivision applies regardless of whether a contract issued by a plan is with an association, or a trust formed for or sponsored by an association, to administer benefits for association members.

For purposes of this subdivision, an association formed by a merger of two or more associations after January 1, 1992, and otherwise meeting the criteria of this subdivision shall be deemed to have been in active existence on January 1, 1992, if its predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and otherwise met the criteria of this subdivision.

(o) "Members of a guaranteed association" means any individual or employer meeting the association's membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association's discretion, it also may include employees of association members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include these persons as members of the guaranteed association, the association shall make that election in advance of purchasing a plan contract. Health care service plans may require an association to adhere to the membership composition it selects for up to 12 months.

(p) "Affiliation period" means a period that, under the terms of the health care service plan contract, is required to elapse before health care services under the contract become effective.

HISTORY:

Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993. Amended Stats 1993 ch 113 § 1 (AB 1742), effective July 12, 1993, ch 217 § 1 (AB 2059), effective July 26, 1993, ch 1146 § 1 (AB 28), effective October 10, 1993; Stats 1994 ch 146 § 97 (AB 3601); Stats 1995 ch 668 § 1 (AB 503); Stats 1996 ch 359 § 1 (AB 8), ch 360 § 1 (SB 371), ch 1062 § 16.5 (AB 1832); Stats 1997 ch 336 § 1 (SB 578), effective August 21, 1997, ch 581 § 1 (SB 392); Stats 1998 ch 418 § 1 (SB 1790); Stats 1999 ch 434 § 1 (SB 737); Stats 2000 ch 389 § 1 (SB 195); Stats 2005 ch 542 § 2 (AB 1533), effective January 1, 2006; Stats 2009 ch 542 § 2 (AB 1541), effective January 1, 2010; Stats 2010 ch 328 § 114 (SB 1330), effective January 1, 2011; Stats 2018 ch 700 § 1 (SB 1375), effective January 1, 2019.

§ 1357.01. Compliance with article

Every health care service plan offering plan contracts to small employer

groups shall in addition to complying with the provisions of this chapter and the rules adopted thereunder comply with the provisions of this article.

HISTORY:
Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993.

§ 1357.02. Application of article

(a) A health care service plan providing or arranging for the provision of basic health care services to small employers shall be subject to this article if either of the following conditions are met:

(1) Any portion of the premium is paid by a small employer, or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium.

(2) The plan contract is treated by the small employer or any of the covered individuals as part of a plan or program for the purposes of Section 106 or 162 of the Internal Revenue Code.

(b) This article shall not apply to health plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, Medi-Cal contracts with the State Department of Health Services, long-term care coverage, or specialized health plan contracts.

HISTORY:
Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993. Amended Stats 1993 ch 1146 § 1.2 (AB 28), effective October 10, 1993.

§ 1357.025. Construction of article

Nothing in this article shall be construed to preclude the application of this chapter to either of the following:

(a) An association, trust, or other organization acting as a "health care service plan" as defined under Section 1345.

(b) An association, trust, or other organization or person presenting information regarding a health care service plan to persons who may be interested in subscribing or enrolling in the plan.

HISTORY:
Added Stats 1993 ch 1146 § 1.4 (AB 28), effective October 10, 1993.

§ 1357.03. Sale of contracts to small employers; Filing of employee participation and employer contribution requirements; Rejection of application; Prohibited activities

(a)(1) Upon the effective date of this article, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are sold to small employers or to associations that include small employers to all small employers in each service area in which the plan provides or arranges for the provision of health care services.

(2) Each plan shall make available to each small employer all small employer health care service plan contracts that the plan offers and sells to small employers or to associations that include small employers in this state.

(3) No plan or solicitor shall induce or otherwise encourage a small

employer to separate or otherwise exclude an eligible employee from a health care service plan contract that is provided in connection with the employee's employment or membership in a guaranteed association.

(4) A plan contracting to participate in the voluntary purchasing pool for small employers provided for under Article 4 (commencing with Section 10730) of Chapter 8 of Part 2 of Division 2 of the Insurance Code shall be deemed in compliance with the requirements of paragraph (1) for a contract offered through the voluntary purchasing pool established under Article 4 (commencing with Section 10730) of Chapter 8 of Part 2 of Division 2 of the Insurance Code in those geographic regions in which plans participate in the pool, if the contract is offered exclusively through the pool.

(5)(A) A plan shall be deemed to meet the requirements of paragraphs (1) and (2) with respect to a plan contract that qualifies as a grandfathered health plan under Section 1251 of PPACA if all of the following requirements are met:

(i) The plan offers to renew the plan contract, unless the plan withdraws the plan contract from the small employer market pursuant to subdivision (e) of Section 1357.11.

(ii) The plan provides appropriate notice of the grandfathered status of the contract in any materials provided to an enrollee of the contract describing the benefits provided under the contract, as required under PPACA.

(iii) The plan makes no changes to the benefits covered under the plan contract other than those required by a state or federal law, regulation, rule, or guidance and those permitted to be made to a grandfathered health plan under PPACA.

(B) For purposes of this paragraph, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder. For purposes of this paragraph, a "grandfathered health plan" shall have the meaning set forth in Section 1251 of PPACA.

(b) Every plan shall file with the director the reasonable employee participation requirements and employer contribution requirements that will be applied in offering its plan contracts. Participation requirements shall be applied uniformly among all small employer groups, except that a plan may vary application of minimum employee participation requirements by the size of the small employer group and whether the employer contributes 100 percent of the eligible employee's premium. Employer contribution requirements shall not vary by employer size. A health care service plan shall not establish a participation requirement that (1) requires a person who meets the definition of a dependent in subdivision (a) of Section 1357 to enroll as a dependent if he or she is otherwise eligible for coverage and wishes to enroll as an eligible employee and (2) allows a plan to reject an otherwise eligible small employer because of the number of persons that waive coverage due to coverage through another employer. Members of an association eligible for health coverage under subdivision (o) of Section 1357, but not electing any health coverage through the association, shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a plan's reasonable participation standards.

(c) The plan shall not reject an application from a small employer for a health care service plan contract if all of the following are met:

(1) The small employer, as defined by paragraph (1) of subdivision (*l*) of Section 1357, offers health benefits to 100 percent of its eligible employees, as defined by paragraph (1) of subdivision (b) of Section 1357. Employees who waive coverage on the grounds that they have other group coverage shall not be counted as eligible employees.

(2) The small employer agrees to make the required premium payments.

(3) The small employer agrees to inform the small employers' employees of the availability of coverage and the provision that those not electing coverage must wait one year to obtain coverage through the group if they later decide they would like to have coverage.

(4) The employees and their dependents who are to be covered by the plan contract work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.

(d) No plan or solicitor shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct small employers to refrain from filing an application for coverage with a plan because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(2) Encourage or direct small employers to seek coverage from another plan or the voluntary purchasing pool established under Article 4 (commencing with Section 10730) of Chapter 8 of Part 2 of Division 2 of the Insurance Code because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(e) A plan shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(f) A policy or contract that covers two or more employees shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(g) A plan shall comply with the requirements of Section 1374.3.

HISTORY:
Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993. Amended Stats 1993 ch 113 § 2 (AB 1742), effective July 12, 1993, ch 1146 § 2 (AB 28), effective October 10, 1993; Stats 1994 ch 147 § 5 (AB 2377), effective July 9, 1994; Stats 1997 ch 336 § 2 (SB 578), effective August 21, 1997; Stats 1999 ch 525 § 61 (AB 78), operative July 1, 2000; Stats 2008 ch 179 § 138 (SB 1498), effective January 1, 2009; Stats 2010 ch 661 § 1 (SB 1163), effective January 1, 2011.

§ 1357.035. Small employer coverage for associations with fewer than 1,000 persons

(a) Between July 26, 1993, and October 24, 1993, as well as 60 days prior to the expiration of an existing plan contract that expires prior to July 1, 1994, or, for plan contracts expiring after July 1, 1994, 60 days prior to July 1, 1994, an association that meets the definition of guaranteed association, as set forth in Section 1357, except for the requirement that 1,000 persons be covered, shall be entitled to purchase small employer health coverage as if the association were a guaranteed association, except that the coverage shall be guaranteed only for those members of an association, as defined in Section 1357, (1) who were receiving coverage or had successfully applied for coverage through the association as of June 30, 1993,(2) who were receiving coverage through the association as of December 31, 1992, and whose coverage lapsed at any time thereafter because the employment through which coverage was received ended or an employer's contribution to health coverage ended, or (3) who were covered at any time between June 30, 1993, and July 1, 1994, under a contract that was in force on June 30, 1993.

(b) An association obtaining health coverage for its members pursuant to this section shall otherwise be afforded all the rights of a guaranteed association under this chapter including, but not limited to, guaranteed renewability of coverage.

(c) No later than August 25, 1993, plans that, at any time during the 1993 calendar year have provided coverage to associations that would be eligible for coverage under this section shall notify those associations of their rights under this section. Ninety days prior to the expiration of a plan contract that expires prior to July 1, 1994, or, for plan contracts expiring after July 1, 1994, 90 days prior to July 1, 1994, health plans that have in force coverage with an association that would be eligible for coverage under this section shall notify the association of its rights under this section.

HISTORY:
Added Stats 1993 ch 217 § 2 (AB 2059), effective July 26, 1993. Amended Stats 1993 ch 1146 § 2.5 (AB 28), effective October 10, 1993.

§ 1357.04. Notification of premium charges; When coverage becomes effective; Option to change coverage

(a) After a small employer submits a completed application form for a plan contract, the plan shall, within 30 days, notify the employer of the employer's actual premium charges for that plan contract established in accordance with Section 1357.12. The employer shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(b) When a small employer submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked,

whichever occurs earlier, within the first 15 days of the month, coverage under the plan contract shall become effective no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(c) During the first 30 days after the effective date of the plan contract, the small employer shall have the option of changing coverage to a different plan contract offered by the same health care service plan. If a small employer notifies the plan of the change within the first 15 days of a month, coverage under the new plan contract shall become effective no later than the first day of the following month. If a small employer notifies the plan of the change after the 15th day of a month, coverage under the new plan contract shall become effective no later than the first day of the second month following notification.

HISTORY:
Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993. Amended Stats 1993 ch 113 § 2.5 (AB 1742), effective July 12, 1993.

§ 1357.05. Exclusion of employee or dependent; Limitation on exclusion of coverage

Except in the case of a late enrollee, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a plan may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that employee or dependent. No plan contract may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted by Section 1357.06.

HISTORY:
Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993. Amended Stats 1995 ch 668 § 2 (AB 503).

§ 1357.06. Preexisting condition provisions

(a)(1) Preexisting condition provisions of a plan contract shall not exclude coverage for a period beyond six months following the individual's effective date of coverage and may only relate to conditions for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(2) Notwithstanding paragraph (1), a plan contract offered to a small employer shall not impose any preexisting condition provision upon any child under 19 years of age.

(b) A plan that does not utilize a preexisting condition provision may impose a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period no premiums shall be charged to the enrollee or the subscriber.

(c) In determining whether a preexisting condition provision or a waiting or affiliation period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination

of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the plan, including any affiliation or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

(d) In addition to the preexisting condition exclusions authorized by subdivision (a) and the waiting or affiliation period authorized by subdivision (b), health plans providing coverage to a guaranteed association may impose on employers or individuals purchasing coverage who would not be eligible for guaranteed coverage if they were not purchasing through the association a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, no premiums shall be charged to the enrollee or the subscriber.

(e) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(e)).

(f) A health care service plan issuing group coverage may not impose a preexisting condition exclusion to a condition relating to benefits for pregnancy or maternity care.

HISTORY:
Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993. Amended Stats 1993 ch 1146 § 3 (AB 28), effective October 10, 1993; Stats 1994 ch 484 § 1 (AB 3655); Stats 1997 ch 336 § 3 (SB 578), effective August 21, 1997; Stats 1998 ch 107 § 1 (AB 112), effective July 6, 1998; Stats 2010 ch 656 § 1 (AB 2244), effective January 1, 2011.

§ 1357.07. Late enrollees

No plan contract may exclude late enrollees from coverage for more than 12 months from the date of the late enrollees application for coverage. No premium shall be charged to the late enrollee until the exclusion period has ended.

HISTORY:
Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993.

§ 1357.08. Services to be provided

All health care service plan contracts offered to a small employer shall provide to subscribers and enrollees at least all of the basic health care services included in subdivision (b) of Section 1345, and in Section 1300.67 of the California Code of Regulations.

HISTORY:
Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993.

§ 1357.09. When plan not required to offer contract

No plan shall be required to offer a health care service plan contract or accept applications for the contract pursuant to this article in the case of any of the following:

(a) To a small employer, if the small employer is not physically located in a plan's approved service areas, or if an eligible employee and dependents who are to be covered by the plan contract do not work or reside within a plan's approved service areas.

(b)(1) Within a specific service area or portion of a service area, if a plan reasonably anticipates and demonstrates to the satisfaction of the director that it will not have sufficient health care delivery resources to assure that health care services will be available and accessible to the eligible employee and dependents of the employee because of its obligations to existing enrollees.

(2) A plan that cannot offer a health care service plan contract to small employers because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a contract in the area in which the plan is not offering coverage to small employers to new employer groups with more than 50 eligible employees until the plan notifies the director that it has the ability to deliver services to small employer groups, and certifies to the director that from the date of the notice it will enroll all small employer groups requesting coverage in that area from the plan unless the plan has met the requirements of subdivision (d).

(3) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity has become impaired.

(c) Offer coverage to a small employer or an eligible employee as defined under paragraph (2) of subdivision (b) of Section 1357 that, within 12 months of application for coverage, disenrolled from a plan contract offered by the plan.

(d)(1) The director approves the plan's certification that the number of eligible employees and dependents enrolled under contracts issued during the current calendar year equals or exceeds either of the following:

(A) In the case of a plan that administers any self-funded health coverage arrangements in California, 10 percent of the total enrollment of the plan in California as of December 31 of the preceding year.

(B) In the case of a plan that does not administer any self-funded health coverage arrangements in California, 8 percent of the total enrollment of the plan in California as of December 31 of the preceding year. If that certification is approved, the plan shall not offer any health care service plan contract to any small employers during the remainder of the current year.

(2) If a health care service plan treats an affiliate or subsidiary as a separate carrier for the purpose of this article because one health care

service plan is qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and does not offer coverage to small employers, while the affiliate or subsidiary offers a plan contract that is not qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and offers plan contracts to small employers, the health care service plan offering coverage to small employers shall enroll new eligible employees and dependents, equal to the applicable percentage of the total enrollment of both the health care service plan qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and its affiliate or subsidiary.

(3)(A) The certified statement filed pursuant to this subdivision shall state the following:

(i) Whether the plan administers any self-funded health coverage arrangements in California.

(ii) The plan's total enrollment as of December 31 of the preceding year.

(iii) The number of eligible employees and dependents enrolled under contracts issued to small employer groups during the current calendar year.

(B) The director shall, within 45 days, approve or disapprove the certified statement. If the certified statement is disapproved, the plan shall continue to issue coverage as required by Section 1357.03 and be subject to disciplinary action as set forth in Article 7 (commencing with Section 1386).

(e) A health care service plan that, as of December 31 of the prior year, had a total enrollment of fewer than 100,000 and 50 percent or more of the plan's total enrollment have premiums paid by the Medi-Cal program.

(f) A social health maintenance organization, as described in subdivision (a) of Section 2355 of the federal Deficit Reduction Act of 1984 (P.L. 98-369), that, as of December 31 of the prior year, had a total enrollment of fewer than 100,000 and has 50 percent or more of the organization's total enrollment premiums paid by the Medi-Cal program or Medicare programs, or by a combination of Medi-Cal and Medicare. In no event shall this exemption be based upon enrollment in Medicare supplement contracts, as described in Article 3.5 (commencing with Section 1358).

HISTORY:

Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993. Amended Stats 1993 ch 113 § 3 (AB 1742), effective July 12, 1993, ch 1146 § 3.5 (AB 28), effective October 10, 1993; Stats 1999 ch 83 § 97 (SB 966), ch 525 § 62 (AB 78), operative July 1, 2000; Stats 2006 ch 538 § 353 (SB 1852), effective January 1, 2007.

§ 1357.10. Requirement that plan discontinue offering contracts or accepting applications

The director may require a plan to discontinue the offering of contracts or acceptance of applications from any small employer or group with more than 50 employees upon a determination by the director that the plan does not have sufficient financial viability, or organizational and administrative capacity to assure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of

Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

HISTORY:
Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993. Amended Stats 1999 ch 525 § 63 (AB 78), operative July 1, 2000.

§ 1357.11. [Section repealed 2011.]

HISTORY:
Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993. Amended Stats 1993 ch 1146 § 4 (AB 28), effective October 10, 1993; Stats 1997 ch 336 § 4 (SB 578), effective August 21, 1997; Stats 1999 ch 525 § 64 (AB 78), operative July 1, 2000; Repealed Stats 2010 ch 658 § 1 (AB 2470), effective January 1, 2011. The repealed section related to renewability of contracts.

§ 1357.12. Requirements for premiums

Premiums for contracts offered or delivered by plans on or after the effective date of this article shall be subject to the following requirements:

(a)(1) The premium for new business shall be determined for an eligible employee in a particular risk category after applying a risk adjustment factor to the plan's standard employee risk rates. The risk adjusted employee risk rate may not be more than 120 percent or less than 80 percent of the plan' s applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent.

(2) The premium charged a small employer for new business shall be equal to the sum of the risk adjusted employee risk rates.

(3) The standard employee risk rates applied to a small employer for new business shall be in effect for no less than six months.

(b)(1) The premium for in force business shall be determined for an eligible employee in a particular risk category after applying a risk adjustment factor to the plan's standard employee risk rates. The risk adjusted employee risk rates may not be more than 120 percent or less than 80 percent of the plan' s applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. The factor effective July 1, 1996, shall apply to in force business at the earlier of either the time of renewal or July 1, 1997. The risk adjustment factor applied to a small employer may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period. The risk adjustment factor for a small employer may not be modified more frequently than every 12 months.

(2) The premium charged a small employer for in force business shall be equal to the sum of the risk adjusted employee risk rates. The standard employee risk rates shall be in effect for no less than six months.

(3) For a contract that a plan has discontinued offering, the risk adjustment factor applied to the standard employee risk rates for the first rating period of the new contract that the small employer elects to purchase shall be no greater than the risk adjustment factor applied in the prior rating period to the discontinued contract. However, the risk adjusted employee risk rate may not be more than 120 percent or less than 80 percent of the plan's applicable standard employee risk rate until July

1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. The factor effective July 1, 1996, shall apply to in force business at the earlier of either the time of renewal or July 1, 1997. The risk adjustment factor for a small employer may not be modified more frequently than every 12 months.

(c)(1) For any small employer, a plan may, with the consent of the small employer, establish composite employee and dependent rates for either new business or renewal of in force business. The composite rates shall be determined as the average of the risk adjusted employee risk rates for the small employer, as determined in accordance with the requirements of subdivisions (a) and (b). The sum of the composite rates so determined shall be equal to the sum of the risk adjusted employee risk rates for the small employer.

(2) The composite rates shall be used for all employees and dependents covered throughout a rating period of no less than six months nor more than 12 months, except that a plan may reserve the right to redetermine the composite rates if the enrollment under the contract changes by more than a specified percentage during the rating period. Any redetermination of the composite rates shall be based on the same risk adjusted employee risk rates used to determine the initial composite rates for the rating period. If a plan reserves the right to redetermine the rates and the enrollment changes more than the specified percentage, the plan shall redetermine the composite rates if the redetermined rates would result in a lower premium for the small employer. A plan reserving the right to redetermine the composite rates based upon a change in enrollment shall use the same specified percentage to measure that change with respect to all small employers electing composite rates.

HISTORY:
Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993. Amended Stats 1993 ch 113 § 4 (AB 1742), effective July 12, 1993, ch 1146 § 4.5 (AB 28), effective October 10, 1993; Stats 1995 ch 668 § 3 (AB 503); Stats 1996 ch 50 § 1 (SB 849), effective May 24, 1996.

§ 1357.13. Risk rates to be applied

Plans shall apply standard employee risk rates consistently with respect to all small employers.

HISTORY:
Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993.

§ 1357.14. Disclosures required with offer of contract

In connection with the offering for sale of any plan contract to a small employer, each plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

(a) The extent to which premium rates for a specified small employer are established or adjusted in part based upon the actual or expected variation in service costs or actual or expected variation in health condition of the employees and dependents of the small employer.

(b) The provisions concerning the plan's right to change premium rates

and the factors other than provision of services experience that affect changes in premium rates.

(c) Provisions relating to the guaranteed issueand renewal of contracts.

(d) Provisions relating to the effect of any preexisting condition provision.

(e) Provisions relating to the small employer's right to apply for any contract written, issued, or administered by the plan at the time of application for a new health care service plan contract, or at the time of renewal of a health care service plan contract.

(f) The availability, upon request, of a listing of all the plan's contracts and benefit plan designs offered to small employers, including the rates for each contract.

(g) At the time it offers a contract to a small employer, each plan shall provide the small employer with a statement of all of its plan contracts offered to small employers, including the rates for each plan contract, in the service area in which the employer's employees and eligible dependents who are to be covered by the plan contract work or reside. For purposes of this subdivision, plans that are affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.

(h) Each plan shall do all of the following:

(1) Prepare a brochure that summarizes all of its plan contracts offered to small employers and to make this summary available to any small employer and to solicitors upon request. The summary shall include for each contract information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard employee risk rates, an explanation of the manner in which creditable coverage is calculated if a preexisting condition or affiliation period is imposed, and a phone number that can be called for more detailed benefit information. Plans are required to keep the information contained in the brochure accurate and up to date and, upon updating the brochure, send copies to solicitors and solicitor firms with whom the plan contracts to solicit enrollments or subscriptions.

(2) For each contract, prepare a more detailed evidence of coverage and make it available to small employers, solicitors, and solicitor firms upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making contract selections.

(3) Provide to small employers and solicitors, upon request, for any given small employer the sum of the standard employee risk rates and the sum of the risk adjusted employee risk rates. When requesting this information, small employers, solicitors, and solicitor firms shall provide the plan with the information the plan needs to determine the small employer's risk adjusted employee risk rate.

(4) Provide copies of the current summary brochure to all solicitors and solicitor firms contracting with the plan to solicit enrollments or subscriptions from small employers.

For purposes of this subdivision, plans that are affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.

(i) Every solicitor or solicitor firm contracting with one or more plans to

solicit enrollments or subscriptions from small employers shall do all of the following:

(1) When providing information on contracts to a small employer but making no specific recommendations on particular plan contracts:

(A) Advise the small employer of the plan's obligation to sell to any small employer any plan contract it offers to small employers and provide them, upon request, with the actual rates that would be charged to that employer for a given contract.

(B) Notify the small employer that the solicitor or solicitor firm will procure rate and benefit information for the small employer on any plan contract offered by a plan whose contract the solicitor sells.

(C) Notify the small employer that upon request the solicitor or solicitor firm will provide the small employer with the summary brochure required under paragraph (1) of subdivision (h) for any plan contract offered by a plan with whom the solicitor or solicitor firm has contracted with to solicit enrollments or subscriptions.

(2) When recommending a particular benefit plan design or designs, advise the small employer that, upon request, the agent will provide the small employer with the brochure required by paragraph (1) of subdivision (h) containing the benefit plan design or designs being recommended by the agent or broker.

(3) Prior to filing an application for a small employer for a particular contract:

(A) For each of the plan contracts offered by the plan whose contract the solicitor or solicitor firm is offering, provide the small employer with the benefit summary required in paragraph (1) of subdivision (h) and the sum of the standard employee risk rates for that particular employer.

(B) Notify the small employer that, upon request, the solicitor or solicitor firm will provide the small employer with an evidence of coverage brochure for each contract the plan offers.

(C) Notify the small employer that, from July 1, 1993, to July 1, 1996, actual rates may be 20 percent higher or lower than the sum of the standard employee risk rates, and from July 1, 1996, and thereafter, actual rates may be 10 percent higher or lower than the sum of the standard employee risk rates, depending on how the plan assesses the risk of the small employer's group.

(D) Notify the small employer that, upon request, the solicitor or solicitor firm will submit information to the plan to ascertain the small employer's sum of the risk adjusted employee risk rate for any contract the plan offers.

(E) Obtain a signed statement from the small employer acknowledging that the small employer has received the disclosures required by this section.

HISTORY:

Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993. Amended Stats 1993 ch 113 § 4.5 (AB 1742), effective July 12, 1993; Stats 1997 ch 336 § 5 (SB 578), effective August 21, 1997.

§ 1357.15. Notice of material modification; Amendments to plan; Maintenance of information; Availability of risk adjustment factor

(a) At least 20 business days prior to renewing or amending a plan contract subject to this article which will be in force on the operative date of this article, a plan shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (j) of Section 1357 and Section 1357.12. The certified statement shall set forth the standard employee risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be renewed or amended. Any action by the director, as permitted under Section 1352, to disapprove, suspend or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

(b) At least 20 business days prior to offering a plan contract subject to this article, all plans shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (j) of Section 1357 and Section 1357.12. The certified statement shall set forth the standard employee risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be offered. Plans that will be offering to a small employer plan contracts approved by the director prior to the effective date of this article shall file a notice of material modification in accordance with this subdivision. Any action by the director, as permitted under Section 1352, to disapprove, suspend or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

(c) Prior to making any changes in the risk categories, risk adjustment factors or standard employee risk rates filed with the director pursuant to subdivision (a) or (b), the plan shall file as an amendment a statement setting forth the changes and certifying that the plan is in compliance with subdivision (j) of Section 1357 and Section 1357.12. A plan may commence offering plan contracts utilizing the changed risk categories set forth in the certified statement on the 31st day from the date of the filing, or at an earlier time determined by the director, unless the director disapproves the amendment by written notice, stating the reasons therefor. If only the standard employee risk rate is being changed, and not the risk categories or risk adjustment factors, a plan may commence offering plan contracts utilizing the changed standard employee risk rate upon filing the certified statement unless the director disapproves the amendment by written notice.

(d) Periodic changes to the standard employee risk rate that a plan proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subdivision (a), (b), or (c).

(e) Each plan shall maintain at its principal place of business all of the information required to be filed with the director pursuant to this section.

(f) Each plan shall make available to the director, on request, the risk adjustment factor used in determining the rate for any particular small employer.

(g) Nothing in this section shall be construed to limit the director's authority to enforce the rating practices set forth in this article.

HISTORY:
Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993. Amended Stats 1999 ch 525 § 65 (AB 78), operative July 1, 2000.

§ 1357.16. Provision of administrative services by qualified associations

(a) Health care service plans may enter into contractual agreements with qualified associations, as defined in subdivision (b), under which these qualified associations may assume responsibility for performing specific administrative services, as defined in this section, for qualified association members. Health care service plans that enter into agreements with qualified associations for assumption of administrative services shall establish uniform definitions for the administrative services that may be provided by a qualified association or its third-party administrator. The health care service plan shall permit all qualified associations to assume one or more of these functions when the health care service plan determines the qualified association demonstrates the administrative capacity to assume these functions.

For the purposes of this section, administrative services provided by qualified associations or their third-party administrators shall be services pertaining to eligibility determination, enrollment, premium collection, sales, or claims administration on a per-claim basis that would otherwise be provided directly by the health care service plan or through a third-party administrator on a commission basis or an agent or solicitor workforce on a commission basis.

Each health care service plan that enters into an agreement with any qualified association for the provision of administrative services shall offer all qualified associations with which it contracts the same premium discounts for performing those services the health care service plan has permitted the qualified association or its third-party administrator to assume. The health care service plan shall apply these uniform discounts to the health care service plan's risk adjusted employee risk rates after the health plan has determined the qualified association's risk adjusted employee risk rates pursuant to Section 1357.12. The health care service plan shall report to the Department of Managed Health Care its schedule of discount for each administrative service.

In no instance may a health care service plan provide discounts to qualified associations that are in any way intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association. In addition to any other remedies available to the director to enforce this chapter, the director may declare a contract between a health care service plan and a qualified association for administrative services pursuant to this section null and void if the director determines any discounts provided to the qualified association are intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association.

(b) For the purposes of this section, a qualified association is a nonprofit corporation comprised of a group of individuals or employers who associate

based solely on participation in a specified profession or industry, that conforms to all of the following requirements:

(1) It accepts for membership any individual or small employer meeting its membership criteria.

(2) It does not condition membership directly or indirectly on the health or claims history of any person.

(3) It uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association.

(4) It is organized and maintained in good faith for purposes unrelated to insurance.

(5) It existed on January 1, 1972, and has been in continuous existence since that date.

(6) It has a constitution and bylaws or other analogous governing documents that provide for election of the governing board of the association by its members.

(7) It offered, marketed, or sold health coverage to its members for 20 continuous years prior to January 1, 1993.

(8) It agrees to offer only to association members any plan contract.

(9) It agrees to include any member choosing to enroll in the plan contract offered by the association, provided that the member agrees to make required premium payments.

(10) It complies with all provisions of this article.

(11) It had at least 10,000 enrollees covered by association sponsored plans immediately prior to enactment of Chapter 1128 of the Statutes of 1992.

(12) It applies any administrative cost at an equal rate to all members purchasing coverage through the qualified association.

(c) A qualified association shall comply with Section 1357.52.

HISTORY:

Added Stats 1996 ch 641 § 1 (AB 1360), operative until January 1, 2003. Amended Stats 1997 ch 336 § 6 (SB 578), effective August 21, 1997; Stats 1998 ch 107 § 2 (AB 112), effective July 6, 1998; Stats 1999 ch 525 § 66 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 30 (AB 2903), operative until January 1, 2003; Stats 2002 ch 227 § 1 (SB 1877); Stats 2012 ch 728 § 82 (SB 71), effective January 1, 2013.

§ 1357.17. Regulations

The director may issue regulations that are necessary to carry out the purposes of this article. Prior to the public comment period required on the regulations under the Administrative Procedure Act, the director shall provide the Insurance Commissioner with a copy of the proposed regulations. The Insurance Commissioner shall have 30 days to notify the director in writing of any comments on the regulations. The Insurance Commissioner's comments shall be included in the public notice issued on the regulations. Any rules and regulations adopted pursuant to this article may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Until December 31, 1994, the adoption of these regulations

shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety or general welfare.

HISTORY:
Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993. Amended Stats 1999 ch 525 § 67 (AB 78), operative July 1, 2000.

§ 1357.18. [Section repealed 2007.]

HISTORY:
Added Stats 2002 ch 649 § 1 (AB 2178). Repealed, January 1, 2007, by its own terms. The repealed section related to health care coverage for employees subject to minimum hourly compensation.

§ 1357.19. Applicability

This article shall not apply to a health care service plan contract that is subject to Article 3.16 (commencing with Section 1357.500) or Article 3.17 (commencing with Section 1357.600), except as otherwise provided in those articles.

HISTORY:
Added Stats 2012 ch 852 § 2 (AB 1083), effective January 1, 2013.

ARTICLE 3.11

Insurance Market Reform (Inoperative)

Section
1357.20. Contingent operative term of article (Inoperative).
1357.21. Application of requirements in Article 3.1 (Inoperative).
1357.22. Requirements of health care plan contracts for certain large and medium employers (Inoperative).
1357.23. Reasonable efforts to contract with county hospital systems and clinics (Inoperative).

HISTORY: Added Stats 2003 ch 673 § 3.

§ 1357.20. Contingent operative term of article (Inoperative)

If the provisions of Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code are held invalid, then the provisions of this article shall become inoperative.

HISTORY:
Added Stats 2003 ch 673 § 3 (SB 2).

§ 1357.21. Application of requirements in Article 3.1 (Inoperative)

(a) Notwithstanding any other provision of law, on and after January 1, 2006, except as specified in subdivision (b), all requirements in Article 3.1 (commencing with Section 1357) applicable to offering, marketing, and selling health care service plan contracts to small employers as defined in that article, including, but not limited to, the obligation to fairly and affirmatively offer, market, and sell all of the plan's contracts to all employers, guaranteed renewal of all health care service plan contracts, use of the risk adjustment factor, and the restriction of risk categories to age, geographic region, and family composition as described in that article, shall be applicable to all health

care service plan contracts offered to all small and medium employers providing coverage to employees pursuant to Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code, except as follows:

(1) For small and medium employers with two to 50 eligible employees, all requirements in that article shall apply. As used in this article, "small employer" shall have the meaning as defined in Section 2122.5 of the Labor Code and "medium employer" shall have the meaning as defined in Section 2122.4 of the Labor Code, unless the context otherwise requires.

(2) For medium employers with 51 or more eligible employees, all requirements in that article shall apply, except that the health care service plan may develop health care coverage benefit plan designs to fairly and affirmatively market only to medium employer groups of 51 to 199 eligible employees, and apply a risk adjustment factor of no more than 115 percent and no less than 85 percent of the standard employee risk rate.

(b) Health care service plans shall be required to comply with this section only beginning with the date when coverage begins to be offered through the State Health Purchasing Program pursuant to Part 8.7 (commencing with Section 2120 of Division 2 of the Labor Code.

HISTORY:
Added Stats 2003 ch 673 § 3 (SB 2).

§ 1357.22. Requirements of health care plan contracts for certain large and medium employers (Inoperative)

On and after January 1, 2006, a health care service plan contract with an employer as defined in Section 2122.6 of the Labor Code providing health coverage to enrollees or subscribers shall meet all of the following requirements:

(a) The employer shall be responsible for the cost of health care coverage except as provided in this section.

(b) An employer may require a potential enrollee to pay up to 20 percent of the cost of the coverage, proof of which is provided by the employer in lieu of paying the fee required by Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code, unless the wages of the potential enrollee are less than 200 percent of the federal poverty guidelines, as specified annually by the United States Department of Health and Human Services. For enrollees making a contribution for family coverage and whose wages are less than 200 percent of the federal poverty guidelines for a family of three, the applicable enrollee contribution shall not exceed 5 percent of wages. For enrollees making a contribution for individual coverage and whose wages are less than 200 percent of the federal poverty guidelines for an individual, the applicable enrollee contribution shall not exceed 5 percent of wages of the individual.

(c) If an employer, as defined in Section 2122.6 of the Labor Code, chooses to purchase more than one means of coverage for potential enrollees and, if applicable, dependents, the employer may require a higher level of contribution from potential enrollees as long as one means of coverage meets the standards of this section.

(d) An employer, as defined in Section 2122.6 of the Labor Code, may purchase health care coverage that includes additional out-of-pocket ex-

penses, such as copayments, coinsurance, or deductibles. In reviewing subscriber or enrollee share-of-premium, deductibles, copayments, and other out-of-pocket costs, the department shall consider those permitted by the board under Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code.

(e) Notwithstanding subdivision (b), a medium employer may require an enrollee to contribute more than 20 percent of the cost of coverage if both of the following apply:

(1) The coverage provided by the employer includes coverage for dependents.

(2) The employer contributes an amount that exceeds 80 percent of the cost of the coverage for an individual employee.

(f) The contract includes prescription drug coverage with out-of-pocket costs for enrollees consistent with subdivision (d).

HISTORY:
Added Stats 2003 ch 673 § 3 (SB 2).

§ 1357.23. Reasonable efforts to contract with county hospital systems and clinics (Inoperative)

On and after January 1, 2006, all health care service plans contracting with employers consistent with Section 1357.22 or with the State Health Purchasing Program shall make reasonable efforts to contract with county hospital systems and clinics, including providers or networks of providers that refer enrollees to such hospitals and clinics, as well as community clinics and other safety net providers. This section shall not prohibit a plan from applying appropriate credentialing requirements consistent with this chapter. This section shall not apply to a nonprofit health care service plan that provides hospital services to its enrollees primarily through a nonprofit hospital corporation with which the health care service plan shares an identical board of directors.

HISTORY:
Added Stats 2003 ch 673 § 3 (SB 2).

ARTICLE 3.15

Preexisting Condition Provisions

Section
1357.50. Definitions.
1357.51. Preexisting condition; Waivered condition.
1357.52. Exclusion criteria.
1357.53. [Section repealed 2011.]
1357.54. [Section repealed 2011.]
1357.55. Operative date of article.

HISTORY: Added Stats 2012 ch 852 § 4 (AB 1083), effective January 1, 2013, operative January 1, 2014. Former Article 3.15, entitled "Preexisting Condition Provisions and Late Enrollees", consisting of §§ 1357.50–1357.55, was added Stats 1992 ch 1128 § 6, operative July 1, 1993, and repealed January 1, 2014, by the terms of former H & S C § 1357.55.

§ 1357.50. Definitions

(a) For purposes of this article, the following definitions shall apply:

(1) "Health benefit plan" means a health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, or coverage under a specialized health care service plan contract.

(2) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(3) "Creditable coverage" means:

(A) Any individual or group policy, contract, or program that is written or administered by a health insurer, nonprofit hospital service plan, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(B) The Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(C) The Medicaid Program pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(D) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(E) 10 U.S.C. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A health plan offered under 5 U.S.C. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

(H) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(I) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Sec. 2504(e)).

(J) Any other creditable coverage as defined by subsection (c) of Section 2704 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(c)).

(4) "Waivered condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period of time for one or more specific, identified, medical conditions.

(5) "Affiliation period" means a period that, under the terms of the health benefit plan, must expire before health care services under the plan become effective.

(6) "Waiting period" means a period that is required to pass with respect to an employee before the employee is eligible to be covered for benefits under the terms of the plan.

(7) "Grandfathered health benefit plan" means a health benefit plan that is a grandfathered health plan, as defined in Section 1251 of PPACA.

(8) "Nongrandfathered health benefit plan" means a health benefit plan that is not a grandfathered health plan as defined in Section 1251 of PPACA.

(9) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

HISTORY:
Added Stats 2012 ch 852 § 4 (AB 1083), effective January 1, 2013, operative January 1, 2014.

§ 1357.51. Preexisting condition; Waivered condition

(a) A health benefit plan for group coverage shall not impose any preexisting condition provision or waivered condition provision upon any enrollee.

(b)(1) A nongrandfathered health benefit plan for individual coverage shall not impose any preexisting condition provision or waivered condition provision upon any enrollee.

(2) A grandfathered health benefit plan for individual coverage shall not exclude coverage on the basis of a waivered condition provision or preexisting condition provision for a period greater than 12 months following the enrollee's effective date of coverage, nor limit or exclude coverage for a specific enrollee by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition provision or waivered condition provision pursuant to this article. Waivered condition provisions or preexisting condition provisions contained in individual grandfathered health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(3) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the Public Health Service Act (42 U.S.C. Sec. 300gg-91), paragraph (1) shall become inoperative 12 months after the date of that repeal or amendment and thereafter paragraph (2)

shall apply also to nongrandfathered health benefit plans for individual coverage.

(4) In determining whether a preexisting condition provision or a waivered condition provision applies to an individual under this subdivision, a plan shall credit the time the individual was covered under creditable coverage, provided that the individual becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage and applies for coverage under the succeeding plan within the applicable enrollment period.

(c) A health benefit plan for group or individual coverage shall not impose a waiting period.

HISTORY:
Added Stats 2012 ch 852 § 4 (AB 1083), effective January 1, 2013, operative January 1, 2014. Amended Stats 2013-2014 1st Ex Sess ch 2 § 2 (SBX1 2), effective September 30, 2013; Stats 2014 ch 71 § 83 (SB 1304), effective January 1, 2015, ch 195 § 2 (SB 1034), effective January 1, 2015 (ch 195 prevails).

§ 1357.52. Exclusion criteria

A health benefit plan for group coverage shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors:

(a) Health status.

(b) Medical condition, including physical and mental illnesses.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of acts of domestic violence.

(h) Disability.

(i) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the Public Health Service Act.

HISTORY:
Added Stats 2012 ch 852 § 4 (AB 1083), effective January 1, 2013, operative January 1, 2014.

§ 1357.53. [Section repealed 2011.]

HISTORY:
Added Stats 1997 ch 336 § 10 (SB 578), effective August 21, 1997. Amended Stats 1999 ch 525 § 68 (AB 78), operative July 1, 2000. Repealed Stats 2010 ch 658 § 2 (AB 2470), effective January 1, 2011. The repealed section related to renewability exceptions for group plans.

§ 1357.54. [Section repealed 2011.]

HISTORY:
Added Stats 1997 ch 336 § 11 (SB 578), effective August 21, 1997. Amended Stats 1999 ch 525 § 69 (AB 78), operative July 1, 2000. Repealed Stats 2010 ch 658 § 3 (AB 2470), effective January 1, 2011. The repealed section related to renewability of individual health benefit plans.

§ 1357.55. Operative date of article

This article shall become operative on January 1, 2014.

HISTORY: Added Stats 2012 ch 852 § 4 (AB 1083), effective January 1, 2013, operative January 1, 2014.

ARTICLE 3.16

Nongrandfathered Small Employer Plans

Section
1357.500. Definitions.
1357.501. Applicability of article.
1357.502. Health care plans subject to article.
1357.502.5. Applicability of article to association, trust, or other organization acting as health care service plan.
1357.503. Small employer health benefit plans; Enrollment periods; Prohibited activities; Participation requirements; Small employer eligibility; Limitations on individual eligibility rules; Single risk pool; Applicability.
1357.503.035. Purchase of small employer health coverage by association meeting definition of guaranteed association.
1357.504. Premium charges for small employers; Effective date of coverage; Changing coverage.
1357.506. Imposition of preexisting condition provision or waiting or affiliation provision prohibited.
1357.507. Restricting enrollment of late enrollees.
1357.508. Provision of essential health benefits required.
1357.509. Exceptions to requirement of offering health care service plan contract or accepting applications for contract; Plan of rehabilitation.
1357.510. Ending of offering of contracts or accepting of applications.
1357.512. Variance of premium rates (Operative term contingent).
1357.514. Disclosures in connection with offering.
1357.515. Notice of material modification.
1357.516. Contracts for specific administrative services.

HISTORY: Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013.

§ 1357.500. Definitions

As used in this article, the following definitions shall apply:

(a) "Child" means a child described in Section 22775 of the Government Code and subdivisions (n) to (p), inclusive, of Section 599.500 of Title 2 of the California Code of Regulations.

(b) "Dependent" means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health care service plan contract covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (m).

(c) "Eligible employee" means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of an average of 30 hours per week over the course of a month, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term does not include sole proprietors or the spouses of those sole proprietors, partners of a partnership or the spouses of those partners, or employees

who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association are eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are eligible employees if all four of the following apply:

(A) They otherwise meet the definition of an eligible employee except for the number of hours worked.

(B) The employer offers the employees health coverage under a health benefit plan.

(C) All similarly situated individuals are offered coverage under the health benefit plan.

(D) The employee shall have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The health care service plan may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

(2) Any member of a guaranteed association as defined in subdivision (m).

(d) "Exchange" means the California Health Benefit Exchange created by Section 100500 of the Government Code.

(e) "In force business" means an existing health benefit plan contract issued by the plan to a small employer.

(f) "Late enrollee" means an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan consistent with the periods provided pursuant to Section 1357.503 and who subsequently requests enrollment in a health benefit plan of that small employer, except where the employee or dependent qualifies for a special enrollment period provided pursuant to Section 1357.503. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's plan contract consistent with the periods provided pursuant to Section 1357.503 and who subsequently requests enrollment in the plan, except where that member or person qualifies for a special enrollment period provided pursuant to Section 1357.503.

(g) "New business" means a health care service plan contract issued to a small employer that is not the plan's in force business.

(h) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage. No health care service plan shall limit or exclude coverage for any individual based on a preexisting condition whether or not any medical

advice, diagnosis, care, or treatment was recommended or received before that date.

(i) "Creditable coverage" means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(3) The Medicaid program pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) Chapter 55 (commencing with Section 1071) of Title 10 of the United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A health plan offered under Chapter 89 (commencing with Section 8901) of Title 5 of the United States Code (Federal Employees Health Benefits Program (FEHBP)).

(8) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the federal Public Health Service Act, as amended by Public Law 104-191, the federal Health Insurance Portability and Accountability Act of 1996.

(9) A health benefit plan under Section 5(e) of the federal Peace Corps Act (22 U.S.C. Sec. 2504(e)).

(10) Any other creditable coverage as defined by subsection (c) of Section 2704 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(c)).

(j) "Rating period" means the period for which premium rates established by a plan are in effect and shall be no less than 12 months from the date of issuance or renewal of the plan contract.

(k)(1) "Small employer" means any of the following:

(A) For plan years commencing on or after January 1, 2014, and on or before December 31, 2015, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 50, eligible employees, the

majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. For plan years commencing on or after January 1, 2016, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a health care service plan shall use the test that ensures eligibility if only one test would establish eligibility. In determining the number of employees or eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, any employer purchasing coverage for employees through a guaranteed association, and any small employer as defined in this paragraph who purchases coverage through any arrangement.

(B) Any guaranteed association, as defined in subdivision (*l*), that purchases health coverage for members of the association.

(2) For plan years commencing on or after January 1, 2019, for purposes of determining whether an employer has one employee, sole proprietors and their spouses, and partners of a partnership and their spouses, are not employees.

(3) For plan years commencing on or after January 1, 2016, the definition of small employer, for purposes of determining employer eligibility in the small employer market, shall be determined using the method for counting full-time employees and full-time equivalent employees set forth in Section 4980H(c)(2) of the Internal Revenue Code.

(*l*) "Guaranteed association" means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that (1) includes one or more small employers as defined in subparagraph (A) of paragraph (1) of subdivision (k), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on

whether the member applies for or purchases insurance offered to the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has included health insurance as a membership benefit for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any plan contract that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the plan contracts offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the health care service plan with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

This subdivision applies regardless of whether a contract issued by a plan is with an association, or a trust formed for or sponsored by an association, to administer benefits for association members.

For purposes of this subdivision, an association formed by a merger of two or more associations after January 1, 1992, and otherwise meeting the criteria of this subdivision shall be deemed to have been in active existence on January 1, 1992, if its predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and otherwise met the criteria of this subdivision.

(m) "Members of a guaranteed association" means any individual or employer meeting the association's membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association's discretion, it also may include employees of association members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include these persons as members of the guaranteed association, the association shall make that election in advance of purchasing a plan contract. Health care service plans may require an association to adhere to the membership composition it selects for up to 12 months.

(n) "Affiliation period" means a period that, under the terms of the health care service plan contract, must expire before health care services under the contract become effective.

(o) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.

(p) "Nongrandfathered small employer health care service plan contract" means a small employer health care service plan contract that is not a grandfathered health plan.

(q) "Plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations.

(r) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(s) "Small employer health care service plan contract" means a health care service plan contract issued to a small employer.

(t) "Waiting period" means a period that is required to pass with respect to an employee before the employee is eligible to be covered for benefits under the terms of the contract.

(u) "Registered domestic partner" means a person who has established a domestic partnership as described in Section 297 of the Family Code.

(v) "Family" means the subscriber and his or her dependent or dependents.

(w) "Health benefit plan" means a health care service plan contract that provides medical, hospital, and surgical benefits for the covered eligible employees of a small employer and their dependents. The term does not include coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, or coverage under a specialized health care service plan contract.

HISTORY:
Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013. Amended Stats 2013-2014 1st Ex Sess ch 2 § 3 (SBX1 2), effective September 30, 2013; Stats 2014 ch 572 § 3 (SB 959), effective January 1, 2015; Stats 2015 ch 9 § 1 (SB 125), effective June 17, 2015; Stats 2018 ch 700 § 2 (SB 1375), effective January 1, 2019.

§ 1357.501. Applicability of article

This article shall apply only to nongrandfathered small employer health care service plan contracts and only with respect to plan years beginning on or after January 1, 2014.

HISTORY:
Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013.

§ 1357.502. Health care plans subject to article

(a) A health care service plan providing or arranging for the provision of essential health benefits, as defined by the state pursuant to Section 1302 of PPACA, to small employers shall be subject to this article if either of the following conditions is met:

(1) Any portion of the premium is paid by a small employer, or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium.

(2) The plan contract is treated by the small employer or any of the covered individuals as part of a plan or program for the purposes of Section 106 or 162 of the Internal Revenue Code.

(b) This article shall not apply to health care service plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, Medi-Cal contracts with the State Department of Health Care Services, long-term care coverage, or specialized health care service plan contracts.

HISTORY:
Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013.

§ 1357.502.5. Applicability of article to association, trust, or other organization acting as health care service plan

Nothing in this article shall be construed to preclude the application of this chapter to either of the following:

(a) An association, trust, or other organization acting as a "health care service plan" as defined under Section 1345.

(b) An association, trust, or other organization or person presenting information regarding a health care service plan to persons who may be interested in subscribing or enrolling in the plan.

HISTORY:
Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013.

§ 1357.503. Small employer health benefit plans; Enrollment periods; Prohibited activities; Participation requirements; Small employer eligibility; Limitations on individual eligibility rules; Single risk pool; Applicability

(a)(1) Each plan shall fairly and affirmatively offer, market, and sell all of the plan's small employer health care service plan contracts to all small employers in each service area in which the plan provides or arranges for the provision of health care services.

(2) Each plan shall make available to each small employer all small employer health care service plan contracts that the plan offers and sells to small employers or to associations that include small employers in this state. Health coverage through an association that is not related to employment shall be considered individual coverage. The status of each distinct member of an association shall determine whether that member's association coverage is individual, small group, or large group health coverage.

(3) A plan that offers qualified health plans through the Exchange shall be deemed to be in compliance with paragraphs (1) and (2) with respect to small employer health care service plan contracts offered through the Exchange in those geographic regions in which the plan offers plan contracts through the Exchange.

(b) A plan shall provide enrollment periods consistent with PPACA and described in Section 155.725 of Title 45 of the Code of Federal Regulations. Each plan shall provide special enrollment periods consistent with the special enrollment periods described in Section 1399.849, to the extent permitted by PPACA, except for both of the following:

(1) The special enrollment period described in paragraph (3) of subdivision (c) of Section 1399.849.

(2) The triggering events identified in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of the Code of Federal Regulations with respect to plan contracts offered through the Exchange.

(c) No plan or solicitor shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health care service plan contract that is provided in connection with employee's employment or membership in a guaranteed association.

(d) Every plan shall file with the director the reasonable employee participation requirements and employer contribution requirements that will be

applied in offering its plan contracts. Participation requirements shall be applied uniformly among all small employer groups, except that a plan may vary application of minimum employee participation requirements by the size of the small employer group and whether the employer contributes 100 percent of the eligible employee's premium. Employer contribution requirements shall not vary by employer size. A health care service plan shall not establish a participation requirement that (1) requires a person who meets the definition of a dependent in Section 1357.500 to enroll as a dependent if he or she is otherwise eligible for coverage and wishes to enroll as an eligible employee and (2) allows a plan to reject an otherwise eligible small employer because of the number of persons that waive coverage due to coverage through another employer. Members of an association eligible for health coverage under subdivision (m) of Section 1357.500, but not electing any health coverage through the association, shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a plan's reasonable participation standards.

(e) The plan shall not reject an application from a small employer for a small employer health care service plan contract if all of the following conditions are met:

(1) The small employer offers health benefits to 100 percent of its eligible employees. Employees who waive coverage on the grounds that they have other group coverage shall not be counted as eligible employees.

(2) The small employer agrees to make the required premium payments.

(3) The small employer agrees to inform the small employer's employees of the availability of coverage and the provision that those not electing coverage must wait until the next open enrollment or a special enrollment period to obtain coverage through the group if they later decide they would like to have coverage.

(4) The employees and their dependents who are to be covered by the plan contract work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.

(f) A plan or solicitor shall not, directly or indirectly, engage in the following activities:

(1) Encourage or direct small employers to refrain from filing an application for coverage with a plan because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(2) Encourage or direct small employers to seek coverage from another plan because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(3) Employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

(g) A plan shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the

compensation paid to a solicitor for the sale of a health care service plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(h)(1) A policy or contract that covers a small employer, as defined in Section 1304(b) of PPACA and in Section 1357.500, shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the policy or contract based on any of the following health status-related factors:

(A) Health status.

(B) Medical condition, including physical and mental illnesses.

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability, including conditions arising out of acts of domestic violence.

(H) Disability.

(I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.

(2) Notwithstanding Section 1389.1, a health care service plan shall not require an eligible employee or dependent to fill out a health assessment or medical questionnaire prior to enrollment under a small employer health care service plan contract. A health care service plan shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

(i)(1) A health care service plan shall consider as a single risk pool for rating purposes in the small employer market the claims experience of all enrollees in all nongrandfathered small employer health benefit plans offered by the health care service plan in this state, whether offered as health care service plan contracts or health insurance policies, including those insureds and enrollees who enroll in coverage through the Exchange and insureds and enrollees covered by the health care service plan outside of the Exchange.

(2) At least each calendar year, and no more frequently than each calendar quarter, a health care service plan shall establish an index rate for the small employer market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 1367.005, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment program established for the state pursuant to Section 1343 of PPACA and Exchange user fees, as described in subdivision (d) of Section 156.80 of Title 45 of the Code of Federal Regulations. The premium rate for all of the nongrandfathered small employer health benefit plans within the

single risk pool required under paragraph (1) shall use the applicable marketwide adjusted index rate, subject only to the adjustments permitted under paragraph (3).

(3) A health care service plan may vary premium rates for a particular nongrandfathered small employer health care service plan contract from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the plan contract.

(B) The plan contract's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the plan contract that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plan contracts that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(E) Administrative costs, excluding any user fees required by the Exchange.

(j) A plan shall comply with the requirements of Section 1374.3.

(k)(1) Except as provided in paragraph (2), if Section 2702 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201 of PPACA, is repealed, this section shall become inoperative 12 months after the repeal date, in which case health care service plans subject to this section shall instead be governed by Section 1357.03 to the extent permitted by federal law, and all references in this article to this section shall instead refer to Section 1357.03 except for purposes of paragraph (2).

(2) Subdivision (b) shall remain operative with respect to health care service plan contracts offered through the Exchange.

HISTORY:

Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013. Amended Stats 2013-2014 1st Ex Sess ch 2 § 4 (SBX1 2), effective September 30, 2013, Stats 2013 ch 316 § 1 (SB 639), effective January 1, 2014; Stats 2014 ch 572 § 4 (SB 959), effective January 1, 2015; Stats 2017 ch 468 § 1 (AB 156), effective January 1, 2018; Stats 2018 ch 700 § 3 (SB 1375), effective January 1, 2019.

§ 1357.503.035. Purchase of small employer health coverage by association meeting definition of guaranteed association

(a) For plan contracts subject to this article, an association that meets the definition of a guaranteed association, as set forth in Section 1357.500, except for the requirement that 1,000 persons be covered, shall be entitled to purchase small employer health coverage as if the association were a guaranteed association, except that the coverage shall be guaranteed only for those members of an association, as defined in subdivision (m) of Section 1357.500, (1) who were receiving coverage or had successfully applied for coverage through the association as of June 30, 1993, (2) who were receiving coverage through the association as of December 31, 1992, and whose coverage lapsed at

any time thereafter because the employment through which coverage was received ended or an employer's contribution to health coverage ended, or (3) who were covered at any time between June 30, 1993, and July 1, 1994, under a contract that was in force on June 30, 1993.

(b) An association obtaining health coverage for its members pursuant to this section shall otherwise be afforded all the rights of a guaranteed association under this chapter, including, but not limited to, guaranteed renewability of coverage.

HISTORY:
Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013.

§ 1357.504. Premium charges for small employers; Effective date of coverage; Changing coverage

(a) With respect to small employer health care service plan contracts offered outside the Exchange, after a small employer submits a completed application form for a plan contract, the health care service plan shall, within 30 days, notify the employer of the employer's actual premium charges for that plan contract established in accordance with Section 1357.512. The employer shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(b) Except as provided in subdivision (c), when a small employer submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan contract shall become effective no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(c)(1) With respect to a small employer health care service plan contract offered through the Exchange, a plan shall apply coverage effective dates consistent with those required under Section 155.720 of Title 45 of the Code of Federal Regulations and of subdivision (e) of Section 1399.849.

(2) With respect to a small employer health care service plan contract offered outside the Exchange for which an individual applies during a special enrollment period described in subdivision (b) of Section 1357.503, the following provisions shall apply:

(A) Coverage under the plan contract shall become effective no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment.

(B) Notwithstanding subparagraph (A), in the case of a birth, adoption, or placement for adoption, coverage under the plan contract shall become effective on the date of birth, adoption, or placement for adoption.

(d) During the first 30 days after the effective date of the plan contract, the small employer shall have the option of changing coverage to a different plan contract offered by the same health care service plan. If a small employer notifies the plan of the change within the first 15 days of a month, coverage under the new plan contract shall become effective no later than the first day of the following month. If a small employer notifies the plan of the change after

the 15th day of a month, coverage under the new plan contract shall become effective no later than the first day of the second month following notification.

(e) All eligible employees and dependents listed on a small employer's completed application shall be covered on the effective date of the health benefit plan.

HISTORY:
Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013. Amended Stats 2013-2014 1st Ex Sess ch 2 § 5 (SBX1 2), effective September 30, 2013; Stats 2015 ch 303 § 250 (AB 731), effective January 1, 2016.

§ 1357.506. Imposition of preexisting condition provision or waiting or affiliation provision prohibited

A small employer health care service plan contract shall not impose a preexisting condition provision or a waiting or affiliation period upon any individual.

HISTORY:
Added Stats 2014 ch 195 § 4 (SB 1034), effective January 1, 2015.

§ 1357.507. Restricting enrollment of late enrollees

Nothing in this article shall be construed as prohibiting a health care service plan from restricting enrollment of late enrollees to open enrollment periods provided under Section 1357.503 as authorized under Section 2702 of the federal Public Health Service Act.

HISTORY:
Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013.

§ 1357.508. Provision of essential health benefits required

A small employer health care service plan contract shall provide to subscribers and enrollees at least all of the essential health benefits as defined by the state pursuant to Section 1302 of PPACA.

HISTORY:
Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013.

§ 1357.509. Exceptions to requirement of offering health care service plan contract or accepting applications for contract; Plan of rehabilitation

(a) To the extent permitted by PPACA, a plan shall not be required to offer a health care service plan contract or accept applications for the contract pursuant to this article in the case of any of the following:

(1) To a small employer, if the eligible employees and dependents who are to be covered by the plan contract do not live, work, or reside within a plan's approved service areas.

(2)(A) Within a specific service area or portion of a service area, if a plan reasonably anticipates and demonstrates to the satisfaction of the director all of the following:

(i) It will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the eligible employee and dependents of the employee because of its obligations to existing enrollees.

(ii) It is applying this subparagraph uniformly to all employers without regard to the claims experience of those employers, and their employees and dependents, or any health status-related factor relating to those employees and dependents.

(iii) The action is not unreasonable or clearly inconsistent with the intent of this chapter.

(B) A plan that cannot offer a health care service plan contract to small employers because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area pursuant to subparagraph (A) may not offer a contract in the area in which the plan is not offering coverage to small employers to new employer groups until the later of the following dates:

(i) The 181st day after the date that coverage is denied pursuant to this paragraph.

(ii) The date the plan notifies the director that it has the ability to deliver services to small employer groups, and certifies to the director that from the date of the notice it will enroll all small employer groups requesting coverage in that area from the plan.

(C) Subparagraph (B) shall not limit the plan's ability to renew coverage already in force or relieve the plan of the responsibility to renew that coverage as described in Section 1365.

(D) Coverage offered within a service area after the period specified in subparagraph (B) shall be subject to the requirements of this section.

(b)(1) A health care service plan may decline to offer a health care service plan contract to a small employer if the plan demonstrates to the satisfaction of the director both of the following:

(A) It does not have the financial reserves necessary to underwrite additional coverage. In determining whether this subparagraph has been satisfied, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

(B) It is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees and dependents or any health status-related factor relating to those employees and dependents.

(2) A plan that denies coverage to a small employer under paragraph (1) shall not offer coverage in the group market before the later of the following dates:

(A) The 181st day after the date that coverage is denied pursuant to paragraph (1).

(B) The date the plan demonstrates to the satisfaction of the director that the plan has sufficient financial reserves necessary to underwrite additional coverage.

(3) Paragraph (2) shall not limit the plan's ability to renew coverage already in force or relieve the plan of the responsibility to renew that coverage as described in Section 1365.

(4) Coverage offered within a service area after the period specified in paragraph (2) shall be subject to the requirements of this section.

(c) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity has become impaired, to the extent permitted by PPACA.

HISTORY:
Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013. Amended Stats 2013-2014 1st Ex Sess ch 2 § 6 (SBX1 2), effective September 30, 2013.

§ 1357.510. Ending of offering of contracts or accepting of applications

The director may require a plan to discontinue the offering of contracts or acceptance of applications from any small employer or group upon a determination by the director that the plan does not have sufficient financial viability, or organizational and administrative capacity to ensure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

HISTORY:
Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013.

§ 1357.512. Variance of premium rates (Operative term contingent)

(a) The premium rate for a small employer health care service plan contract issued, amended, or renewed on or after January 1, 2014, shall vary with respect to the particular coverage involved only by the following:

(1) Age, pursuant to the age bands established by the United States Secretary of Health and Human Services and the age rating curve established by the Centers for Medicare and Medicaid Services pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall be determined using the individual's age as of the date of the contract issuance or renewal, as applicable, and shall not vary by more than three to one for like individuals of different age who are 21 years of age or older as described in federal regulations adopted pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)).

(2)(A) Geographic region. The geographic regions for purposes of rating shall be the following:

(i) Region 1 shall consist of the Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

(ii) Region 2 shall consist of the Counties of Marin, Napa, Solano, and Sonoma.

(iii) Region 3 shall consist of the Counties of El Dorado, Placer, Sacramento, and Yolo.

(iv) Region 4 shall consist of the City and County of San Francisco.

(v) Region 5 shall consist of the County of Contra Costa.

(vi) Region 6 shall consist of the County of Alameda.

(vii) Region 7 shall consist of the County of Santa Clara.

(viii) Region 8 shall consist of the County of San Mateo.

(ix) Region 9 shall consist of the Counties of Monterey, San Benito, and Santa Cruz.

(x) Region 10 shall consist of the Counties of Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.

(xi) Region 11 shall consist of the Counties of Fresno, Kings, and Madera.

(xii) Region 12 shall consist of the Counties of San Luis Obispo, Santa Barbara, and Ventura.

(xiii) Region 13 shall consist of the Counties of Imperial, Inyo, and Mono.

(xiv) Region 14 shall consist of the County of Kern.

(xv) Region 15 shall consist of the ZIP Codes in the County of Los Angeles starting with 906 to 912, inclusive, 915, 917, 918, and 935.

(xvi) Region 16 shall consist of the ZIP Codes in the County of Los Angeles other than those identified in clause (xv).

(xvii) Region 17 shall consist of the Counties of Riverside and San Bernardino.

(xviii) Region 18 shall consist of the County of Orange.

(xix) Region 19 shall consist of the County of San Diego.

(B) No later than June 1, 2017, the department, in collaboration with the Exchange and the Department of Insurance, shall review the geographic rating regions specified in this paragraph and the impacts of those regions on the health care coverage market in California, and submit a report to the appropriate policy committees of the Legislature. The requirement for submitting a report under this subparagraph is inoperative June 1, 2021, pursuant to Section 10231.5 of the Government Code.

(3) Whether the contract covers an individual or family, as described in PPACA.

(b) The rate for a health care service plan contract subject to this section shall not vary by any factor not described in this section.

(c) The total premium charged to a small employer pursuant to this section shall be determined by summing the premiums of covered employees and dependents in accordance with Section 147.102(c)(1) of Title 45 of the Code of Federal Regulations.

(d) The rating period for rates subject to this section shall be no less than 12 months from the date of issuance or renewal of the plan contract.

(e) If Section 2701 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg), as added by Section 1201 of PPACA, is repealed, this section shall become inoperative 12 months after the repeal date, in which case rates for health care service plan contracts subject to this section shall instead be subject to Section 1357.12, to the extent permitted by federal law, and all references to this section shall be deemed to be references to Section 1357.12.

HISTORY:
Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013. Amended Stats 2013-2014 1st Ex Sess ch 2 § 7 (SBX1 2), effective September 30, 2013.

§ 1357.514. Disclosures in connection with offering

In connection with the offering for sale of a small employer health care service plan contract subject to this article, each plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

(a) The provisions concerning the plan's right to change premium rates and the factors other than provision of services experience that affect changes in premium rates. The plan shall disclose that claims experience cannot be used.

(b) Provisions relating to the guaranteed issue and renewal of contracts.

(c) A statement that no preexisting condition provisions shall be allowed.

(d) Provisions relating to the small employer's right to apply for any small employer health care service plan contract written, issued, or administered by the plan at the time of application for a new health care service plan contract, or at the time of renewal of a health care service plan contract, consistent with the requirements of PPACA.

(e) The availability, upon request, of a listing of all the plan's contracts and benefit plan designs offered, both inside and outside the Exchange, to small employers, including the rates for each contract.

(f) At the time it offers a contract to a small employer, each plan shall provide the small employer with a statement of all of its small employer health care service plan contracts, including the rates for each plan contract, in the service area in which the employer's employees and eligible dependents who are to be covered by the plan contract work or reside. For purposes of this subdivision, plans that are affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.

(g) Each plan shall do all of the following:

(1) Prepare a brochure that summarizes all of its plan contracts offered to small employers and to make this summary available to any small employer and to solicitors upon request. The summary shall include for each contract information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, and a telephone number that can be called for more detailed benefit information. Plans are required to keep the information contained in the brochure accurate and up to date and, upon updating the brochure, send copies to solicitors and solicitor firms with whom the plan contracts to solicit enrollments or subscriptions.

(2) For each contract, prepare a more detailed evidence of coverage and make it available to small employers, solicitors, and solicitor firms upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making contract selections.

(3) Provide copies of the current summary brochure to all solicitors and solicitor firms contracting with the plan to solicit enrollments or subscriptions from small employers.

For purposes of this subdivision, plans that are affiliated plans or that

are eligible to file a consolidated income tax return shall be treated as one health plan.

(h) Every solicitor or solicitor firm contracting with one or more plans to solicit enrollments or subscriptions from small employers shall do all of the following:

(1) When providing information on contracts to a small employer but making no specific recommendations on particular plan contracts:

(A) Advise the small employer of the plan's obligation to sell to any small employer any small employer health care service plan contract, consistent with PPACA, and provide the small employer, upon request, with the actual rates that would be charged to that employer for a given contract.

(B) Notify the small employer that the solicitor or solicitor firm will procure rate and benefit information for the small employer on any plan contract offered by a plan whose contract the solicitor sells.

(C) Notify the small employer that upon request the solicitor or solicitor firm will provide the small employer with the summary brochure required under paragraph (1) of subdivision (g) for any plan contract offered by a plan with which the solicitor or solicitor firm has contracted to solicit enrollments or subscriptions.

(D) Notify the small employer of the availability of coverage and the availability of tax credits for certain employers consistent with PPACA and state law, including any rules, regulations, or guidance issued in connection therewith.

(2) When recommending a particular benefit plan design or designs, advise the small employer that, upon request, the agent will provide the small employer with the brochure required by paragraph (1) of subdivision (g) containing the benefit plan design or designs being recommended by the agent or broker.

(3) Prior to filing an application for a small employer for a particular contract:

(A) For each of the plan contracts offered by the plan whose contract the solicitor or solicitor firm is offering, provide the small employer with the benefit summary required in paragraph (1) of subdivision (g) and the premium for that particular employer.

(B) Notify the small employer that, upon request, the solicitor or solicitor firm will provide the small employer with an evidence of coverage brochure for each contract the plan offers.

(C) Obtain a signed statement from the small employer acknowledging that the small employer has received the disclosures required by this section.

HISTORY:
Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013. Amended Stats 2014 ch 195 § 5 (SB 1034), effective January 1, 2015.

§ 1357.515. Notice of material modification

(a) At least 20 business days prior to renewing or amending a plan contract subject to this article which will be in force on the operative date of this article, a plan shall file a notice of material modification with the director in

accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with Section 1357.512. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

(b) At least 20 business days prior to offering a plan contract subject to this article, all plans shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with Section 1357.512. Plans that will be offering to a small employer plan contracts approved by the director prior to the effective date of this article shall file a notice of material modification in accordance with this subdivision. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

(c) Each plan shall maintain at its principal place of business all of the information required to be filed with the director pursuant to this section.

(d) Nothing in this section shall be construed to limit the director's authority to enforce the rating practices set forth in this article.

HISTORY:
Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013.

§ 1357.516. Contracts for specific administrative services

(a) Health care service plans may enter into contractual agreements with qualified associations, as defined in subdivision (b), under which these qualified associations may assume responsibility for performing specific administrative services, as defined in this section, for qualified association members. Health care service plans that enter into agreements with qualified associations for assumption of administrative services shall establish uniform definitions for the administrative services that may be provided by a qualified association or its third-party administrator. The health care service plan shall permit all qualified associations to assume one or more of these functions when the health care service plan determines the qualified association demonstrates the administrative capacity to assume these functions.

For the purposes of this section, administrative services provided by qualified associations or their third-party administrators shall be services pertaining to eligibility determination, enrollment, premium collection, sales, or claims administration on a per-claim basis that would otherwise be provided directly by the health care service plan or through a third-party administrator on a commission basis or an agent or solicitor workforce on a commission basis. Each health care service plan that enters into an agreement with any qualified association for the provision of administrative services shall offer all qualified associations with which it contracts the same premium discounts for performing those services the health care service plan has permitted the qualified association or its third-party administrator to assume. The health care service

plan shall report to the department its schedule of discounts for each administrative service.

In no instance may a health care service plan provide discounts to qualified associations that are in any way intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association. In addition to any other remedies available to the director to enforce this chapter, the director may declare a contract between a health care service plan and a qualified association for administrative services pursuant to this section null and void if the director determines any discounts provided to the qualified association are intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association.

(b) For the purposes of this section, a qualified association is a nonprofit corporation comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry that conforms to all of the following requirements:

(1) It accepts for membership any individual or small employer meeting its membership criteria.

(2) It does not condition membership directly or indirectly on the health or claims history of any person.

(3) It uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association.

(4) It is organized and maintained in good faith for purposes unrelated to insurance.

(5) It existed on January 1, 1972, and has been in continuous existence since that date.

(6) It has a constitution and bylaws or other analogous governing documents that provide for election of the governing board of the association by its members.

(7) It offered, marketed, or sold health coverage to its members for 20 continuous years prior to January 1, 1993.

(8) It agrees to offer only to association members any plan contract.

(9) It agrees to include any member choosing to enroll in the plan contract offered by the association, provided that the member agrees to make required premium payments.

(10) It complies with all provisions of this article.

(11) It had at least 10,000 enrollees covered by association sponsored plans immediately prior to enactment of Chapter 1128 of the Statutes of 1992.

(12) It applies any administrative cost at an equal rate to all members purchasing coverage through the qualified association.

(c) A qualified association shall comply with Section 1357.52.

HISTORY:
Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013.

ARTICLE 3.17

Grandfathered Small Employer Plans

Section
1357.600. Definitions.
1357.601. Applicability of article.
1357.602. Plans subject to this article.
1357.603. Construction of article.
1357.604. Sale of contracts to small employers; Filing of employee participation and employer contribution requirements; Rejection of application; Prohibited activities.
1357.606. Small employer coverage for associations with fewer than 1,000 persons.
1357.607. Imposition of preexisting condition provision or waiting or affiliation provision prohibited.
1357.608. Late enrollees.
1357.609. Services to be provided.
1357.610. When plan not required to offer contract.
1357.611. Requirement that plan discontinue offering contracts or accepting applications.
1357.612. Requirements for premiums.
1357.613. Risk rates to be applied.
1357.614. Disclosures required with offer of contract.
1357.615. Notice of material modification; Amendments to plan; Maintenance of information; Availability of risk adjustment factor.
1357.616. Provision of administrative services by qualified associations.
1357.618. Emergency regulations.

HISTORY: Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

§ 1357.600. Definitions

As used in this article, the following definitions shall apply:

(a) "Dependent" means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health care service plan contract covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (n).

(b) "Eligible employee" means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of an average of 30 hours per week over the course of a month, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term does not include sole proprietors or the spouses of those sole proprietors, partners of a partnership or the spouses of those partners, or employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association are eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are eligible employees if all four of the following apply:

(A) They otherwise meet the definition of an eligible employee except for the number of hours worked.

(B) The employer offers the employees health coverage under a health benefit plan.

(C) All similarly situated individuals are offered coverage under the health benefit plan.

(D) The employee shall have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The health care service plan may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

(2) Any member of a guaranteed association as defined in subdivision (n).

(c) "In force business" means an existing health benefit plan contract issued by the plan to a small employer.

(d) "Late enrollee" means an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's plan contract and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, any other person eligible for coverage through a guaranteed association pursuant to subdivision (n), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) He or she was covered under another employer health benefit plan, the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, the Medi-Cal program, or coverage through the California Health Benefit Exchange at the time the individual was eligible to enroll.

(B) He or she certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program, the AIM Program, the Medi-Cal program, or coverage through the California Health Benefit Exchange was the reason for declining enrollment, provided that, if the individual was covered under another employer health benefit plan, including a plan offered through the California Health Benefit Exchange, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) He or she has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution

toward an employee's or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, or divorce; or he or she has lost or will lose coverage under the Healthy Families Program, the AIM Program, the Medi-Cal program, or coverage through the California Health Benefit Exchange.

(D) He or she requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within 60 days after termination of Medi-Cal program coverage, AIM Program coverage, Healthy Families Program coverage, or coverage through the California Health Benefit Exchange.

(2) The employer offers multiple health benefit plans and the employee elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan.

(4)(A) In the case of an eligible employee, as defined in paragraph (1) of subdivision (b), the plan cannot produce a written statement from the employer stating that the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed, acknowledgment of an explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from eligibility for coverage until the next open enrollment period, unless the individual meets the criteria specified in paragraph (1), (2), or (3). This exclusion from eligibility for coverage shall not be considered a waiting period in violation of Section 1357.51 or 1357.607.

(B) In the case of an association member who did not purchase coverage through a guaranteed association, the plan cannot produce a written statement from the association stating that the association sent a written notice in boldface type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from eligibility for coverage until the next open enrollment period, unless the individual meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or meets the requirements of paragraph (2) or (3). This exclusion from eligibility for coverage shall not be considered a waiting period in violation of Section 1357.51 or 1357.607.

(C) In the case of an employer or person who is not a member of an association, was eligible to purchase coverage through a guaranteed association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association, the employer or person can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1), or meets the requirements of paragraph (2) or (3), or that he or she recently had a change in status that would make him or her eligible and that application for enrollment was made within 30 days of the change.

(5) The individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision and the coverage under that provision has been exhausted. For purposes of this section, the definition of "COBRA" set forth in subdivision (e) of Section 1373.621 shall apply.

(6) The individual is a dependent of an enrolled eligible employee who has lost or will lose his or her coverage under the Healthy Families Program, the AIM Program, the Medi-Cal program, or a health benefit plan offered through the California Health Benefit Exchange and requests enrollment within 60 days after termination of that coverage.

(7) The individual is an eligible employee who previously declined coverage under an employer health benefit plan, including a plan offered through the California Health Benefit Exchange, and who has subsequently acquired a dependent who would be eligible for coverage as a dependent of the employee through marriage, birth, adoption, or placement for adoption, and who enrolls for coverage under that employer health benefit plan on his or her behalf and on behalf of his or her dependent within 30 days following the date of marriage, birth, adoption, or placement for adoption, in which case the effective date of coverage shall be the first day of the month following the date the completed request for enrollment is received in the case of marriage, or the date of birth, or the date of adoption or placement for adoption, whichever applies. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(8) The individual is an eligible employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan, including a plan offered through the California Health Benefit Exchange, at the time of the previous enrollment period. That individual may enroll himself or herself or his or her dependents for plan coverage during a special open enrollment opportunity if his or her dependents have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the employee not more than 30 days after the date that the other health coverage is exhausted or terminated. Upon enrollment, coverage shall be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(e) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage. A health care service plan shall not limit or exclude coverage for any individual based on a preexisting condition whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

(f) "Creditable coverage" means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(3) The Medicaid program pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) Chapter 55 (commencing with Section 1071) of Title 10 of the United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A health plan offered under Chapter 89 (commencing with Section 8901) of Title 5 of the United States Code (Federal Employees Health Benefits Program (FEHBP)).

(8) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the federal Public Health Service Act, as amended by Public Law 104-191, the federal Health Insurance Portability and Accountability Act of 1996.

(9) A health benefit plan under Section 5(e) of the federal Peace Corps Act (22 U.S.C. Sec. 2504(e)).

(10) Any other creditable coverage as defined by subsection (c) of Section 2704 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(c)).

(g) "Rating period" means the period for which premium rates established by a plan are in effect and shall be no less than 12 months from the date of issuance or renewal of the health care service plan contract.

(h) "Risk adjusted employee risk rate" means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.

(i) "Risk adjustment factor" means the percentage adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard cost of services. This factor may not be more than 110 percent or less than 90 percent.

(j) "Risk category" means the following characteristics of an eligible employee: age, geographic region, and family composition of the employee, plus the health benefit plan selected by the small employer.

(1) No more than the following age categories may be used in determining premium rates:

Under 30
30-39
40-49
50-54
55-59
60-64
65 and over.

However, for the 65 years of age and over category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided by the Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(2) Small employer health care service plans shall base rates to small employers using no more than the following family size categories:

(A) Single.

(B) Married couple or registered domestic partners.

(C) One adult and child or children.

(D) Married couple or registered domestic partners and child or children.

(3)(A) In determining rates for small employers, a plan that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and divide no county into more than two regions. Plans shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state's population. Geographic regions established pursuant to this section shall, as a group, cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

(B)(i) In determining rates for small employers, a plan that does not operate statewide shall use no more than the number of geographic regions in the state that is determined by the following formula: the population, as determined in the last federal census, of all counties that are included in their entirety in a plan's service area divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. A region shall not be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. A plan shall not have less than one geographic area.

(ii) If the formula in clause (i) results in a plan that operates in more than one county having only one geographic region, then the formula in clause (i) shall not apply and the plan may have two

geographic regions, provided that no county is divided into more than one region.

This section does not require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan's existing service area.

(k)(1) "Small employer" means any of the following:

(A) For plan years commencing on or after January 1, 2014, and on or before December 31, 2015, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. For plan years commencing on or after January 1, 2016, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a health care service plan shall use the test that ensures eligibility if only one test would establish eligibility. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this subparagraph who purchases coverage through a guaranteed association, any employer purchasing coverage for employees through a guaranteed association, and any small employer as defined in this paragraph who purchases coverage through any arrangement.

(B) Any guaranteed association, as defined in subdivision (m), that purchases health coverage for members of the association.

(2) For plan years commencing on or after January 1, 2019, for purposes of determining whether an employer has one employee, sole proprietors and their spouses, and partners of a partnership and their spouses, are not employees.

(*l*) "Standard employee risk rate" means the rate applicable to an eligible employee in a particular risk category in a small employer group.

(m) "Guaranteed association" means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that (1) includes one or more small employers as defined in subparagraph (A) of paragraph (1) of subdivision (k), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered to the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has included health insurance as a membership benefit for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any plan contract that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the plan contracts offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the health care service plan with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

This subdivision applies regardless of whether a contract issued by a plan is with an association, or a trust formed for or sponsored by an association, to administer benefits for association members.

For purposes of this subdivision, an association formed by a merger of two or more associations after January 1, 1992, and otherwise meeting the criteria of this subdivision shall be deemed to have been in active existence on January 1, 1992, if its predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and otherwise met the criteria of this subdivision.

(n) "Members of a guaranteed association" means any individual or employer meeting the association's membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association's discretion, it also may include employees of association members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include these persons as members of the guaranteed association, the association shall make that election in advance of purchasing a plan contract. Health care service plans may require an association to adhere to the membership composition it selects for up to 12 months.

(o) "Affiliation period" means a period that, under the terms of the health care service plan contract, must expire before health care services under the contract become effective.

(p) "Grandfathered small employer health care service plan contract" means a small employer health care service plan contract that constitutes a grandfathered health plan.

(q) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.

(r) "Nongrandfathered small employer health care service plan contract" means a small employer health care service plan contract that is not a grandfathered health plan.

(s) "Plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations.

(t) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(u) "Registered domestic partner" means a person who has established a domestic partnership as described in Section 297 of the Family Code.

(v) "Small employer health care service plan contract" means a health care service plan contract issued to a small employer.

(w) "Waiting period" means a period that is required to pass with respect to an employee before the employee is eligible to be covered for benefits under the terms of the contract.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013. Amended Stats 2014 ch 195 § 6 (SB 1034), effective January 1, 2015; Stats 2018 ch 700 § 4 (SB 1375), effective January 1, 2019.

§ 1357.601. Applicability of article

This article shall apply only to grandfathered small group health care service plan contracts and only with respect to plan years commencing on or after January 1, 2014.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

§ 1357.602. Plans subject to this article

(a) A health care service plan providing or arranging for the provision of basic health care services to small employers shall be subject to this article if either of the following conditions are met:

(1) Any portion of the premium is paid by a small employer, or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium.

(2) The plan contract is treated by the small employer or any of the covered individuals as part of a plan or program for the purposes of Section 106 or 162 of the Internal Revenue Code.

(b) This article shall not apply to health care service plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, Medi-Cal contracts with the State Department of Health Care Services, long-term care coverage, or specialized health care service plan contracts.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

§ 1357.603. Construction of article

Nothing in this article shall be construed to preclude the application of this chapter to either of the following:

(a) An association, trust, or other organization acting as a "health care service plan" as defined under Section 1345.

(b) An association, trust, or other organization or person presenting information regarding a health care service plan to persons who may be interested in subscribing or enrolling in the plan.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

§ 1357.604. Sale of contracts to small employers; Filing of employee participation and employer contribution requirements; Rejection of application; Prohibited activities

(a)(1) A plan shall fairly and affirmatively renew a grandfathered health plan contract with a small employer.

(2) Each plan shall make available to each small employer all nongrandfathered small employer health care service plan contracts that the plan offers and sells to small employers or to associations that include small employers in this state consistent with Article 3.1 (commencing with Section 1357).

(3) No plan or solicitor shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health care service plan contract that is provided in connection with the employee's employment or membership in a guaranteed association.

(b) Every plan shall file with the director the reasonable employee participation requirements and employer contribution requirements that will be applied in renewing its grandfathered health care service plan contracts. Participation requirements shall be applied uniformly among all small employer groups, except that a plan may vary application of minimum employee participation requirements by the size of the small employer group and whether the employer contributes 100 percent of the eligible employee's premium. Employer contribution requirements shall not vary by employer size. A health care service plan shall not establish a participation requirement that (1) requires a person who meets the definition of a dependent in subdivision (a) of Section 1357.600 to enroll as a dependent if he or she is otherwise eligible for coverage and wishes to enroll as an eligible employee and (2) allows a plan to reject an otherwise eligible small employer because of the number of persons that waive coverage due to coverage through another employer. Members of an association eligible for health coverage under subdivision (n) of Section 1357.600, but not electing any health coverage through the association, shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a plan's reasonable participation standards.

(c) No plan or solicitor shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct small employers to refrain from filing an application for coverage or renewal of coverage with a plan because of the health

status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(2) Encourage or direct small employers to seek coverage from another plan, or coverage offered through the California Health Benefit Exchange, because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(d) A plan shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer or small employer's employees.

(e) A policy or contract that covers a small employer, as defined in Section 1304(b) of PPACA and in subdivision (k) of Section 1357.600 shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(9) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.

(f) A plan shall comply with the requirements of Section 1374.3.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

§ 1357.606. Small employer coverage for associations with fewer than 1,000 persons

(a) For plan contracts expiring after July 1, 1994, 60 days prior to July 1, 1994, an association that meets the definition of a guaranteed association, as set forth in Section 1357.600, except for the requirement that 1,000 persons be covered, shall be entitled to renew grandfathered small employer health care service plan contracts as if the association were a guaranteed association, except that the coverage shall be guaranteed only for those members of an association, as defined in Section 1357.600, (1) who were receiving coverage or

had successfully applied for coverage through the association as of June 30, 1993, (2) who were receiving coverage through the association as of December 31, 1992, and whose coverage lapsed at any time thereafter because the employment through which coverage was received ended or an employer's contribution to health coverage ended, or (3) who were covered at any time between June 30, 1993, and July 1, 1994, under a contract that was in force on June 30, 1993.

(b) An association obtaining health coverage for its members pursuant to this section shall otherwise be afforded all the rights of a guaranteed association under this chapter, including, but not limited to, guaranteed renewability of coverage.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

§ 1357.607. Imposition of preexisting condition provision or waiting or affiliation provision prohibited

A small employer health care service plan contract shall not impose a preexisting condition provision or a waiting or affiliation period upon any individual.

HISTORY:
Added Stats 2014 ch 195 § 8 (SB 1034), effective January 1, 2015.

§ 1357.608. Late enrollees

Nothing in this article shall be construed as prohibiting a health care service plan from restricting enrollment of late enrollees to open enrollment periods consistent with federal law.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

§ 1357.609. Services to be provided

All grandfathered small employer health care service plan contracts shall provide to subscribers and enrollees at least all of the basic health care services included in subdivision (b) of Section 1345, and in Section 1300.67 of the California Code of Regulations.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

§ 1357.610. When plan not required to offer contract

(a) No plan shall be required by the provisions of this article:

(1) To offer coverage under a small employer's health care service plan contract to an otherwise eligible employee or dependent, when the eligible employee or dependent does not work or reside within the plan's approved

service area, except as provided in Chapter 7 (commencing with Section 3750) of Part 1 of Division 9 of the Family Code.

(2) To offer coverage under a small employer's health care service plan contract to an eligible employee, as defined in paragraph (2) of subdivision (b) of Section 1357.600, who within 12 months of application for coverage terminated from a small employer health care service plan contract offered by the plan.

(b) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity has become impaired.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

§ 1357.611. Requirement that plan discontinue offering contracts or accepting applications

(a) The director may require a plan to discontinue the renewal of grandfathered small employer health care service plan contracts or the offering or acceptance of applications from any group upon a determination by the director that the plan does not have sufficient financial viability, or organizational and administrative capacity to ensure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

(b) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity has become impaired.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

§ 1357.612. Requirements for premiums

Premiums for grandfathered contracts renewed by plans on or after January 1, 2014, shall be subject to the following requirements:

(a)(1) The premium for in force business shall be determined for an eligible employee in a particular risk category after applying a risk adjustment factor to the plan's standard employee risk rates. The risk adjusted employee risk rates may not be more than 110 percent or less than 90 percent. The risk adjustment factor applied to a small employer may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period. The risk adjustment factor for a small employer may not be modified more frequently than every 12 months.

(2) The premium charged a small employer for in force business shall be

equal to the sum of the risk adjusted employee risk rates. The standard employee risk rates shall be in effect for no less than 12 months.

(b)(1) For any small employer, a plan may, with the consent of the small employer, establish composite employee and dependent rates for renewal of in force business. The composite rates shall be determined as the average of the risk adjusted employee risk rates for the small employer, as determined in accordance with the requirements of subdivision (a). The sum of the composite rates so determined shall be equal to the sum of the risk adjusted employee risk rates for the small employer.

(2) The composite rates shall be used for all employees and dependents covered throughout a rating period of 12 months, except that a plan may reserve the right to redetermine the composite rates if the enrollment under the contract changes by more than a specified percentage during the rating period. Any redetermination of the composite rates shall be based on the same risk adjusted employee risk rates used to determine the initial composite rates for the rating period. If a plan reserves the right to redetermine the rates and the enrollment changes more than the specified percentage, the plan shall redetermine the composite rates if the redetermined rates would result in a lower premium for the small employer. A plan reserving the right to redetermine the composite rates based upon a change in enrollment shall use the same specified percentage to measure that change with respect to all small employers electing composite rates.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

§ 1357.613. Risk rates to be applied

Plans shall apply standard employee risk rates consistently with respect to all small employers.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

§ 1357.614. Disclosures required with offer of contract

In connection with the renewal of a grandfathered small employer health care service plan contract, each plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

(a) The extent to which premium rates for a specified small employer are established or adjusted in part based upon the actual or expected variation in service costs of the employees and dependents of the small employer.

(b) The provisions concerning the plan's right to change premium rates and the factors other than provision of services experience that affect changes in premium rates.

(c) Provisions relating to the guaranteed issue and renewal of contracts.

(d) Provisions relating to the effect of any waiting or affiliation provision.

(e) Provisions relating to the small employer's right to apply for any nongrandfathered small employer health care service plan contract written, issued, or administered by the plan at the time of application for a new

health care service plan contract, or at the time of renewal of a health care service plan contract, consistent with the requirements of PPACA.

(f) The availability, upon request, of a listing of all the plan's nongrandfathered small employer health care service plan contracts and benefit plan designs offered, both inside and outside the California Health Benefit Exchange, including the rates for each contract.

(g) At the time it renews a grandfathered small employer health care service plan contract, each plan shall provide the small employer with a statement of all of its nongrandfathered small employer health care service plan contracts, including the rates for each plan contract, in the service area in which the employer's employees and eligible dependents who are to be covered by the plan contract work or reside. For purposes of this subdivision, plans that are affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.

(h) Each plan shall do all of the following:

(1) Prepare a brochure that summarizes all of its small employer health care service plan contracts and to make this summary available to any small employer and to solicitors upon request. The summary shall include for each contract information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard employee risk rates, and a telephone number that can be called for more detailed benefit information. Plans are required to keep the information contained in the brochure accurate and up to date and, upon updating the brochure, send copies to solicitors and solicitor firms with which the plan contracts to solicit enrollments or subscriptions.

(2) For each contract, prepare a more detailed evidence of coverage and make it available to small employers, solicitors, and solicitor firms upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making contract selections.

(3) Provide to small employers and solicitors, upon request, for any given small employer the sum of the standard employee risk rates and the sum of the risk adjusted employee risk rates. When requesting this information, small employers, solicitors, and solicitor firms shall provide the plan with the information the plan needs to determine the small employer's risk adjusted employee risk rate.

(4) Provide copies of the current summary brochure to all solicitors and solicitor firms contracting with the plan to solicit enrollments or subscriptions from small employers.

For purposes of this subdivision, plans that are affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013. Amended Stats 2014 ch 195 § 9 (SB 1034), effective January 1, 2015.

§ 1357.615. Notice of material modification; Amendments to plan; Maintenance of information; Availability of risk adjustment factor

(a) At least 20 business days prior to renewing or amending a small

employer health care service plan contract subject to this article, a plan shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (i) of Section 1357.600 and Section 1357.612. The certified statement shall set forth the standard employee risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be renewed or amended. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

(b) Prior to making any changes in the risk categories, risk adjustment factors or standard employee risk rates filed with the director pursuant to subdivision (a), the plan shall file as an amendment a statement setting forth the changes and certifying that the plan is in compliance with subdivision (i) of Section 1357.600 and Section 1357.612. A plan may commence utilizing the changed risk categories set forth in the certified statement on the 31st day from the date of the filing, or at an earlier time determined by the director, unless the director disapproves the amendment by written notice, stating the reasons therefor. If only the standard employee risk rate is being changed, and not the risk categories or risk adjustment factors, a plan may commence utilizing the changed standard employee risk rate upon filing the certified statement unless the director disapproves the amendment by written notice.

(c) Periodic changes to the standard employee risk rate that a plan proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subdivision (a) or (b).

(d) Each plan shall maintain at its principal place of business all of the information required to be filed with the director pursuant to this section.

(e) Each plan shall make available to the director, on request, the risk adjustment factor used in determining the rate for any particular small employer.

(f) Nothing in this section shall be construed to limit the director's authority to enforce the rating practices set forth in this article.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

§ 1357.616. Provision of administrative services by qualified associations

(a) Health care service plans may enter into contractual agreements with qualified associations, as defined in subdivision (b), under which these qualified associations may assume responsibility for performing specific administrative services, as defined in this section, for qualified association members. Health care service plans that enter into agreements with qualified associations for assumption of administrative services shall establish uniform definitions for the administrative services that may be provided by a qualified association or its third-party administrator. The health care service plan shall permit all qualified associations to assume one or more of these functions when

the health care service plan determines the qualified association demonstrates the administrative capacity to assume these functions.

For the purposes of this section, administrative services provided by qualified associations or their third-party administrators shall be services pertaining to eligibility determination, enrollment, premium collection, sales, or claims administration on a per-claim basis that would otherwise be provided directly by the health care service plan or through a third-party administrator on a commission basis or an agent or solicitor workforce on a commission basis.

Each health care service plan that enters into an agreement with any qualified association for the provision of administrative services shall offer all qualified associations with which it contracts the same premium discounts for performing those services the health care service plan has permitted the qualified association or its third-party administrator to assume. The health care service plan shall apply these uniform discounts to the health care service plan's risk adjusted employee risk rates after the health plan has determined the qualified association's risk adjusted employee risk rates pursuant to Section 1357.612. The health care service plan shall report to the department its schedule of discounts for each administrative service.

In no instance may a health care service plan provide discounts to qualified associations that are in any way intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association. In addition to any other remedies available to the director to enforce this chapter, the director may declare a contract between a health care service plan and a qualified association for administrative services pursuant to this section null and void if the director determines any discounts provided to the qualified association are intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association.

(b) For the purposes of this section, a qualified association is a nonprofit corporation comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, that conforms to all of the following requirements:

(1) It accepts for membership any individual or small employer meeting its membership criteria.

(2) It does not condition membership directly or indirectly on the health or claims history of any person.

(3) It uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association.

(4) It is organized and maintained in good faith for purposes unrelated to insurance.

(5) It existed on January 1, 1972, and has been in continuous existence since that date.

(6) It has a constitution and bylaws or other analogous governing documents that provide for election of the governing board of the association by its members.

(7) It offered, marketed, or sold health coverage to its members for 20 continuous years prior to January 1, 1993.

(8) It agrees to offer only to association members any plan contract.

(9) It agrees to include any member choosing to enroll in the plan contract offered by the association, provided that the member agrees to make required premium payments.

(10) It complies with all provisions of this article.

(11) It had at least 10,000 enrollees covered by association sponsored plans immediately prior to enactment of Chapter 1128 of the Statutes of 1992.

(12) It applies any administrative cost at an equal rate to all members purchasing coverage through the qualified association.

(c) A qualified association shall comply with Section 1357.52.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

§ 1357.618. Emergency regulations

(a) The department may adopt emergency regulations implementing this article no later than August 31, 2013. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(b) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

HISTORY:
Added Stats 2012 ch 852 § 6 (AB 1083), effective January 1, 2013.

ARTICLE 3.2

Additional Requirements for Medicare Supplement Contracts [Renumbered.]

HISTORY: Added Stats 1992 ch 287 § 5, effective July 21, 1992. Renumbered Article 3.5 by Stats 1992 ch 1014 § 1, effective September 27, 1992.

ARTICLE 3.5

Additional Requirements for Medicare Supplement Contracts

Section
1358. [Section repealed 2000.]
1358.1. Compliance with article.
1358.2. Purpose of article.
1358.3. Applicability of article.

Section
1358.4. Definitions.
1358.5. Required definitions.
1358.6. Prohibited provisions; Medicare supplement contract with prescription drug benefits.
1358.7. Contracts prior to January 1, 2001.
1358.8. General standards for contracts with effective date prior to June 1, 2010; Core benefits; Additional benefits to Medicare supplement benefit plans B to L.
1358.81. General standards for contracts with an effective date on or after June 1, 2010; Core benefits; Additional benefits.
1358.9. Standards applicable to contracts with effective date prior to June 1, 2010; Benefit plans that may be offered in state; Availability of contract form containing only core benefits; Innovative benefits.
1358.91. Mandatory standards applicable to contracts with effective date on or after June 1, 2010; Benefit plans that may be offered in state; Innovative benefits [Effective until January 1, 2020].
1358.91. Mandatory standards applicable to contracts with effective date on or after June 1, 2010; Benefit plans that may be offered in state; Innovative benefits [Effective January 1, 2020].
1358.92. Mandatory standards applicable to policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020.
1358.10. Medicare Select contracts.
1358.11. Discriminatory practices; Age; Time periods; Open enrollment periods; Standardized Medicare supplement benefit plan offerings [Effective until January 1, 2020].
1358.11. Discriminatory practices; Age; Time periods; Open enrollment periods; Standardized Medicare supplement benefit plan offerings [Effective January 1, 2020].
1358.12. Guaranteed issue of contract; Eligible persons; Enrollment in case of involuntary termination; Entitlement to benefit packages; Notice of rights; Refund.
1358.13. Compliance with federal statutes.
1358.14. Loss ratio standards; Refund or credit calculations; Prepaid or periodic charges and supporting documentation; Public hearings.
1358.145. Calculation of loss ratios; Copies to department; Compliance with standards.
1358.146. Format for reporting loss ratio experience.
1358.15. Approval of contract by director as prerequisite to advertising or issuance; Requirements; Filing of certain changes; Time periods.
1358.16. Compensation for solicitors and sales representatives.
1358.17. Renewal or continuation provision; Amendments to contract; Contract limitations; Notice of right to return; Guide to health insurance; Notice of changes; Outline of coverage; Disclosure pages; Required notices.
1358.18. Application form; Copy to applicant; Notice as to replacement of coverage; Buyer's guide; Group contracts; Health information from applicant who is guaranteed coverage.
1358.19. Director's approval of advertisement.
1358.20. Duties of issuer as to marketing procedures; Prohibited acts [Effective until January 1, 2020].
1358.20. Duties of issuer as to marketing procedures; Prohibited acts [Effective January 1, 2020].
1358.21. Appropriateness of recommended purchase or replacement; Multiple contracts; Issuance to individual enrolled in Part C.
1358.22. Annual report.
1358.225. Annual filing of list of contracts in state; Contents.
1358.23. Waiver of time periods for preexisting conditions.
1358.24. Adherence to Genetic Information Nondiscrimination Act of 2008.

HISTORY: Added Stats 2000 ch 706 § 2. Former Article 3.5, consisting of §§ 1358–1358.21, was added as Article 3.2 by Stats 1992 ch 287 § 5, effective July 1, 1992, renumbered Article 3.5 by Stats 1992 ch 1014 § 1, effective September 27, 1992, and repealed Stats 2000 ch 706 § 1.

§ 1358. [Section repealed 2000.]

HISTORY:

Added Stats 1992 ch 287 § 5 (SB 925), effective July 21, 1992. Amended Stats 1993 ch 735 § 1 (AB 2079); Stats 1996 ch 1118 § 1 (SB 2043), effective September 30, 1996; Stats 1999 ch 525 § 70 (AB 78); Repealed Stats 2000 ch 706 § 1 (SB 764). See H & S C § 1358.1.

§ 1358.1. Compliance with article

Every health care service plan that offers any contract that primarily or solely supplements Medicare or that is advertised or represented as a supplement to Medicare, shall, in addition to complying with this chapter and rules of the director, comply with this article. The basic health care services required to be provided pursuant to Sections 1345 and 1367 shall not be included in Medicare supplement contracts subject to this article, to the extent that California is required to disallow coverage for these health care services under the federal Medicare supplement standardization requirements set forth in Section 1882 of the federal Social Security Act (42 U.S.C.A. Sec. 1395ss).

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).

§ 1358.2. Purpose of article

The purpose of this article is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement contracts, to facilitate public understanding and comparison of those contracts, to eliminate provisions contained in those contracts that may be misleading or confusing in connection with the purchase of the contracts or with the settlement of claims, and to provide for full disclosures in the sale of Medicare supplement contracts to persons eligible for Medicare.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).

§ 1358.3. Applicability of article

(a) Except as otherwise provided in this section or in Sections 1358.7, 1358.12, 1358.13, 1358.16, and 1358.21, this article shall apply to all group and individual Medicare supplement contracts advertised, solicited, or issued for delivery in this state on or after January 1, 2001.

(b) This article shall not apply to a contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

(c) This article shall not apply to Medicare supplement policies or certificates subject to Article 6 (commencing with Section 10192.1) of Chapter 1 of Part 1 of Division 2 of the Insurance Code.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).

§ 1358.4. Definitions

The following definitions apply for the purposes of this article:

(a) "Applicant" means:

(1) An individual enrollee who seeks to contract for health coverage, in the case of an individual Medicare supplement contract.

(2) An enrollee who seeks to obtain health coverage through a group, in the case of a group Medicare supplement contract.

(b) "Bankruptcy" means that situation in which a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(c) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

(d)(1) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(A) Any individual or group contract, policy, certificate, or program that is written or administered by a health care service plan, health insurer, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage.

(B) Part A or B of Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395c et seq.) (Medicare).

(C) Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) (Medicaid), other than coverage consisting solely of benefits under Section 1928 of that act.

(D) Chapter 55 of Title 10 of the United States Code (CHAMPUS).

(E) A medical care program of the Indian Health Service or of a tribal organization.

(F) A state health benefits risk pool.

(G) A health plan offered under Chapter 89 of Title 5 of the United States Code (Federal Employees Health Benefits Program).

(H) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the federal Public Health Service Act, as amended by Public Law 104-191, the federal Health Insurance Portability and Accountability Act of 1996.

(I) A health benefit plan under Section 5(e) of the federal Peace Corps Act (22 U.S.C. Sec. 2504(e)).

(J) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(K) Any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(c)).

(2) "Creditable coverage" shall not include one or more, or any combination of, the following:

(A) Coverage for accident-only or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for onsite medical clinics.

(H) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate, or contract or are otherwise not an integral part of the plan:

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Other similar, limited benefits as are specified in federal regulations.

(4) "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(5) "Creditable coverage" shall not include the following if offered as a separate policy, certificate, or contract:

(A) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the federal Social Security Act.

(B) Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code.

(C) Similar supplemental coverage provided to coverage under a group health plan.

(e) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in Section 1002 of Title 29 of the United States Code (Employee Retirement Income Security Act).

(f) "Insolvency" means when an issuer, licensed to transact the business of a health care service plan in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(g) "Issuer" means a health care service plan delivering, or issuing for delivery, Medicare supplement contracts in this state, but does not include entities subject to Article 6 (commencing with Section 10192.1) of Chapter 1 of Part 2 of Division 2 of the Insurance Code.

(h) "Medicare" means the federal Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

(i) "Medicare Advantage Plan" means a plan of coverage for health benefits under Medicare Part C and includes:

(1) Coordinated care plans that provide health care services, including, but not limited to, health care service plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organizations plans.

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account.

(3) Medicare Advantage private fee-for-service plans.

(j) "Medicare supplement contract" means a group or individual plan contract of hospital and medical service associations or health care service

plans, other than a contract issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Sec. 1395mm) or an issued contract under a demonstration project specified in Section 1395ss(g)(1) of Title 42 of the United States Code, that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. "Contract" means "Medicare supplement contract," unless the context requires otherwise. "Medicare supplement contract" does not include a Medicare Advantage plan established under Medicare Part C, an outpatient prescription drug plan established under Medicare Part D, or a health care prepayment plan that provides benefits pursuant to an agreement under subparagraph (A) of paragraph (1) of subsection (a) of Section 1833 of the federal Social Security Act.

(k) "1990 standardized Medicare supplement benefit plan," "1990 standardized benefit plan," or "1990 plan" means a group or individual Medicare supplement contract issued on or after July 21, 1992, and with an effective date prior to June 1, 2010, and includes Medicare supplement contracts renewed on or after that date that are not replaced by the issuer at the request of the enrollee or subscriber.

(*l*) "2010 standardized Medicare supplement benefit plan," "2010 standardized benefit plan," or "2010 plan" means a group or individual Medicare supplement contract issued with an effective date on or after June 1, 2010.

(m) "Secretary" means the Secretary of the United States Department of Health and Human Services.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2005 ch 206 § 1 (SB 375), effective January 1, 2006; Stats 2009 ch 10 § 1 (AB 1543), effective July 2, 2009; Stats 2010 ch 328 § 116 (SB 1330), effective January 1, 2011.

§ 1358.5. Required definitions

(a) A contract shall not be advertised, solicited, or issued for delivery as a Medicare supplement contract unless the contract contains definitions or terms that conform to the requirements of this section.

(1)(A) "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or other similar words of description or characterization.

(B) The definition shall not be more restrictive than the following: "injury or injuries for which benefits are provided means accidental bodily injury sustained by the covered person that is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while coverage is in force."

(C) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability, or similar law, unless prohibited by law.

(2) "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

(3) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

(4) "Health care expenses" means for purposes of Section 1358.14, expenses of health care service plans associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

(5) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare Program.

(6) "Medicare" shall be defined in the contract. "Medicare" may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended," or "Title I, Part I of Public Law 89-97, as enacted by the 89th Congress and popularly known as the Health Insurance for the Aged Act, as amended," or words of similar import.

(7) "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

(8) "Physician" shall not be defined more restrictively than as defined in the Medicare Program.

(9)(A) "Sickness" shall not be defined more restrictively than as follows: "sickness means illness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force."

(B) The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

(b) Nothing in this section shall be construed as prohibiting any contract, by definitions or express provisions, from limiting or restricting any or all of the benefits provided under the contract, except in-area and out-of-area emergency services, to those health care services that are delivered by issuer, employed, owned, or contracting providers, and provider facilities, so long as the contract complies with the provisions of Sections 1358.14 and 1367 and with Section 1300.67 of Title 28 of the California Code of Regulations.

(c) Nothing in this section shall be construed as prohibiting any contract that limits or restricts any or all of the benefits provided under the contract in the manner contemplated in subdivision (b) from limiting its obligation to deliver services, and disclaiming any liability from any delay or failure to provide those services (1) in the event of a major disaster or epidemic or (2) in the event of circumstances not reasonably within the control of the issuer, such as the partial or total destruction of facilities, war, riot, civil insurrection, disability of a significant part of its health personnel, or similar circumstances so long as the provisions comply with the provisions of subdivision (h) of Section 1367.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).
Amended Stats 2005 ch 206 § 2 (SB 375), effective January 1, 2006.

§ 1358.6. Prohibited provisions; Medicare supplement contract with prescription drug benefits

(a)(1) Except for permitted preexisting condition clauses as described in

Sections 1358.7, 1358.8, and 1358.81, a contract shall not be advertised, solicited, or issued for delivery as a Medicare supplement contract if the contract contains definitions, limitations, exclusions, conditions, reductions, or other provisions that are more restrictive or limiting than that term as officially used in Medicare, except as expressly authorized by this article.

(2) No issuer may advertise, solicit, or issue for delivery any Medicare supplement contract with hospital or medical coverage if the contract contains any of the prohibited provisions described in subdivision (b).

(b) The following provisions shall be deemed to be unfair, unreasonable, and inconsistent with the objectives of this chapter and shall not be contained in any Medicare supplement contract:

(1) Any waiver, exclusion, limitation, or reduction based on or relating to a preexisting disease or physical condition, unless that waiver, exclusion, limitation, or reduction (A) applies only to coverage for specified services rendered not more than six months from the effective date of coverage, (B) is based on or relates only to a preexisting disease or physical condition defined no more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage, (C) does not apply to any coverage under any group contract, and (D) is approved in advance by the director. Any limitations with respect to a preexisting condition shall appear as a separate paragraph of the contract and be labeled "Preexisting Condition Limitations."

(2) Except with respect to a group contract subject to, and in compliance with, Section 1399.62, any provision denying coverage, after termination of the contract, for services provided continuously beginning while the contract was in effect, during the continuous total disability of the subscriber or enrollee, except that the coverage may be limited to a reasonable period of time not less than the duration of the contract benefit period, if any, and may be limited to the maximum benefits provided under the contract.

(c) A Medicare supplement contract in force shall not contain benefits that duplicate benefits provided by Medicare.

(d)(1) Subject to paragraphs (4) and (5) of subdivision (a) of Section 1358.8, a Medicare supplement contract with benefits for outpatient prescription drugs that was issued prior to January 1, 2006, shall be renewed for current enrollees and subscribers, at their option, who do not enroll in Medicare Part D.

(2) A Medicare supplement contract with benefits for outpatient prescription drugs shall not be issued on and after January 1, 2006.

(3) On and after January 1, 2006, a Medicare supplement contract with benefits for outpatient prescription drugs shall not be renewed after the enrollee or subscriber enrolls in Medicare Part D unless both of the following conditions exist:

(A) The contract is modified to eliminate outpatient prescription drug coverage for outpatient prescription drug expenses incurred after the effective date of the individual's coverage under a Medicare Part D plan.

(B) The premium is adjusted to reflect the elimination of outpatient prescription drug coverage at the time of enrollment in Medicare Part D, accounting for any claims paid if applicable.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2005 ch 206 § 3 (SB 375), effective January 1, 2006; Stats 2009 ch 10 § 2 (AB 1543), effective July 2, 2009.

§ 1358.7. Contracts prior to January 1, 2001

A contract shall not be advertised, solicited, or issued for delivery as a Medicare supplement contract prior to January 1, 2001, unless it meets or exceeds requirements applicable pursuant to this code that were in effect prior to that date.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).

§ 1358.8. General standards for contracts with effective date prior to June 1, 2010; Core benefits; Additional benefits to Medicare supplement benefit plans B to L

The following standards are applicable to all Medicare supplement contracts advertised, solicited, or issued for delivery on or after January 1, 2001, and with an effective date prior to June 1, 2010. A contract shall not be advertised, solicited, or issued for delivery as a Medicare supplement contract unless it complies with these benefit standards.

(a) The following general standards apply to Medicare supplement contracts and are in addition to all other requirements of this article:

(1) A Medicare supplement contract shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The contract shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(2) A Medicare supplement contract shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement contract shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Prepaid or periodic charges may be modified to correspond with those changes.

(4) A Medicare supplement contract shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the covered person, other than the nonpayment of the prepaid or periodic charge.

(5) Each Medicare supplement contract shall be guaranteed renewable.

(A) The issuer shall not cancel or nonrenew the contract solely on the ground of health status of the individual.

(B) The issuer shall not cancel or nonrenew the contract for any reason other than nonpayment of the prepaid or periodic charge or misrepresentation of the risk by the applicant that is shown by the plan to be material to the acceptance for coverage. The contestability period for Medicare supplement contracts shall be two years.

(C) If a group Medicare supplement contract is terminated by the subscriber and is not replaced as provided under subparagraph (E), the issuer shall offer enrollees an individual Medicare supplement contract that, at the option of the enrollee, either provides for continuation of the benefits contained in the terminated contract or provides for benefits that otherwise meet the requirements of this subsection.

(D) If an individual is an enrollee in a group Medicare supplement contract and the individual membership in the group is terminated, the issuer shall either offer the enrollee the conversion opportunity described in subparagraph (C) or, at the option of the subscriber, shall offer the enrollee continuation of coverage under the group contract.

(E) If a group Medicare supplement contract is replaced by another group Medicare supplement contract purchased by the same subscriber, the issuer of the replacement contract shall offer coverage to all persons covered under the old group contract on its date of termination. Coverage under the new contract shall not result in any exclusion for preexisting conditions that would have been covered under the group contract being replaced.

(F) If a Medicare supplement contract eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), the contract as modified as a result of that act shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(6) Termination of a Medicare supplement contract shall be without prejudice to any continuous loss that commenced while the contract was in force, but the extension of benefits beyond the period during which the contract was in force may be predicated upon the continuous total disability of the covered person, limited to the duration of the contract benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

(7)(A)(i) A Medicare supplement contract shall provide that benefits and prepaid or periodic charges under the contract shall be suspended at the request of the enrollee for the period, not to exceed 24 months, in which the enrollee has applied for and is determined to be entitled to medical assistance under Title XIX of the federal Social Security Act, but only if the enrollee notifies the issuer of the contract within 90 days after the date the individual becomes entitled to assistance.

If suspension occurs and if the enrollee loses entitlement to medical assistance, the contract shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the enrollee provides notice of loss of entitlement within 90 days after the date of loss and pays the prepaid or periodic charge attributable to the period, effective as of the date of termination of entitlement. Upon receipt of timely notice, the issuer shall return directly to the enrollee that portion of the prepaid or periodic charge attributable to the period the enrollee was entitled to medical assistance, subject to adjustment for paid claims.

(ii) A Medicare supplement contract shall provide that benefits and premiums under the contract shall be suspended at the request of the enrollee or subscriber for any period that may be provided by federal regulation if the enrollee or subscriber is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan, as defined in Section 1862(b)(1) (A)(v) of the Social Security Act. If suspension occurs and the enrollee or subscriber loses coverage under the group health plan, the contract shall be automatically reinstituted, effective as of the date of loss of coverage if the enrollee or subscriber provides notice within 90 days of the date of the loss of coverage.

(B) Reinstitution of coverages:

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions.

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement contract provided coverage for outpatient prescription drugs, reinstitution of the contract for a Medicare Part D enrollee shall not include coverage for outpatient prescription drugs but shall otherwise provide coverage that is substantially equivalent to the coverage in effect before the date of suspension.

(iii) Shall provide for classification of prepaid or periodic charges on terms at least as favorable to the enrollee as the prepaid or periodic charge classification terms that would have applied to the enrollee had the coverage not been suspended.

(8) If an issuer makes a written offer to the Medicare supplement enrollee or subscriber of one or more of its plan contracts, to exchange during a specified period from his or her 1990 standardized plan, as described in Section 1358.9, to a 2010 standardized plan, as described in Section 1358.91, the offer and subsequent exchange shall comply with the following requirements:

(A) An issuer need not provide justification to the director if the enrollee or subscriber replaces a 1990 standardized plan contract with an issue age rated 2010 standardized plan contract at the enrollee or subscriber's original issue age and duration. If an enrollee or subscriber's plan contract to be replaced is priced on an issue age rate schedule at the time of that offer, the rate charged to the enrollee or subscriber for the new exchanged plan shall recognize the plan contract reserve buildup, due to the prefunding inherent in the use of an issue age rate basis, for the benefit of the enrollee or subscriber. The method proposed to be used by an issuer shall be filed with the director.

(B) The rating class of the new plan contract shall be the class closest to the enrollee or subscriber's class of the replaced coverage.

(C) An issuer may not apply new preexisting condition limitations or a new incontestability period to the new plan contract for those benefits contained in the exchanged 1990 standardized plan contract of the enrollee or subscriber, but may apply preexisting condition limitations of no more than six months to any added benefits contained in the new 2010 standardized plan contract not contained in the exchanged plan

contract. This subparagraph shall not apply to an applicant who is guaranteed issue under Section 1358.11 or 1358.12.

(D) The new plan contract shall be offered to all enrollees or subscribers within a given plan, except where the offer or issue would be in violation of state or federal law.

(9) A Medicare supplement contract shall not be limited to coverage for a single disease or affliction.

(10) A Medicare supplement contract shall provide an examination period of 30 days after the receipt of the contract by the applicant for purposes of review, during which time the applicant may return the contract as described in subdivision (e) of Section 1358.17.

(11) A Medicare supplement contract shall additionally meet any other minimum benefit standards as established by the director.

(12) Within 30 days prior to the effective date of any Medicare benefit changes, an issuer shall file with the director, and notify its subscribers and enrollees of, modifications it has made to Medicare supplement contracts.

(A) The notice shall include a description of revisions to the Medicare Program and a description of each modification made to the coverage provided under the Medicare supplement contract.

(B) The notice shall inform each subscriber and enrollee as to when any adjustment in the prepaid or periodic charges will be made due to changes in Medicare benefits.

(C) The notice of benefit modifications and any adjustments to the prepaid or periodic charges shall be in outline form and in clear and simple terms so as to facilitate comprehension. The notice shall not contain or be accompanied by any solicitation.

(13) No modifications to existing Medicare supplement coverage shall be made at the time of, or in connection with, the notice requirements of this article except to the extent necessary to eliminate duplication of Medicare benefits and any modifications necessary under the contract to provide indexed benefit adjustment.

(b) With respect to the standards for basic (core) benefits for benefit plans A to J, inclusive, every issuer shall make available a contract including only the following basic "core" package of benefits to each prospective applicant. This "core" package of benefits shall be referred to as standardized Medicare supplement benefit plan "A". An issuer may make available to prospective applicants any of the other Medicare supplement benefit plans in addition to the basic core package, but not in lieu of that package.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day to the 90th day, inclusive, in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate Medicare standard of payment,

subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the enrollee or subscriber for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient services, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(c) The following additional benefits shall be included in Medicare supplement benefit plans B to J, inclusive, only as provided by Section 1358.9.

(1) With respect to the Medicare Part A deductible, coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) With respect to skilled nursing facility care, coverage for the actual billed charges up to the coinsurance amount from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

(3) With respect to the Medicare Part B deductible, coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) With respect to 80 percent of the Medicare Part B excess charges, coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare Program or state law, and the Medicare-approved Part B charge.

(5) With respect to 100 percent of the Medicare Part B excess charges, coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare Program or state law, and the Medicare-approved Part B charge.

(6) With respect to the basic outpatient prescription drug benefit, coverage for 50 percent of outpatient prescription drug charges, after a two-hundred-fifty-dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. On and after January 1, 2006, no Medicare supplement contract may be sold or issued if it includes a prescription drug benefit.

(7) With respect to the extended outpatient prescription drug benefit, coverage for 50 percent of outpatient prescription drug charges, after a two-hundred-fifty-dollar ($250) calendar year deductible, to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. On and after January 1, 2006, no Medicare supplement contract may be sold or issued if it includes a prescription drug benefit.

(8) With respect to medically necessary emergency care in a foreign country, coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign

country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) With respect to the preventive medical care benefit, coverage for the following preventive health services:

(A) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (B) and patient education to address preventive health care measures.

(B) The following screening tests or preventive services that are not covered by Medicare, the selection and frequency of which are determined to be medically appropriate by the attending physician:

(i) Fecal occult blood test.

(ii) Mammogram.

(C) Influenza vaccine administered at any appropriate time during the year.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMACPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) With respect to the at-home recovery benefit, coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(A) For purposes of this benefit, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide or homemaker, or a personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without any limit on the duration of the visit, except that each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

(B) With respect to coverage requirements and limitations, the following shall apply:

(i) At-home recovery services provided shall be primarily services that assist in activities of daily living.

(ii) The covered person's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to the following:

(I) No more than the number and type of at-home recovery visits certified as necessary by the covered person's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit.

(III) One thousand six hundred dollars ($1,600) per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in subparagraph (A).

(VII) At-home recovery visits while the covered person is covered under the contract and not otherwise excluded.

(VIII) At-home recovery visits received during the period the covered person is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.

(C) Coverage is excluded for the following:

(i) Home care visits paid for by Medicare or other government programs.

(ii) Care provided by family members, unpaid volunteers, or providers who are not care providers.

(d) The standardized Medicare supplement benefit plan "K" shall consist of the following benefits:

(1) Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each day used from the 61st to the 90th day, inclusive, in any Medicare benefit period.

(2) Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st to the 150th day, inclusive, in any Medicare benefit period.

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment for this benefit as payment in full and shall not bill the enrollee or subscriber for any balance.

(4) With respect to the Medicare Part A deductible, coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation described in paragraph (10) is met.

(5) With respect to skilled nursing facility care, coverage for 50 percent of the coinsurance amount for each day used from the 21st day to the

100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation described in paragraph (10) is met.

(6) With respect to hospice care, coverage for 50 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation described in paragraph (10) is met.

(7) Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations, until the out-of-pocket limitation described in paragraph (10) is met.

(8) Except for coverage provided in paragraph (9), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the enrollee or subscriber pays the Part B deductible, until the out-of-pocket limitation is met as described in paragraph (10).

(9) Coverage of 100 percent of the cost sharing for Medicare Part B preventive services, after the enrollee or subscriber pays the Medicare Part B deductible.

(10) Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary.

(e) The standardized Medicare supplement benefit plan "L" shall consist of the following benefits:

(1) The benefits described in paragraphs (1), (2), (3), and (9) of subdivision (d).

(2) With respect to the Medicare Part A deductible, coverage for 75 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation described in paragraph (8) is met.

(3) With respect to skilled nursing facility care, coverage for 75 percent of the coinsurance amount for each day used from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation described in paragraph (8) is met.

(4) With respect to hospice care, coverage for 75 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation described in paragraph (8) is met.

(5) Coverage for 75 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations, until the out-of-pocket limitation described in paragraph (8) is met.

(6) Except for coverage provided in paragraph (7), coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the enrollee or subscriber pays the Part B deductible until the out-of-pocket limitation described in paragraph (8) is met.

(7) Coverage for 100 percent of the cost sharing for Medicare Part B

preventive services after the enrollee or subscriber pays the Part B deductible.

(8) Coverage of 100 percent of the cost sharing for Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of two thousand dollars ($2,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary.

(f) A contract shall not contain any provision delaying the effective date of coverage beyond the first day of the month following the date of receipt by the issuer of the applicant's properly completed application, except that the effective date of coverage may be delayed until the 65th birthday of an applicant who is to become eligible for Medicare by reason of age if the application is received any time during the three months immediately preceding the applicant's 65th birthday.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2005 ch 206 § 4 (SB 375), effective January 1, 2006; Stats 2009 ch 10 § 3 (AB 1543), effective July 2, 2009.

§ 1358.81. General standards for contracts with an effective date on or after June 1, 2010; Core benefits; Additional benefits

The following standards are applicable to all Medicare supplement contracts delivered or issued for delivery in this state with an effective date on or after June 1, 2010. No contract may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement contract unless it complies with these benefit standards. No issuer may offer any 1990 standardized Medicare supplement contract for sale with an effective date on or after June 1, 2010. Benefit standards applicable to Medicare supplement contracts issued with an effective date before June 1, 2010, remain subject to the requirements of Section 1358.8.

(a) The following general standards apply to Medicare supplement contracts and are in addition to all other requirements of this article.

(1) A Medicare supplement contract shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The contract shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by, or received from, a physician within six months before the effective date of coverage.

(2) A Medicare supplement contract shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement contract shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Prepaid or periodic charges may be modified to correspond with those changes.

(4) A Medicare supplement contract shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified

for termination of coverage of the enrollee or subscriber, other than the nonpayment of prepaid or periodic charges.

(5) Each Medicare supplement contract shall be guaranteed renewable.

(A) The issuer shall not cancel or nonrenew the contract solely on the ground of health status of the individual.

(B) The issuer shall not cancel or nonrenew the contract for any reason other than nonpayment of prepaid or periodic charges or misrepresentation of the risk by the applicant that is shown by the plan to be material to the acceptance for coverage. The contestability period for Medicare supplement contracts shall be two years.

(C) If the Medicare supplement contract is terminated by the group contractholder and is not replaced as provided under subparagraph (E), the issuer shall offer enrollees or subscribers an individual Medicare supplement contract which, at the option of the enrollee or subscriber, does one of the following:

(i) Provides for continuation of the benefits contained in the group contract.

(ii) Provides for benefits that otherwise meet the requirements of one of the standardized contracts defined in this article.

(D) If an individual is an enrollee or subscriber in a group Medicare supplement contract and the individual terminates membership in the group, the issuer shall do one of the following:

(i) Offer the enrollee or subscriber the conversion opportunity described in subparagraph (C).

(ii) At the option of the group contractholder, offer the enrollee or subscriber continuation of coverage under the group contract.

(E)(i) If a group Medicare supplement contract is replaced by another group Medicare supplement contract purchased by the same group contractholder, the issuer of the replacement contract shall offer coverage to all persons covered under the old group contract on its date of termination. Coverage under the new contract shall not result in any exclusion for preexisting conditions that would have been covered under the group contract being replaced.

(ii) If a Medicare supplement contract replaces another Medicare supplement contract that has been in force for six months or more, the replacing issuer shall not impose an exclusion or limitation based on a preexisting condition. If the original coverage has been in force for less than six months, the replacing issuer shall waive any time period applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new contract to the extent the time was spent under the original coverage.

(6) Termination of a Medicare supplement contract shall be without prejudice to any continuous loss that commenced while the contract was in force, but the extension of benefits beyond the period during which the contract was in force may be predicated upon the continuous total disability of the enrollee or subscriber, limited to the duration of the contract benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

(7)(A)(i) A Medicare supplement contract shall provide that benefits and prepaid or periodic charges under the contract shall be suspended at the request of the enrollee or subscriber for the period, not to exceed 24 months, in which the enrollee or subscriber has applied for, and is determined to be entitled to, medical assistance under Medi-Cal under Title XIX of the federal Social Security Act, but only if the enrollee or subscriber notifies the issuer of the contract within 90 days after the date the individual becomes entitled to assistance. Upon receipt of timely notice, the insurer shall return directly to the enrollee or subscriber that portion of the prepaid or periodic charge attributable to the period of Medi-Cal eligibility, subject to adjustment for paid claims.

(ii) If suspension occurs and if the enrollee or subscriber loses entitlement to medical assistance under Medi-Cal, the Medicare supplement contract shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the enrollee or subscriber provides notice of loss of entitlement within 90 days after the date of loss and pays the prepaid or periodic charge attributable to the period, effective as of the date of termination of entitlement or equivalent coverage shall be provided if the prior contract is no longer available.

(iii) Each Medicare supplement contract shall provide that benefits and prepaid or periodic charges under the contract shall be suspended (for any period that may be provided by federal regulation) at the request of the enrollee or subscriber if the enrollee or subscriber is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the enrollee or subscriber loses coverage under the group health plan, the contract shall be automatically reinstituted (effective as of the date of loss of coverage) if the enrollee or subscriber provides notice of loss of coverage within 90 days after the date of the loss and pays the applicable prepaid or periodic charge.

(B) Reinstitution of coverages shall comply with all of the following requirements:

(i) Not provide for any waiting period with respect to treatment of preexisting conditions.

(ii) Provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension.

(iii) Provide for classification of prepaid or periodic charges on terms at least as favorable to the enrollee or subscriber as the classification of the prepaid or periodic charge that would have applied to the enrollee or subscriber had the coverage not been suspended.

(8) A Medicare supplement contract shall not be limited to coverage for a single disease or affliction.

(9) A Medicare supplement contract shall provide an examination period of 30 days after the receipt of the contract by the applicant for purposes of review, during which time the applicant may return the contract as described in subdivision (e) of Section 1358.17.

(10) A Medicare supplement contract shall additionally meet any other minimum benefit standards as established by the director.

(11) Within 30 days prior to the effective date of any Medicare benefit changes, an issuer shall file with the director, and notify its subscribers and enrollees of, modifications it has made to Medicare supplement contracts.

(A) The notice shall include a description of revisions to the Medicare Program and a description of each modification made to the coverage provided under the Medicare supplement contract.

(B) The notice shall inform each subscriber and enrollee as to when any adjustment in the prepaid or periodic charges will be made due to changes in Medicare benefits.

(C) The notice of benefit modifications and any adjustments to the prepaid or periodic charges shall be in outline form and in clear and simple terms so as to facilitate comprehension. The notice shall not contain or be accompanied by any solicitation.

(12) No modifications to existing Medicare supplement coverage shall be made at the time of, or in connection with, the notice requirements of this article except to the extent necessary to eliminate duplication of Medicare benefits and any modifications necessary under the contract to provide indexed benefit adjustment.

(b) With respect to the standards for basic (core) benefits for benefit plans A, B, C, D, F, high deductible F, G, M, and N, every issuer of Medicare supplement benefit plans shall make available a contract including only the following basic "core" package of benefits to each prospective enrollee or subscriber. An issuer may make available to prospective enrollees or subscribers any of the other Medicare supplement benefit plans in addition to the basic core package, but not in lieu of that package.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day, inclusive, in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(6) Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(c) The following additional benefits shall be included in Medicare supplement benefit plans B, C, D, F, high deductible F, G, M, and N, consistent with the plan type and benefits for each plan as provided in Section 1358.91:

(1) With respect to the Medicare Part A deductible, coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) With respect to the Medicare Part A deductible, coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

(3) With respect to skilled nursing facility care, coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

(4) With respect to the Medicare Part B deductible, coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(5) With respect to 100 percent of the Medicare Part B excess charges, coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) With respect to medically necessary emergency care in a foreign country, coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

HISTORY:
Added Stats 2009 ch 10 § 4 (AB 1543), effective July 2, 2009.

§ 1358.9. Standards applicable to contracts with effective date prior to June 1, 2010; Benefit plans that may be offered in state; Availability of contract form containing only core benefits; Innovative benefits

The following standards are applicable to all Medicare supplement contracts delivered or issued for delivery in this state on or after July 21, 1992, and with an effective date prior to June 1, 2010.

(a) An issuer shall make available to each prospective enrollee a contract form containing only the basic (core) benefits, as defined in subdivision (b) of Section 1358.8.

(b) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted by subdivision (f) and by Section 1358.10.

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans A to L, inclusive, listed in subdivision (e), and shall conform to the definitions in Section 1358.4. Each benefit shall be structured in accordance with the format provided in subdivisions (b), (c), (d), and (e) of Section 1358.8 and list the benefits in the order listed in subdivision (e). For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(d) An issuer may use, in addition to the benefit plan designations required in subdivision (c), other designations to the extent permitted by law.

(e) With respect to the makeup of benefit plans, the following shall apply:

(1) Standardized Medicare supplement benefit plan A shall be limited to the basic (core) benefit common to all benefit plans, as defined in subdivision (b) of Section 1358.8.

(2) Standardized Medicare supplement benefit plan B shall include only the following: the core benefit, plus the Medicare Part A deductible as defined in paragraph (1) of subdivision (c) of Section 1358.8.

(3) Standardized Medicare supplement benefit plan C shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (3), and (8) of subdivision (c) of Section 1358.8, respectively.

(4) Standardized Medicare supplement benefit plan D shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (1), (2), (8), and (10) of subdivision (c) of Section 1358.8, respectively.

(5) Standardized Medicare supplement benefit plan E shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in paragraphs (1), (2), (8), and (9) of subdivision (c) of Section 1358.8, respectively.

(6) Standardized Medicare supplement benefit plan F shall include only the following: the core benefit, plus the Medicare Part A deductible, the skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (3), (5), and (8) of subdivision (c) of Section 1358.8, respectively.

(7) Standardized Medicare supplement benefit high deductible plan F shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (3), (5), and (8) of subdivision (c) of Section 1358.8, respectively. The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The

annual high deductible Plan F deductible shall be one thousand five hundred dollars ($1,500) for 1998 and 1999, and shall be based on the calendar year, as adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(8) Standardized Medicare supplement benefit plan G shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, 80 percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (1), (2), (4), (8), and (10) of subdivision (c) of Section 1358.8, respectively.

(9) Standardized Medicare supplement benefit plan H shall consist of only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (6), and (8) of subdivision (c) of Section 1358.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement contract sold on or after January 1, 2006.

(10) Standardized Medicare supplement benefit plan I shall consist of only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in paragraphs (1), (2), (5), (6), (8), and (10) of subdivision (c) of Section 1358.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement contract sold on or after January 1, 2006.

(11) Standardized Medicare supplement benefit plan J shall consist of only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision (c) of Section 1358.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement contract sold on or after January 1, 2006.

(12) Standardized Medicare supplement benefit high deductible plan J shall consist of only the following: 100 percent of covered expenses following the payment of the annual high deductible plan J deductible. The covered expenses include the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit, and at-home recovery benefit as defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision (c) of Section 1358.8, respectively. The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums,

for services covered by the Medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be one thousand five hundred dollars ($1,500) for 1998 and 1999, and shall be based on a calendar year, as adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10). The outpatient prescription drug benefit shall not be included in a Medicare supplement contract sold on or after January 1, 2006.

(13) Standardized Medicare supplement benefit plan K shall consist of only those benefits described in subdivision (d) of Section 1358.8.

(14) Standardized Medicare supplement benefit plan L shall consist of only those benefits described in subdivision (e) of Section 1358.8.

(f) An issuer may, with the prior approval of the director, offer contracts with new or innovative benefits in addition to the benefits provided in a contract that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement contracts, that are not otherwise available and that are cost-effective and offered in a manner that is consistent with the goal of simplification of Medicare supplement contracts. On and after January 1, 2006, the innovative benefit shall not include an outpatient prescription drug benefit.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2005 ch 206 § 5 (SB 375), effective January 1, 2006; Stats 2009 ch 10 § 5 (AB 1543), effective July 2, 2009.

§ 1358.91. Mandatory standards applicable to contracts with effective date on or after June 1, 2010; Benefit plans that may be offered in state; Innovative benefits [Effective until January 1, 2020]

The following standards are applicable to all Medicare supplement contracts delivered or issued for delivery in this state with an effective date on or after June 1, 2010. No contract may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement contract unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement contracts issued with an effective date before June 1, 2010, remain subject to the requirements of Section 1358.9.

(a)(1) An issuer shall make available to each prospective enrollee and subscriber a contract containing only the basic (core) benefits, as defined in subdivision (b) of Section 1358.81.

(2) If an issuer makes available any of the additional benefits described in subdivision (c) of Section 1358.81, or offers standardized benefit plan K or L, as described in paragraphs (8) and (9) of subdivision (e), then the issuer shall make available to each prospective enrollee and subscriber, in addition to a contract with only the basic (core) benefits as described in paragraph (1), a contract containing either standardized benefit plan C, as described in paragraph (3) of subdivision (e), or standardized benefit plan F, as described in paragraph (5) of subdivision (e).

(b) No groups, packages or combinations of Medicare supplement benefits

other than those listed in this section shall be offered for sale in this state, except as may be permitted in subdivision (f) and by Section 1358.10.

(c) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans listed in subdivision (e) and conform to the definitions in Section 1358.4. Each benefit shall be structured in accordance with the format provided in subdivisions (b) and (c) of Section 1358.81; or, in the case of plan K or L, in paragraph (8) or (9) of subdivision (e) of Section 1358.91 and list the benefits in the order shown in subdivision (e). For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(d) In addition to the benefit plan designations required in subdivision (c), an issuer may use other designations to the extent permitted by law.

(e) With respect to the makeup of 2010 standardized benefit plans, the following shall apply:

(1) Standardized Medicare supplement benefit plan A shall include only the following: the basic (core) benefits as defined in subdivision (b) of Section 1358.81.

(2) Standardized Medicare supplement benefit plan B shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 1358.81, plus 100 percent of the Medicare Part A deductible as defined in paragraph (1) of subdivision (c) of Section 1358.81.

(3) Standardized Medicare supplement benefit plan C shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 1358.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country, as defined in paragraphs (1), (3), (4), and (6) of subdivision (c) of Section 1358.81, respectively.

(4) Standardized Medicare supplement benefit plan D shall include only the following: the basic (core) benefit, as defined in subdivision (b) of Section 1358.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as defined in paragraphs (1), (3), and (6) of subdivision (c) of Section 1358.81, respectively.

(5) Standardized Medicare supplement benefit plan F shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 1358.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, as defined in paragraphs (1), (3), (4), (5), and (6) of subdivision (c) of Section 1358.81, respectively.

(6) Standardized Medicare supplement benefit high deductible plan F shall include only the following: 100 percent of covered expenses following the payment of the annual deductible set forth in subparagraph (B).

(A) The basic (core) benefit as defined in subdivision (b) of Section 1358.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, as defined in paragraphs (1), (3), (4), (5), and (6) of subdivision (c) of Section 1358.81, respectively.

(B) The annual deductible in high deductible plan F shall consist of out-of-pocket expenses, other than premiums, for services covered by plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be one thousand five hundred dollars ($1,500) and shall be adjusted annually from 1999 by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(7)(A) Standardized Medicare supplement benefit plan G shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 1358.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, as defined in paragraphs (1), (3), (5), and (6) of subdivision (c) of Section 1358.81, respectively.

(B) Effective January 1, 2020, the standardized benefit plans described in paragraph (4) of subdivision (a) of Section 1358.92 (redesignated high deductible plan G) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

(8) Standardized Medicare supplement benefit plan K shall include only the following:

(A) Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period.

(B) Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period.

(C) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(D) Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (J).

(E) Coverage for 50 percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (J).

(F) Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (J).

(G) Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless

replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph (J).

(H) Except for coverage provided in subparagraph (I), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the enrollee or subscriber pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (J).

(I) Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the enrollee or subscriber pays the Part B deductible.

(J) Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the United States Department of Health and Human Services.

(9) Standardized Medicare supplement benefit plan L shall include only the following:

(A) The benefits described in subparagraphs (A), (B), (C), and (I) of paragraph (8).

(B) The benefits described in subparagraphs (D), (E), (F), (G), and (H) of paragraph (8), but substituting 75 percent for 50 percent.

(C) The benefit described in subparagraph (J) of paragraph (8), but substituting two thousand dollars ($2,000) for four thousand dollars ($4,000).

(10) Standardized Medicare supplement benefit plan M shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 1358.81, plus 50 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as defined in paragraphs (2), (3), and (6) of subdivision (c) of Section 1358.81, respectively.

(11) Standardized Medicare supplement benefit plan N shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 1358.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as defined in paragraphs (1), (3), and (6) of subdivision (c) of Section 1358.81, respectively, with copayments in the following amounts:

(A) The lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists.

(B) The lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the enrollee or subscriber is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(f) An issuer may, with the prior approval of the director, offer contracts with new or innovative benefits, in addition to the standardized benefits provided in a contract that otherwise complies with the applicable stan-

dards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement contracts, are new or innovative, are not otherwise available, and are cost effective. Approval of new or innovative benefits shall not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

HISTORY:
Added Stats 2009 ch 10 § 6 (AB 1543), effective July 2, 2009. Amended Stats 2010 ch 328 § 118 (SB 1330), effective January 1, 2011; Stats 2019 ch 157 § 1 (SB 784), effective July 30, 2019.

§ 1358.91. Mandatory standards applicable to contracts with effective date on or after June 1, 2010; Benefit plans that may be offered in state; Innovative benefits [Effective January 1, 2020]

The following standards are applicable to all Medicare supplement contracts delivered or issued for delivery in this state with an effective date on or after June 1, 2010. No contract may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement contract unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement contracts issued with an effective date before June 1, 2010, remain subject to the requirements of Section 1358.9.

(a)(1) An issuer shall make available to each prospective enrollee and subscriber a contract containing only the basic (core) benefits, as defined in subdivision (b) of Section 1358.81.

(2) If an issuer makes available any of the additional benefits described in subdivision (c) of Section 1358.81, or offers standardized benefit plan K or L, as described in paragraphs (8) and (9) of subdivision (e), then the issuer shall make available to each prospective enrollee and subscriber, in addition to a contract with only the basic (core) benefits as described in paragraph (1), a contract containing either standardized benefit plan C, as described in paragraph (3) of subdivision (e), or standardized benefit plan F, as described in paragraph (5) of subdivision (e).

(b) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in subdivision (f) and by Section 1358.10.

(c) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans listed in subdivision (e) and conform to the definitions in Section 1358.4. Each benefit shall be structured in accordance with the format provided in subdivisions (b) and (c) of Section 1358.81; or, in the case of plan K or L, in paragraph (8) or (9) of subdivision (e) of Section 1358.91 and list the benefits in the order shown in subdivision (e). For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(d) In addition to the benefit plan designations required in subdivision (c), an issuer may use other designations to the extent permitted by law.

(e) With respect to the makeup of 2010 standardized benefit plans, the following shall apply:

(1) Standardized Medicare supplement benefit plan A shall include only

the following: the basic (core) benefits as defined in subdivision (b) of Section 1358.81.

(2) Standardized Medicare supplement benefit plan B shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 1358.81, plus 100 percent of the Medicare Part A deductible as defined in paragraph (1) of subdivision (c) of Section 1358.81.

(3) Standardized Medicare supplement benefit plan C shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 1358.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country, as defined in paragraphs (1), (3), (4), and (6) of subdivision (c) of Section 1358.81, respectively.

(4) Standardized Medicare supplement benefit plan D shall include only the following: the basic (core) benefit, as defined in subdivision (b) of Section 1358.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as defined in paragraphs (1), (3), and (6) of subdivision (c) of Section 1358.81, respectively.

(5) Standardized Medicare supplement benefit plan F shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 1358.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, as defined in paragraphs (1), (3), (4), (5), and (6) of subdivision (c) of Section 1358.81, respectively.

(6) Standardized Medicare supplement benefit high deductible plan F shall include only the following: 100 percent of covered expenses following the payment of the annual deductible set forth in subparagraph (B).

(A) The basic (core) benefit as defined in subdivision (b) of Section 1358.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, as defined in paragraphs (1), (3), (4), (5), and (6) of subdivision (c) of Section 1358.81, respectively.

(B) The annual deductible in high deductible plan F shall consist of out-of-pocket expenses, other than premiums, for services covered by plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be one thousand five hundred dollars ($1,500) and shall be adjusted annually from 1999 by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(7)(A) Standardized Medicare supplement benefit plan G shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 1358.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country,

as defined in paragraphs (1), (3), (5), and (6) of subdivision (c) of Section 1358.81, respectively.

(B) Effective January 1, 2020, the standardized benefit plans described in paragraph (4) of subdivision (a) of Section 1358.92 (redesignated high deductible plan G) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

(8) Standardized Medicare supplement benefit plan K shall include only the following:

(A) Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period.

(B) Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period.

(C) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(D) Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (J).

(E) Coverage for 50 percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (J).

(F) Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (J).

(G) Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph (J).

(H) Except for coverage provided in subparagraph (I), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the enrollee or subscriber pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (J).

(I) Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the enrollee or subscriber pays the Part B deductible.

(J) Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by

the Secretary of the United States Department of Health and Human Services.

(9) Standardized Medicare supplement benefit plan L shall include only the following:

(A) The benefits described in subparagraphs (A), (B), (C), and (I) of paragraph (8).

(B) The benefits described in subparagraphs (D), (E), (F), (G), and (H) of paragraph (8), but substituting 75 percent for 50 percent.

(C) The benefit described in subparagraph (J) of paragraph (8), but substituting two thousand dollars ($2,000) for four thousand dollars ($4,000).

(10) Standardized Medicare supplement benefit plan M shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 1358.81, plus 50 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as defined in paragraphs (2), (3), and (6) of subdivision (c) of Section 1358.81, respectively.

(11) Standardized Medicare supplement benefit plan N shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 1358.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as defined in paragraphs (1), (3), and (6) of subdivision (c) of Section 1358.81, respectively, with copayments in the following amounts:

(A) The lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists.

(B) The lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the enrollee or subscriber is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(f)(1)(A) An issuer may, with the prior approval of the director, offer contracts with new or innovative benefits, in addition to the standardized benefits provided in a contract that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement contracts, are new or innovative, are not otherwise available, and are cost effective. Approval of new or innovative benefits shall not adversely impact the goal of Medicare supplement simplification.

(B) New or innovative benefits shall exclude an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing, in any standardized plan.

(C) Commencing July 1, 2020, the portion of the premium attributed to the new or innovative benefits shall be identified as a separate line item on the payment invoice or bill.

(2) In the interest of full and fair disclosure, and to ensure the availability of necessary consumer information to current and potential

enrollees or subscribers, for purposes of implementing this paragraph, the department shall collaborate with the Department of Insurance, consumer group representatives, and issuers to develop and implement policies and procedures, as necessary, including, but not limited to, all of the following:

(A) The development and dissemination of information and material about any new or innovative benefits approved for sale.

(B) The revision of materials described in Sections 1358.15 and 1358.18 of this code, and Sections 10192.15 and 10192.18 of the Insurance Code, as may be necessary.

(C) The standardization of new or innovative benefits, as appropriate, for purposes of allowing consumer comparison of benefits, out-of-pocket costs, and premiums.

(3) On or before July 1, 2020, the director may issue guidance to issuers regarding compliance with this section and that guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Any guidance issued pursuant to this subdivision shall be effective only through December 31, 2022, or until the director adopts and effects regulations pursuant to the Administrative Procedure Act, whichever occurs first.

HISTORY:
Added Stats 2009 ch 10 § 6 (AB 1543), effective July 2, 2009. Amended Stats 2010 ch 328 § 118 (SB 1330), effective January 1, 2011; Stats 2019 ch 157 § 1 (SB 784), effective July 30, 2019; Stats 2019 ch 549 § 1 (SB 407), effective January 1, 2020.

§ 1358.92. Mandatory standards applicable to policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in the state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of Section 1358.91 or 1358.9, as applicable.

(a) The standards and requirements of Section 1358.91 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(1) Standardized Medicare supplement benefit plan C is redesignated as plan D and shall provide the benefits described in paragraph (3) of subdivision (e) of Section 1358.91 but shall not provide coverage for 100 percent, or any portion, of the Medicare Part B deductible.

(2) Standardized Medicare supplement benefit plan F is redesignated as plan G and shall provide the benefits described in paragraph (5) of

subdivision (e) of Section 1358.91, but shall not provide coverage for 100 percent, or any portion, of the Medicare Part B deductible.

(3) Standardized Medicare supplement benefit plans C, F, and high deductible plan F may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(4) Standardized Medicare supplement benefit high deductible plan F is redesignated as high deductible plan G and shall provide the benefits described for standardized Medicare supplement benefit high deductible plan F in paragraph (6) of subdivision (e) of Section 1358.91, but shall not provide coverage for 100 percent, or any portion, of the Medicare Part B deductible. The Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual deductible under high deductible plan G.

(5) The reference to standardized Medicare supplement benefit plan C or F in paragraph (2) of subdivision (a) of Section 1358.91 shall, for purposes of this section, be deemed a reference to standardized Medicare supplement benefit plan D or G, respectively.

(b) This section shall apply only to individuals who are newly eligible for Medicare on or after January 1, 2020. For purposes of this section, "newly eligible Medicare beneficiary" means an individual who satisfies one of the following:

(1) The individual has attained 65 years of age on or after January 1, 2020.

(2) The individual is entitled to benefits under Medicare Part A pursuant to Section 226(b) or 226A of the Social Security Act, or is deemed eligible for benefits under Section 226(a) of the Social Security Act, on or after January 1, 2020.

(c) For purposes of subdivision (e) of Section 1358.12, in the case of an individual newly eligible for Medicare on or after January 1, 2020, any reference to standardized Medicare supplement benefit plan C, plan F, or high deductible plan F shall be deemed to be a reference to standardized Medicare supplement benefit plan D, plan G, or high deductible plan G, respectively, that meet the requirements of subdivision (a).

(d) On or after January 1, 2020, the standardized Medicare supplement benefit plans described in paragraph (4) of subdivision (a) may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized Medicare supplement benefit plans described in subdivision (e) of Section 1358.91.

HISTORY:
Added Stats 2019 ch 157 § 2 (SB 784), effective July 30, 2019.

§ 1358.10. Medicare Select contracts

(a)(1) This section shall apply to Medicare Select contracts, as defined in this section.

(2) A contract shall not be advertised as a Medicare Select contract unless it meets the requirements of this section.

(b) For the purposes of this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) "Grievance" means dissatisfaction expressed in writing by an individual covered by a Medicare Select contract with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select contract.

(4) "Medicare Select contract" means a Medicare supplement contract that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits covered under a Medicare Select contract. "Provider network" means a grouping of network providers.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the director within which an issuer is authorized to offer a Medicare Select contract.

(c) The director may authorize an issuer to offer a Medicare Select contract pursuant to Section 4358 of the federal Omnibus Budget Reconciliation Act (OBRA) of 1990 if the director finds that the issuer's Medicare Select contracts are in compliance with this chapter and if the director finds that the issuer has satisfied all of the requirements of this section.

(d) A Medicare Select issuer shall not issue a Medicare Select contract in this state until its plan of operation has been approved by the director.

(e) A Medicare Select issuer shall file a proposed plan of operation with the director in a format prescribed by the director. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration of all of the following:

(A) That services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and afterhour care. The hours of operation and availability of afterhour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(B) That the number of network providers in the service area is sufficient, with respect to current and expected enrollees, as to either of the following:

(i) To deliver adequately all services that are subject to a restricted network provision.

(ii) To make appropriate referrals.

(C) There are written agreements with network providers describing specific responsibilities.

(D) Emergency care is available 24 hours per day and seven days per week.

(E) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, that there are written agreements with network providers prohibiting the providers

from billing or otherwise seeking reimbursement from or recourse against any individual covered under a Medicare Select contract.

This subparagraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select contract.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including all of the following:

(A) The formal organizational structure.

(B) The written criteria for selection, retention, and removal of network providers.

(C) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with subdivision (i).

(7) Any other information requested by the director.

(f)(1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the director prior to implementing the changes. Changes shall be considered approved by the director after 30 days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the director at least quarterly.

(g) A Medicare Select contract shall not restrict payment for covered services provided by nonnetwork providers if:

(1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or condition.

(2) It is not reasonable to obtain services through a network provider.

(h) A Medicare Select contract shall provide payment for full coverage under the contract for covered services that are not available through network providers.

(i) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select contract to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and charges of the Medicare Select contract with both of the following:

(A) Other Medicare supplement contracts offered by the issuer.

(B) Other Medicare Select contracts.

(2) A description, including address, telephone number, and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. The description shall inform the applicant that expenses incurred when using out-of-network providers are excluded from the out-of-pocket annual limit in benefit plans K and L, unless the contract provides otherwise.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the enrollee's rights to purchase any other Medicare supplement contract otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

(j) Prior to the sale of a Medicare Select contract, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subdivision (i) and that the applicant understands the restrictions of the Medicare Select contract.

(k) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the enrollees. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure shall be described in the contract and in the outline of coverage.

(2) At the time the contract is issued, the issuer shall provide detailed information to the enrollee describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decisionmakers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the director regarding its grievance procedure. The report shall be in a format prescribed by the director and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of those grievances.

(*l*) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select contract the opportunity to purchase any Medicare supplement contract otherwise offered by the issuer.

(m)(1) At the request of an enrollee under a Medicare Select contract, a Medicare Select issuer shall make available to the enrollee the opportunity to purchase a Medicare supplement contract offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision, if a Medicare supplement contract of that nature is offered by the issuer. The issuer shall make the contracts available without regard to the health status of the enrollee and without requiring evidence of insurability after the Medicare Select contract has been in force for six months.

(2) For the purposes of this subdivision, a Medicare supplement contract will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select contract being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Medicare Part B excess charges.

(n) Medicare Select contracts shall provide for continuation of coverage in the event the secretary determines that Medicare Select contracts issued

pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each enrollee covered by a Medicare Select contract the opportunity to purchase any Medicare supplement contract offered by the issuer that has comparable or lesser benefits and that does not contain a restricted provider network provision, if a Medicare supplement contract of that nature is offered by the issuer. The issuer shall make the contracts available without regard to the health status of the enrollee and without requiring evidence of insurability after the Medicare Select contract has been in force for six months.

(2) For the purposes of this subdivision, a Medicare supplement contract will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select contract being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Medicare Part B excess charges.

(o) An issuer offering Medicare Select contracts shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select program. An issuer shall not issue a Medicare Select contract in this state until the contract has been approved by the director.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).
Amended Stats 2005 ch 206 § 6 (SB 375).

§ 1358.11. Discriminatory practices; Age; Time periods; Open enrollment periods; Standardized Medicare supplement benefit plan offerings [Effective until January 1, 2020]

(a)(1) An issuer shall not deny or condition the offering or effectiveness of any Medicare supplement contract available for sale in this state, nor discriminate in the pricing of a contract because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a contract that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement contract currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

(2)(A) An issuer shall make available Medicare supplement benefit plans A, B, C, and F, if currently available, to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement benefit plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.

(B) For contracts sold or issued on or after January 1, 2020, to newly

eligible Medicare beneficiaries, as defined in subdivision (b) of Section 1358.92, an issuer shall make available Medicare supplement benefit plans A, B, D, and G, if currently available, to applicants who qualify under this subdivision who are 64 years of age or younger and who do not have end-stage renal disease. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement benefit plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.

(3) This section and Section 1358.12 do not prohibit an issuer in determining subscriber rates from treating applicants who are under 65 years of age and are eligible for Medicare Part B as a separate risk classification.

(b)(1) If an applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this subdivision shall be as specified by the director.

(c) Except as provided in subdivision (b) and Section 1358.23, subdivision (a) shall not be construed as preventing the exclusion of benefits under a contract, during the first six months, based on a preexisting condition for which the enrollee received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(d) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for six months after the date of their enrollment in Medicare Part B, or if notified retroactively of their eligibility for Medicare, for six months following notice of eligibility. Sales during the open enrollment period shall not be discouraged by any means, including the altering of the commission structure.

(e)(1) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(A) Receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(B) Receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(C) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

(2) For purposes of this subdivision, "employer-sponsored retiree health plan" includes any coverage for medical expenses, including coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the California Continuation Benefits Replacement Act (Cal-COBRA), that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included covered persons.

(f) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the issuer.

(g)(1) An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any and all Medicare supplement coverage available on a guaranteed basis under state and federal law or regulations for persons terminated by their Medicare Advantage plan.

(2) Health plans that terminate Medicare enrollees shall notify those enrollees in the termination notice of the additional open enrollment period authorized by this subdivision. Health plan notices shall inform enrollees of the opportunity to secure advice and assistance from the HICAP in their area, along with the toll-free telephone number for HICAP.

(h)(1) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement coverage that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no issuer that falls under this provision shall deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy, certificate, or contract. An issuer that offers Medicare supplement contracts shall notify an enrollee of their rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period.

(2) For purposes of this subdivision, the following provisions shall apply:

(A) A 1990 standardized Medicare supplement benefit plan A shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan A.

(B) A 1990 standardized Medicare supplement benefit plan B shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan B.

(C) A 1990 standardized Medicare supplement benefit plan C shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan C.

(D) A 1990 standardized Medicare supplement benefit plan D shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan D.

(E) A 1990 standardized Medicare supplement benefit plan E shall be

deemed to offer benefits equal to those provided by a 2010 standardized Medicare benefit plan D.

(F)(i) A 1990 standardized Medicare supplement benefit plan F shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare benefit plan F.

(ii) A 1990 standardized Medicare supplement benefit high deductible plan F shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit high deductible plan F.

(G) A 1990 standardized Medicare supplement benefit plan G shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan G.

(H) A 1990 standardized Medicare supplement benefit plan H shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan D.

(I) A 1990 standardized Medicare supplement benefit plan I shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan G.

(J)(i) A 1990 standardized Medicare supplement benefit plan J shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan F.

(ii) A 1990 standardized Medicare supplement benefit high deductible plan J shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit high deductible plan F.

(K) A 1990 standardized Medicare supplement benefit plan K shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan K.

(L) A 1990 standardized Medicare supplement benefit plan L shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan L.

(i) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that, because of an increase in the individual's income or assets, they meet one of the following requirements:

(1) They are no longer eligible for Medi-Cal benefits.

(2) They are only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that they have not met the share of cost.

HISTORY:

Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2000 ch 707 § 1 (SB 1814), effective September 27, 2000, operative January 1, 2001; Stats 2001 ch 159 § 125 (SB 662); Stats 2002 ch 555 § 1 (SB 1531); Stats 2003 ch 13 § 1 (SB 581), effective May 28, 2003; Stats 2005 ch 206 § 7 (SB 375), effective January 1, 2006; Stats 2009 ch 10 § 7 (AB 1543), effective July 2, 2009; Stats 2011 ch 270 § 1 (AB 151), effective January 1, 2012; Stats 2019 ch 157 § 3 (SB 784), effective July 30, 2019.

§ 1358.11. Discriminatory practices; Age; Time periods; Open enrollment periods; Standardized Medicare supplement benefit plan offerings [Effective January 1, 2020]

(a)(1) An issuer shall not deny or condition the offering or effectiveness of any Medicare supplement contract available for sale in this state, nor discriminate in the pricing of a contract because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the

case of an application for a contract that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement contract currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

(2)(A) An issuer shall make available Medicare supplement benefit plans A, B, C, and F, if currently available, to an applicant who qualifies under this subdivision, who is 64 years of age or younger, and who does not have end-stage renal disease. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement benefit plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.

(B) For contracts sold or issued on or after January 1, 2020, to newly eligible Medicare beneficiaries, as defined in subdivision (b) of Section 1358.92, an issuer shall make available Medicare supplement benefit plans A, B, D, and G, if currently available, to applicants who qualify under this subdivision who are 64 years of age or younger and who do not have end-stage renal disease. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement benefit plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.

(3) This section and Section 1358.12 do not prohibit an issuer in determining subscriber rates from treating applicants who are under 65 years of age and are eligible for Medicare Part B as a separate risk classification.

(b)(1) If an applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this subdivision shall be as specified by the director.

(c) Except as provided in subdivision (b) and Section 1358.23, subdivision (a) does not prevent the exclusion of benefits under a contract, during the first six months, based on a preexisting condition for which the enrollee received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(d) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for six months after the date of their enrollment in Medicare Part B, or if notified retroactively of their

eligibility for Medicare, for six months following notice of eligibility. Sales during the open enrollment period shall not be discouraged by any means, including the altering of the commission structure.

(e)(1) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(A) Receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(B) Receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(C) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

(2) For purposes of this subdivision, "employer-sponsored retiree health plan" includes any coverage for medical expenses, including coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the California Continuation Benefits Replacement Act (Cal-COBRA), that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included covered persons.

(f) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the issuer.

(g)(1) An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any and all Medicare supplement coverage available on a guaranteed basis under state and federal law or regulations for persons terminated by their Medicare Advantage plan.

(2) Health plans that terminate Medicare enrollees shall notify those enrollees in the termination notice of the additional open enrollment period authorized by this subdivision. Health plan notices shall inform enrollees of the opportunity to secure advice and assistance from the HICAP in their area, along with the toll-free telephone number for HICAP.

(h)(1) An individual shall be entitled to an annual open enrollment period lasting 60 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement coverage that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, an issuer that falls under this paragraph shall not deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy, certificate, or contract. An issuer that offers Medicare supplement contracts shall notify

an enrollee of their rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period, and on any notice related to a benefit modification or premium adjustment.

(2) For purposes of this subdivision, the following provisions apply:

(A) A 1990 standardized Medicare supplement benefit plan A shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan A.

(B) A 1990 standardized Medicare supplement benefit plan B shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan B.

(C) A 1990 standardized Medicare supplement benefit plan C shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan C.

(D) A 1990 standardized Medicare supplement benefit plan D shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan D.

(E) A 1990 standardized Medicare supplement benefit plan E shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare benefit plan D.

(F)(i) A 1990 standardized Medicare supplement benefit plan F shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare benefit plan F.

(ii) A 1990 standardized Medicare supplement benefit high deductible plan F shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit high deductible plan F.

(G) A 1990 standardized Medicare supplement benefit plan G shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan G.

(H) A 1990 standardized Medicare supplement benefit plan H shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan D.

(I) A 1990 standardized Medicare supplement benefit plan I shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan G.

(J)(i) A 1990 standardized Medicare supplement benefit plan J shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan F.

(ii) A 1990 standardized Medicare supplement benefit high deductible plan J shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit high deductible plan F.

(K) A 1990 standardized Medicare supplement benefit plan K shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan K.

(L) A 1990 standardized Medicare supplement benefit plan L shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan L.

(M) New or innovative benefits, as described in subdivision (f) of Section 1358.9 and subdivision (f) of Section 1358.91, shall not be included when determining whether benefits are equal to or lesser than those provided by the previous coverage.

(i) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that, because of an increase in the individual's income or assets, they meet one of the following requirements:

(1) They are no longer eligible for Medi-Cal benefits.

(2) They are only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that they have not met the share of cost.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2000 ch 707 § 1 (SB 1814), effective September 27, 2000, operative January 1, 2001; Stats 2001 ch 159 § 125 (SB 662); Stats 2002 ch 555 § 1 (SB 1531); Stats 2003 ch 13 § 1 (SB 581), effective May 28, 2003; Stats 2005 ch 206 § 7 (SB 375), effective January 1, 2006; Stats 2009 ch 10 § 7 (AB 1543), effective July 2, 2009; Stats 2011 ch 270 § 1 (AB 151), effective January 1, 2012; Stats 2019 ch 157 § 3 (SB 784), effective July 30, 2019; Stats 2019 ch 549 § 2 (SB 407), effective January 1, 2020.

§1358.12. Guaranteed issue of contract; Eligible persons; Enrollment in case of involuntary termination; Entitlement to benefit packages; Notice of rights; Refund

(a)(1) With respect to the guaranteed issue of a Medicare supplement contract, eligible persons are those individuals described in subdivision (b) who seek to enroll under the contract during the period specified in subdivision (c), and who submit evidence of the date of termination or disenrollment or enrollment in Medicare Part D with the application for a Medicare supplement contract.

(2) With respect to eligible persons, an issuer shall not take any of the following actions:

(A) Deny or condition the issuance or effectiveness of a Medicare supplement contract described in subdivision (e) that is offered and is available for issuance to new enrollees by the issuer.

(B) Discriminate in the pricing of that Medicare supplement contract because of health status, claims experience, receipt of health care, or medical condition.

(C) Impose an exclusion of benefits based on a preexisting condition under that Medicare supplement contract.

(b) An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and either of the following applies:

(A) The plan either terminates or ceases to provide all of those supplemental health benefits to the individual.

(B) The employer no longer provides the individual with insurance that covers all of the payment for the 20-percent coinsurance.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply:

(A) The certification of the organization or plan has been terminated.

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circum-

stances specified by the secretary. Those changes in circumstances shall not include termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856 of the federal Social Security Act, or the plan is terminated for all individuals within a residence area.

(D) The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual. An individual shall be eligible under this subparagraph for a Medicare supplement contract issued by the same issuer through which the individual was enrolled at the time the reduction, increase, or discontinuance described above occurs or, commencing January 1, 2007, for one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer.

(i) The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing or premium or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual. An individual shall be eligible under this subparagraph for a Medicare supplement contract issued by the same issuer through which the individual was enrolled at the time the reduction, increase, or discontinuance described above occurs or, commencing January 1, 2007, for one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer. If no Medicare supplement contract is available to the individual from the same issuer, a subsidiary of the parent company of the issuer, or a network that contracts with the parent company of the issuer, the individual shall be eligible for a Medicare supplement contract pursuant to paragraph (1) of subdivision (e) issued by any issuer, if the Medicare Advantage plan in which the individual is enrolled does any of the following:

(I) Increases the premium by 15 percent or more.

(II) Increases physician, hospital, or drug copayments by 15 percent or more.

(III) Reduces any benefits under the plan.

(IV) Discontinues, for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual.

(ii) Enrollment in a Medicare supplement contract from an issuer unaffiliated with the issuer of the Medicare Advantage plan in which the individual is enrolled shall be permitted only during the annual election period for a Medicare Advantage plan, except where the Medicare Advantage plan has discontinued its relationship with a provider currently furnishing services to the individual. Nothing in this section shall be construed to authorize an individual to enroll in a group

Medicare supplement policy if the individual does not meet the eligibility requirements for the group.

(E) The individual demonstrates, in accordance with guidelines established by the secretary, either of the following:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this article in relation to the individual, including the failure to provide on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards.

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(F) The individual meets other exceptional conditions as the secretary may provide.

(3) The individual is 65 years of age or older, is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the federal Social Security Act, and circumstances similar to those described in paragraph (2) exist that would permit discontinuance of the individual's enrollment with the provider, if the individual were enrolled in a Medicare Advantage plan.

(4) The individual meets both of the following conditions:

(A) The individual is enrolled with any of the following:

(i) An eligible organization under a contract under Section 1876 of the federal Social Security Act (Medicare cost).

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.

(iii) An organization under an agreement under Section 1833(a)(1)(A) of the federal Social Security Act (health care prepayment plan).

(iv) An organization under a Medicare Select policy.

(B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) or (3).

(5) The individual is enrolled under a Medicare supplement contract, and the enrollment ceases because of any of the following circumstances:

(A) The insolvency of the issuer or bankruptcy of the nonissuer organization, or other involuntary termination of coverage or enrollment under the contract.

(B) The issuer of the contract substantially violated a material provision of the contract.

(C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the contract's provisions in marketing the contract to the individual.

(6) The individual meets both of the following conditions:

(A) The individual was enrolled under a Medicare supplement contract and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract under Section 1876 of the federal Social Security Act (Medicare cost), any

similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the federal Social Security Act, or a Medicare Select policy.

(B) The subsequent enrollment under subparagraph (A) is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under Section 1851(e) of the federal Social Security Act).

(7) The individual upon first becoming eligible for benefits under Medicare Part A at 65 years of age, enrolls in a Medicare Advantage plan under Medicare Part C or with a PACE provider under Section 1894 of the federal Social Security Act, and disenrolls from the plan or program not later than 12 months after the effective date of enrollment.

(8) The individual while enrolled under a Medicare supplement contract that covers outpatient prescription drugs enrolls in a Medicare Part D plan during the initial enrollment period, terminates enrollment in the Medicare supplement contract, and submits evidence of enrollment in Medicare Part D along with the application for a contract described in paragraph (4) of subdivision (e).

(c)(1) In the case of an individual described in paragraph (1) of subdivision (b), the guaranteed issue period begins on the later of the following two dates and ends on the date that is 63 days after the date the applicable coverage terminated:

(A) The date the individual receives a notice of termination or cessation of all supplemental health benefits or, if no notice is received, the date of the notice denying a claim because of a termination or cessation of benefits.

(B) The date that the applicable coverage terminates or ceases.

(2) In the case of an individual described in paragraphs (2), (3), (4), (6), and (7) of subdivision (b) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in subparagraph (A) of paragraph (5) of subdivision (b), the guaranteed issue period begins on the earlier of the following two dates and ends on the date that is 63 days after the date the coverage is terminated:

(A) The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice if any.

(B) The date that the applicable coverage is terminated.

(4) In the case of an individual described in paragraph (2), (3), (6), or (7) of, or in subparagraph (B) or (C) of paragraph (5) of, subdivision (b) who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date of the disenrollment.

(5) In the case of an individual described in paragraph (8) of subdivision (b), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the federal Social Security Act

from the Medicare supplement issuer during the 60-day period immediately preceding the initial enrollment period for Medicare Part D and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) In the case of an individual described in subdivision (b) who is not included in this subdivision, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date of disenrollment.

(d)(1) In the case of an individual described in paragraph (6) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (6) of subdivision (b).

(2) In the case of an individual described in paragraph (7) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with a plan or in a program described in paragraph (7) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (7) of subdivision (b).

(3) For purposes of paragraphs (6) and (7) of subdivision (b), an enrollment of an individual with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b), or with a plan or in a program described in paragraph (7) of subdivision (b), shall not be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(e)(1) Under paragraphs (1), (2), (3), (4), and (5) of subdivision (b), an eligible individual is entitled to a Medicare supplement contract that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, L, M, or N offered by any issuer.

(2)(A) Under paragraph (6) of subdivision (b), an eligible individual is entitled to the same Medicare supplement contract in which he or she was most recently enrolled, if available from the same issuer. If that contract is not available, the eligible individual is entitled to a Medicare supplement contract that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, L, M, or N offered by any issuer.

(B) On and after January 1, 2006, an eligible individual described in this paragraph who was most recently enrolled in a Medicare supplement contract with an outpatient prescription drug benefit, is entitled to a Medicare supplement contract that is available from the same issuer but without an outpatient prescription drug benefit or, at the election of the individual, has a benefit package classified as a Plan A, B, C, F (including high deductible Plan F), K, L, M, or N that is offered by any issuer.

(3) Under paragraph (7) of subdivision (b), an eligible individual is entitled to any Medicare supplement contract offered by any issuer.

(4) Under paragraph (8) of subdivision (b), an eligible individual is entitled to a Medicare supplement contract that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, L, M, or N and that is offered and is available for issuance to a new enrollee by the same issuer that issued the individual's Medicare supplement contract with outpatient prescription drug coverage.

(f)(1) At the time of an event described in subdivision (b) by which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy or contract, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section and of the obligations of issuers of Medicare supplement contracts under subdivision (a). The notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subdivision (b) by which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy or contract, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement contracts under subdivision (a). The notice shall be communicated within 10 working days of the date the issuer received notification of disenrollment.

(g) An issuer shall refund any unearned premium that an enrollee or subscriber paid in advance and shall terminate coverage upon the request of an enrollee or subscriber.

HISTORY:
Added Stats 2005 ch 206 § 9 (SB 375), effective January 1, 2006. Amended Stats 2009 ch 10 § 8 (AB 1543), effective July 2, 2009; Stats 2010 ch 328 § 117 (SB 1330), effective January 1, 2011; Stats 2011 ch 270 § 2 (AB 151), effective January 1, 2012.

§ 1358.13. Compliance with federal statutes

(a) An issuer shall comply with Section 1882(c)(3) of the federal Social Security Act (as enacted by Section 4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act of 1987 (OBRA), Public Law 100-203) by doing all of the following:

(1) Accepting a notice from a Medicare Administrative Contractor, formerly known as a fiscal intermediary or carrier, on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice.

(2) Notifying the participating physician or supplier and the beneficiary of the payment determination.

(3) Paying the participating physician or supplier directly.

(4) Furnishing, at the time of enrollment, each enrollee with a card listing the contract name, number, and a central mailing address to which notices respecting coverage from a Medicare Administrative Contractor may be sent.

(5) Paying user fees established under Section 1395u(h)(3)(B) of Title 42 of

the United States Code, for claim notices that are transmitted electronically or otherwise.

(6) Providing to the secretary, at least annually, a central mailing address to which all claims may be sent by Medicare Administrative Contractors.

(b) Compliance with the requirements set forth in subdivision (a) shall be certified on the Medicare supplement insurance experience reporting form provided by the director.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2009 ch 10 § 9 (AB 1543), effective July 2, 2009.

§ 1358.14. Loss ratio standards; Refund or credit calculations; Prepaid or periodic charges and supporting documentation; Public hearings

(a)(1)(A) With respect to loss ratio standards, a Medicare supplement contract shall not be advertised, solicited, or issued for delivery unless the contract can be expected, as estimated for the entire period for which prepaid or periodic charges are computed to provide coverage, to return to subscribers and enrollees in the form of aggregate benefits under the contract, not including anticipated refunds or credits provided under the contract, at least 75 percent of the aggregate amount of charges earned in the case of group contracts, or at least 65 percent of the aggregate amount of charges earned in the case of individual contracts, on the basis of incurred claims or costs of health care services experience and earned prepaid or periodic charges for that period and in accordance with accepted actuarial principles and practices.

(B) Loss ratio standards shall be calculated on the basis of incurred health care expenses where coverage is provided by a health care service plan on a service rather than reimbursement basis, and earned prepaid or periodic charges shall be calculated for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health care service plan shall not include any of the following:

(i) Home office and overhead costs.

(ii) Advertising costs.

(iii) Commissions and other acquisition costs.

(iv) Taxes.

(v) Capital costs.

(vi) Administrative costs.

(vii) Claims processing costs.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to prepaid or periodic charges comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying paragraph (1) of subdivision (a) and paragraph (3) of subdivision (d) of Section 1358.15 only, contracts issued as a

result of solicitations of individuals through the mail or by mass media advertising, including both print and broadcast advertising, shall be deemed to be individual contracts.

(b)(1) With respect to refund or credit calculations, an issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form required by the director (NAIC Appendix A) for each type of coverage in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type of contract offered by the issuer. For purposes of the refund or credit calculation, experience on contracts issued within the reporting year shall be excluded.

(3) For the purposes of this section, with respect to contracts advertised, solicited, or issued for delivery prior to January 1, 2001, the issuer shall make the refund or credit calculation separately for all individual contracts, including all group contracts subject to an individual loss ratio standard when issued, combined and all other group contracts combined for experience after January 1, 2001. The first report pursuant to paragraph (1) shall be due by May 31, 2003.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds ten dollars ($10). The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against prepaid or periodic charges due shall be made by September 30 following the experience year upon which the refund or credit is based.

(c) An issuer of Medicare supplement contracts shall file annually its prepaid or periodic charges and supporting documentation including ratios of incurred losses to earned prepaid or periodic charges by contract duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which charges are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for contracts in force less than three years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement contracts shall file with the director, in accordance with applicable filing procedures, all of the following:

(1)(A) Appropriate prepaid or periodic charge adjustments necessary to produce loss ratios as anticipated for the current charge for the applicable contracts. The supporting documents necessary to justify the adjustment shall accompany the filing.

(B) An issuer shall make prepaid or periodic charge adjustments necessary to produce an expected loss ratio under the contract to conform

to minimum loss ratio standards for Medicare supplement contracts and that are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current charges by the issuer for the Medicare supplement contracts. No charge adjustment that would modify the loss ratio experience under the contract other than the adjustments described in this section shall be made with respect to a contract at any time other than upon its renewal date or anniversary date.

(C) If an issuer fails to make prepaid or periodic charge adjustments acceptable to the director, the director may order charge adjustments, refunds, or credits deemed necessary to achieve the loss ratio required by this section.

(2) Any appropriate contract amendments needed to accomplish the Medicare supplement contract modifications necessary to eliminate benefit duplications with Medicare. The contract amendments shall provide a clear description of the Medicare supplement benefits provided by the contract.

(d)(1) The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a contract form issued before or after the effective date of January 1, 2001, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

(2) The director may conduct a public hearing to gather information if the experience of the form filed under paragraph (1) of subdivision (b) for the previous reporting period is not in compliance with the applicable loss ratio standard.

The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).
Amended Stats 2005 ch 206 § 10 (SB 375), effective January 1, 2006.

§ 1358.145. Calculation of loss ratios; Copies to department; Compliance with standards

(a) The calculation of actual or expected loss ratios shall be pursuant to the formula in subdivision (a) of Section 1358.14, and pursuant to definitions, procedures, and other provisions as may be deemed by the director, with due consideration of the circumstances of the particular issuer, to be fair, reasonable, and consistent with the objectives of this chapter.

(b) Each issuer shall submit to the department a copy of the calculations for the actual or expected loss ratio as required by Section 1358.14. The calculations shall include the following data: the actual loss ratio for the entire period in which the contract has been in force, as well as for the immediate past three years and for each year in which the contract has been in force, the scale of prepaid or periodic charges for the loss ratio calculation period, a description of all assumptions, the formula used to calculate gross prepaid or periodic charges, the expected level of earned prepaid or periodic charges in the loss ratio calculation period, and the expected level of incurred claims for reim-

bursement, including paid claims and incurred but not paid claims, in the loss ratio calculation period. The calculations shall be accompanied by an actuarial certification, consisting of a signed declaration of an actuary who is a member in good standing of the American Academy of Actuaries in which the actuary states that the assumptions used in calculating the expected loss ratio are appropriate and reasonable, taking into account that the calculations are in accordance with the provisions of subdivision (a) and the provisions referred to therein. In addition, the director may require the issuer to submit actuarial certification, as described above, by one or more unaffiliated actuaries acceptable to the director.

(c) Notwithstanding the calculations required by subdivision (b), contracts shall be deemed to comply with the loss ratio standards if, and shall be deemed not to comply with the loss standards unless: (1) for the most recent year, the ratio of the incurred losses to earned prepaid charges for contracts that have been in force for three years or more is greater than or equal to the applicable percentages contained in this section; and (2) the expected losses in relation to charges over the entire period for which the contract is rated comply with the requirements of this section. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for contracts in force less than three years.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).

§ 1358.146. Format for reporting loss ratio experience

The following format shall be used for reporting loss ratio experience:

MEDICARE SUPPLEMENT
HEALTH CARE SERVICE PLAN
CONTRACT EXPERIENCE EXHIBIT

For the year ended December 31, 20____ .
For the State of California.

Of the _____ health care service plan.
Address (City, State, and Zip Code)_____
Person Completing this Exhibit_____

To be filed by June 30th following the filing under Section 1358.14 of the Health and Safety Code

Costs for Health Care Services

Classification	Prepaid or Periodic Charges Earned	Amount	Percentage of Prepaid or Periodic Charges Earned
Experience on Individual Plan Contracts			

1. Contracts issued
through 20 ____
Reporting State _____
Nationwide _____

2. Contracts issued
after 20 ____
Reporting State _____
Nationwide _____

Experience on Group
Plan Contracts

1. Contracts issued
through 20 ____
Reporting State _____
Nationwide _____

2. Contracts issued
after 20 ____
Reporting State _____
Nationwide _____

The undersigned officer hereby certifies that the company named above has complied with the requirements contained in the federal Omnibus Budget Reconciliation Act of 1987, Section 4081.

Signature _____
Title and name (please type) _____

INSTRUCTIONS FOR COMPLETING MEDICARE SUPPLEMENT HEALTH CARE SERVICE PLAN CONTRACT EXPERIENCE EXHIBIT

1. Experience on plan contracts issued more than three years prior to the reporting year should be shown separately as indicated on the form. For example, for the reporting year ended 12/31/88 (filed on June 30, 1989), experience on plan contracts issued in 1985 and prior should be shown separately from that of plan contracts issued in 1986 and later. For group coverage, the year of issue should be based on when the contract was issued if available; otherwise use the master plan contract year of issue.

2. Allocation of reserves on a state-by-state basis should be on sound actuarial principles and be consistent from year to year.

3. Membership or plan contract fees, if any, constitute, and should be included with, prepaid or periodic charges earned. Earned prepaid or periodic charges may be shown on an annual basis net of loadings for nonannual modes.

4. Mass marketing group coverage subject to individual loss ratio standards should be included with individual plan contracts.

5. Any dividends paid to subscribers should be included with costs for health care.

6. Neither costs for health care services nor earned prepaid or periodic charges

should be adjusted for changes in plan contract (additional) reserves.

DEFINITIONS

For purposes of this form:

1. "Costs for health care services" means payment for health care services plus the increase in claim reserves. Claim reserves include only those unpaid liabilities for claims that have already been incurred. Costs for health care services in this exhibit do not include plan contract additional reserves.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).

§ 1358.15. Approval of contract by director as prerequisite to advertising or issuance; Requirements; Filing of certain changes; Time periods

(a) An issuer shall not advertise, solicit, or issue for delivery a Medicare supplement contract to a resident of this state unless the contract has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director. Until January 1, 2001, or 90 days after approval of Medicare supplement contracts submitted for approval pursuant to this section, whichever is later, issuers may continue to offer and market previously approved Medicare supplement contracts.

(b) An issuer shall file any riders or amendments to contract forms to delete outpatient prescription drug benefits, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), only in the state where the contract was issued.

(c) An issuer shall not use or change prepaid or periodic charges for a Medicare supplement contract unless the charges and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.

(d)(1) Except as provided in paragraph (2), an issuer shall not file for approval more than one contract of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the director, up to four additional contracts of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(A) The inclusion of new or innovative benefits.

(B) The addition of either direct response or agent marketing methods.

(C) The addition of either guaranteed issue or underwritten coverage.

(D) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a "type" means an individual contract, a group contract, an individual Medicare Select contract, or a group Medicare Select contract.

(e)(1) Except as provided in subdivision (a), an issuer shall continue to make available for purchase any contract issued after January 1, 2001, that has been approved by the director. A contract shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(A) An issuer may discontinue the availability of a contract if the issuer provides to the director in writing its decision at least 30 days prior to discontinuing the availability of the form of the contract. After receipt of the notice by the director, the issuer shall no longer offer for sale the contract in this state.

(B) An issuer that discontinues the availability of a contract pursuant to subparagraph (A) shall not file for approval a new contract of the same type for the same standard Medicare supplement benefit plan as the discontinued contract for a period of five years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section.

(3) A change in the rating structure or methodology shall be considered a discontinuance under paragraph (1) unless the issuer complies with the following requirements:

(A) The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(B) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The director may approve a change to the differential that is in the public interest.

(f)(1) Except as provided in paragraph (2), the experience of all contracts of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 1358.14.

(2) Contracts assumed under an assumption reinsurance agreement shall not be combined with the experience of other contracts for purposes of the refund or credit calculation.

(g) A Medicare supplement contract shall be deemed not to be fair, just, or consistent with the objectives of this chapter at all times, and shall not be advertised, solicited, or issued for delivery at any time, except during that period of time, if any, beginning with the date of receipt by the plan of notification by the director that the provisions of the contract are deemed to be fair, just, and consistent with the objectives of this chapter, and ending with the earlier to occur of the events indicated in subdivision (h).

(h) The period of time indicated in subdivision (g) shall terminate at the earlier to occur of (1) receipt by the plan of written revocation by the director of the immediate past notification referred to in subdivision (g) specifying the basis for the revocation, (2) the last day of the prepaid or periodic charge calculation period, that in no event may exceed one year, or (3) June 30, of the next succeeding calendar year.

(i) An issuer shall secure the director's review of a contract subject to this article by submitting, not less than 30 days prior to any proposed advertising or other use of the contract not already protected by a currently effective notice under subdivision (g), the following for the director's review:

(1) A copy of the contract.

(2) A copy of the disclosure form.

(3) A representation that the contract complies with the provisions of this chapter and the rules adopted thereunder.

(4) A completed copy of the "Medicare Supplement Health Care Service Plan Contract Experience Exhibit" set forth in Section 1358.145.

(5) A copy of the calculations for the actual or expected loss ratio.

(6) Supporting data used in calculating the actual or expected loss ratio as indicated in Section 1358.14.

(7) An actuarial certification, as specified in Section 1358.14, of the loss ratio computations.

(8) If required by the director, actuarial certification, as specified in Section 1358.14, of the loss ratio computations by one or more unaffiliated actuaries acceptable to the director.

(9) An undertaking by the issuer to notify the subscribers in writing within 60 days of decertification, if the contract is identified as a certified contract at the time of sale and later decertified.

(10) A signed statement of the president of the issuer or other officer of the issuer designated by that person attesting that the information submitted for review is accurate and complete and does not misrepresent any material fact.

(j) An issuer that submits information pursuant to subdivision (i) shall provide any additional information as may be requested by the director to enable the director to conclude that the contract complies with the provisions of this chapter and rules adopted thereunder.

(k) For the purposes of this section, the term "decertified," as applied to a contract, means that the director by written notice has found that the contract no longer complies with the provisions of this chapter and the rules adopted thereunder and has revoked the prior authorization to display on the contract the emblem indicating certification.

(*l*) Benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors and the amount of prepaid charges may be modified, as indicated in paragraph (6) of subdivision (a) of Section 1300.67.4 of Title 28 of the California Code of Regulations, to correspond with those changes.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).
Amended Stats 2005 ch 206 § 11 (SB 375), effective January 1, 2006.

§ 1358.16. Compensation for solicitors and sales representatives

(a) An issuer or other entity may provide a commission or other compensation to a solicitor or other representative for the sale of a Medicare supplement contract only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the contract in the second year or period.

(b) The commission or other compensation provided in subsequent renewal years shall be the same as that provided in the second year or period and shall be provided for no fewer than five renewal years.

(c) No issuer shall provide compensation to a solicitor or solicitor firm, and no solicitor or solicitor firm shall receive compensation, greater than the renewal compensation payable by the replacing issuer on renewal contracts if an existing contract is replaced.

(d) For purposes of this section, "commission" or "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the contract, including, but not limited to, bonuses, gifts, prizes, awards, and finders' fees.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).
Amended Stats 2005 ch 206 § 12 (SB 375), effective January 1, 2006.

§ 1358.17. Renewal or continuation provision; Amendments to contract; Contract limitations; Notice of right to return; Guide to health insurance; Notice of changes; Outline of coverage; Disclosure pages; Required notices

(a)(1) Medicare supplement contracts shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with subdivision (a) of Section 1365 and the rules adopted thereunder. The provision shall be appropriately captioned and shall appear on the first page of the contract, and shall include any reservation by the issuer of the right to change prepaid or periodic charges and any automatic renewal increases based on the enrollee's age.

(2) The contract shall contain the provisions required to be set forth by Section 1300.67.4 of Title 28 of the California Code of Regulations.

(b)(1) Except for contract amendments by which the issuer effectuates a request made in writing by the enrollee, exercises a specifically reserved right under a Medicare supplement contract, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all amendments to a Medicare supplement contract after the date of issue or upon reinstatement or renewal that reduce or eliminate benefits or coverage in the contract shall require a signed acceptance by the subscriber. After the date of contract issue, any amendment that increases benefits or coverage with a concomitant increase in prepaid or periodic charges during the contract term shall be agreed to in writing signed by the subscriber, unless the benefits are required by the minimum standards for Medicare supplement contracts, or if the increased benefits or coverage is required by law. If a separate additional charge is made for benefits provided in connection with contract amendments, the charge shall be set forth in the contract.

(2) An issuer shall not in any way reduce or eliminate any benefit or coverage under a Medicare supplement contract at any time after the date of entering the contract, including dates of reinstatement or renewal, unless and until the change is voluntarily agreed to in writing signed by the subscriber or enrollee, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits. The issuer shall not increase benefits or coverage with a concomitant increase in prepaid or periodic charges during the term of the contract unless and until the change is voluntarily agreed to in writing signed by the subscriber or enrollee or unless the increased benefits or coverage is required by law or regulation.

(c) Medicare supplement contracts shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

(d) If a Medicare supplement contract contains any limitations with respect to preexisting conditions, those limitations shall appear as a separate paragraph of the contract and be labeled as "Preexisting Condition Limitations."

(e)(1) Medicare supplement contracts shall have a notice prominently printed in no less than 10-point uppercase type, on the cover page of the contract or attached thereto stating that the applicant shall have the right to return the contract within 30 days of its receipt via regular mail, and to have any charges refunded in a timely manner if, after examination of the contract, the covered person is not satisfied for any reason. The return shall void the contract from the beginning, and the parties shall be in the same position as if no contract had been issued.

(2) For purposes of this section, a timely manner shall be no later than 30 days after the issuer receives the returned contract.

(3) If the issuer fails to refund all prepaid or periodic charges paid in a timely manner, then the applicant shall receive interest on the paid charges at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure. The interest shall be paid from the date the issuer received the returned contract.

(f)(1) Issuers of health care service plan contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a guide to health insurance for people with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services and in a type size no smaller than 12-point type. Delivery of the guide shall be made whether or not the contracts are advertised, solicited, or issued for delivery as Medicare supplement contracts as defined in this article. Except in the case of direct response issuers, delivery of the guide shall be made to the applicant at the time of application, and acknowledgment of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request, but not later than at the time the contract is delivered.

(2) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(g) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its enrollees and subscribers of modifications it has made to Medicare supplement contracts in a format acceptable to the director. The notice shall include both of the following:

(1) A description of revisions to the Medicare Program and a description of each modification made to the coverage provided under the Medicare supplement contract.

(2) Inform each enrollee as to when any adjustment in prepaid or periodic charges is to be made due to changes in Medicare.

(h) The notice of benefit modifications and any adjustments of prepaid or periodic charges shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(i) The notices shall not contain or be accompanied by any solicitation.

(j)(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant. If an outline of coverage is provided at the time of application and the Medicare supplement contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the contract shall accompany the contract when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(2) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, information about prepaid or periodic charges, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All Medicare supplement plans authorized by federal law shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Information about prepaid or periodic charges for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The charge and mode shall be stated for all plans that are offered to the prospective applicant. All possible charges for the prospective applicant shall be illustrated.

(3)(A) The following shall only apply to contracts sold for effective dates prior to June 1, 2010:

(i) The outline of coverage shall include the items, and in the same order, specified in the chart set forth in Section 17 of the Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners in 2004.

(ii) The cover page shall contain the 14-plan (A-L) charts. The plans offered by the issuer shall be clearly identified. Innovative benefits shall be explained in a manner approved by the director.

(B) The following shall only apply to policies sold for effective dates on or after June 1, 2010:

(i) The outline of coverage shall include the items, and in the same order specified in the chart set forth in Section 17 of the Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners in 2008.

(ii) The cover page shall contain all Medicare supplement benefit plan charts A to D, inclusive, F, high deductible F, G, and K to N, inclusive. The plans offered by the issuer shall be clearly identified. Innovative benefits shall be explained in a manner approved by the director.

The text shall read: "Medicare supplement contracts can be sold in only standard plans. This chart shows the benefits included in each plan. Every insurance company must offer Plan A. Some plans may not

be available. Plans E, H, I, and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]"

(4) The disclosure pages shall be in the language and format described below in no less than 12-point type.

INFORMATION ABOUT PREPAID OR PERIODIC CHARGES

[Insert plan's name] can only raise your charges if it raises the charge for all contracts like yours in this state. [If the charge is based on the increasing age of the enrollee, include information specifying when charges will change.]

DISCLOSURES

Use this outline to compare benefits and charges among policies.

[The following additional language shall be included under "DISCLOSURES" for contracts with effective dates on or after June 1, 2010, but shall not appear after June 1, 2011.]

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing the most important features of your Medicare supplement plan contract. This is not the plan contract and only the actual contract provisions will control. You must read the contract itself to understand all of the rights and duties of both you and [insert the health care service plan's name].

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your contract, you may return it to [insert plan's address]. If you send the contract back to us within 30 days after you receive it, we will treat the contract as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing other health coverage, do NOT cancel it until you have actually received your new contract and are sure you want to keep it.

NOTICE

This contract may not fully cover all of your medical costs. Neither [insert the health care service plan's name] nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult "The Medicare Handbook" for further details and limitations applicable to Medicare.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new contract, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your contract and refuse to pay any claims if you leave out or falsify important medical information. [If the contract is guaranteed issue, this paragraph need not appear.] Review the application carefully before you sign it. Be certain that all information has been properly recorded. [The charts displaying the features of each benefit plan offered by the issuer shall use the uniform format and language shown in the charts set forth in Section 17 of the Model Regulation to Implement the NAIC Medicare

Supplement Insurance Minimum Standards Model Act, as most recently adopted by the National Association of Insurance Commissioners. No more than four benefit plans may be shown on one chart. For purposes of illustration, charts for each benefit plan are set forth below. An issuer may use additional benefit plan designations on these charts.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

(k) Notwithstanding Section 1300.63.2 of Title 28 of the California Code of Regulations, no issuer shall combine the evidence of coverage and disclosure form into a single document relating to a contract that supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage.

(*l*) The director may adopt regulations to implement this article, including, but not limited to, regulations that specify the required information to be contained in the outline of coverage provided to applicants pursuant to this section, including the format of tables, charts, and other information.

(m)(1) Any health care service plan contract, other than a Medicare supplement contract, a contract issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.), a disability income policy, or any other contract identified in subdivision (b) of Section 1358.3, issued for delivery in this state to persons eligible for Medicare, shall notify enrollees under the contract that the contract is not a Medicare supplement contract. The notice shall either be printed or attached to the first page of the outline of coverage delivered to enrollees under the contract, or if no outline of coverage is delivered, to the first page of the contract delivered to enrollees. The notice shall be in no less than 12-point type and shall contain the following language:

"THIS CONTRACT IS NOT A MEDICARE SUPPLEMENT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance contracts described in paragraph (1) shall disclose the extent to which the contract duplicates Medicare in a manner required by the director. The disclosure statement shall be provided as a part of, or together with, the application for the contract.

(n) A Medicare supplement contract that does not cover custodial care shall, on the cover page of the outline of coverages, contain the following statement in uppercase type: "THIS POLICY DOES NOT COVER CUSTODIAL CARE IN A SKILLED NURSING CARE FACILITY."

(o) An issuer shall comply with all notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173).

HISTORY:

Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2005 ch 206 § 13 (SB 375); Stats 2009 ch 10 § 10 (AB 1543), effective July 2, 2009.

§ 1358.18. Application form; Copy to applicant; Notice as to replacement of coverage; Buyer's guide; Group contracts; Health information from applicant who is guaranteed coverage

In the interest of full and fair disclosure, and to ensure the availability of necessary consumer information to potential subscribers or enrollees not possessing a special knowledge of Medicare, health care service plans, or Medicare supplement contracts, an issuer shall comply with the following provisions:

(a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medi-Cal coverage, or another health insurance policy or certificate or plan contract in force or whether a Medicare supplement contract is intended to replace any other disability policy or certificate, or plan contract, presently in force. A supplementary application or other form to be signed by the applicant and solicitor containing those questions and statements may be used.

"(Statements)

(1) You do not need more than one Medicare supplement policy or contract.

(2) If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare supplement contract.

(4) If, after purchasing this contract, you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare supplement contract or, if that is no longer available, a substantially equivalent contract, will be reinstituted if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in, a Medicare supplement contract by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement contract under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement contract or, if that is no longer available, a substantially equivalent contract, will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled

in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services are available in this state to provide advice concerning your purchase of Medicare supplement coverage and concerning medical assistance through the Medi-Cal or Medicaid Program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). Information regarding counseling services may be obtained from the California Department of Aging.

(Questions)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance contract or that you had certain rights to buy such a contract, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X."]

To the best of your knowledge,

(1) (a) Did you turn 65 years of age in the last 6 months?

_____Yes_____No

(b) Did you enroll in Medicare Part B in the last 6 months?

_____Yes_____No

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through California's Medi-Cal program?

NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.

_____Yes_____No

If yes,

(a) Will Medi-Cal pay your premiums for this Medicare supplement contract?

_____Yes_____No

(b) Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?

_____Yes_____No

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START _____/____/____ END _____/____/____

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement contract?

_____Yes_____No

(c) Was this your first time in this type of Medicare plan?

_____Yes_____No

(d) Did you drop a Medicare supplement contract to enroll in the Medicare plan?

_____Yes_____No

(4) (a) Do you have another Medicare supplement policy or certificate or contract in force?

_____Yes_____No

(b) If so, with what company, and what plan do you have? [optional for Direct Mailers]

_____Yes_____No

(c) If so, do you intend to replace your current Medicare supplement policy or certificate or contract with this contract?

_____Yes_____No

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

_____Yes_____No

(a) If so, with what companies and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START _____/____/____ END _____/____/____

(If you are still covered under the other policy, leave "END" blank)."

(b) Solicitors shall list any other health insurance policies or plan contracts they have sold to the applicant as follows:

(1) List policies and contracts sold that are still in force.

(2) List policies and contracts sold in the past five years that are no longer in force.

(c) An issuer issuing Medicare supplement contracts without a solicitor or solicitor firm (a direct response issuer) shall return to the applicant, upon delivery of the contract, a copy of the application or supplemental forms, signed by the applicant and acknowledged by the issuer.

(d) Upon determining that a sale will involve replacement of Medicare supplement coverage, an issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance for delivery of the Medicare supplement contract, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the contract the notice regarding replacement of Medicare supplement coverage.

(e) The notice required by subdivision (d) for an issuer shall be provided in substantially the following form in no less than 12-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE

(Company name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate an existing Medicare supplement policy or contract or Medicare Advantage plan and replace it with a contract to be issued by [Plan Name]. Your contract to be issued by [Plan Name] will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or contract only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY PLAN, SOLICITOR, SOLICITOR FIRM, OR OTHER REPRESENTATIVE:

(1) I have reviewed your current medical or health coverage. To the best of my knowledge, the replacement of coverage involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement contract is being purchased for the following reason (check one):

__ Additional benefits.

__ No change in benefits, but lower premiums or charges.

__ Fewer benefits and lower premiums or charges.

__ Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D.

__ Disenrollment from a Medicare Advantage plan. Reasons for disenrollment:

__ Other. (please specify)_____.

(2) If the issuer of the Medicare supplement contract being applied for does not impose, or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.

(3) State law provides that your replacement Medicare supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.

(4) If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

(5) Do not cancel your present Medicare supplement coverage until you have received your new contract and are sure you want to keep it.

(Signature of Solicitor, Solicitor Firm, or Other Representative)
[Typed Name and Address of Plan, Solicitor, or Solicitor Firm]

_____
(Applicant's Signature)

_____
(Date)

(f) The application form or other consumer information for persons eligible for Medicare and used by an issuer shall contain, as an attachment, a Medicare supplement buyer's guide in the form approved by the director. The application or other consumer information, containing, as an attachment, the buyer's guide, shall be mailed or delivered to each applicant applying for that coverage at or before the time of application and, to establish compliance with this subdivision, the issuer shall obtain an acknowledgment of receipt of the attached buyer's guide from each applicant. An issuer shall not make use of or otherwise disseminate any buyer's guide that does not accurately outline current Medicare supplement benefits. An issuer shall not be required to provide more than one copy of the buyer's guide to any applicant.

(g) An issuer may comply with the requirement of this section in the case of group contracts by causing the subscriber (1) to disseminate copies of the disclosure form containing as an attachment the buyer's guide to all persons eligible under the group contract at the time those persons are offered the Medicare supplement plan, and (2) collecting and forwarding to the issuer an acknowledgment of receipt of the disclosure form containing, as an attachment, the buyer's guide from each enrollee.

(h) An issuer shall not require, request, or obtain health information as part of the application process for an applicant who is eligible for guaranteed issuance of, or open enrollment for, any Medicare supplement coverage pursuant to Section 1358.11 or 1358.12, except for purposes of paragraph (1) or (2) of subdivision (a) of Section 1358.11 when the applicant is first enrolled in Medicare Part B. The application form shall include a clear and conspicuous statement that the applicant is not required to provide health information during a period where guaranteed issue or open enrollment applies, as specified in Section 1358.11 or 1358.12, except for purposes of paragraph (1) or (2) of subdivision (a) of Section 1358.11 when the applicant is first enrolled in Medicare Part B, and shall inform the applicant of those periods of guaranteed issuance of Medicare supplement coverage. This subdivision does not prohibit an issuer from requiring proof of eligibility for a guaranteed issuance of Medicare supplement coverage.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2005 ch 206 § 14 (SB 375); Stats 2009 ch 10 § 11 (AB 1543), effective July 2, 2009; Stats 2015 ch 303 § 251 (AB 731), effective January 1, 2016; Stats 2016 ch 86 § 176 (SB 1171), effective January 1, 2017.

§ 1358.19. Director's approval of advertisement

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, or television medium to the director for review or approval.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).

§ 1358.20. Duties of issuer as to marketing procedures; Prohibited acts [Effective until January 1, 2020]

(a) An issuer, directly or through solicitors or other representatives, shall do each of the following:

(1) Establish marketing procedures to ensure that any comparison of Medicare supplement coverage by its solicitors or other representatives will be fair and accurate.

(2) Establish marketing procedures to ensure that excessive coverage is not sold or issued.

(3) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and contract, the following:

"Notice to buyer: This Medicare supplement contract may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant for a Medicare supplement contract already has health care coverage and the types and amounts of that coverage.

(5) Provide, on the application form for Medicare supplement contracts, a statement that reads as follows: "A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Managed Health Care's consumer toll-free telephone number (1-888-HMO-2219), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Managed Health Care's Internet Web site (www.dmhc.ca.gov)."

(6) Establish auditable procedures for verifying compliance with this subdivision.

(b) In addition to the practices prohibited by this code or any other law, the following acts and practices are prohibited:

(1) Twisting, which means knowingly making any misleading representation or incomplete or fraudulent comparison of any coverages or issuers for the purpose of inducing or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any coverage or to take out coverage with another plan or insurer.

(2) High pressure tactics, which means employing any method of marketing having the effect of or tending to induce the purchase of coverage through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of coverage.

(3) Cold lead advertising, which means making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is the solicitation of coverage and that contact will be made by a health care service plan or its representative.

(c) The terms "Medicare supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the contract is issued in compliance with this article.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2005 ch 206 § 15 (SB 375); Stats 2009 ch 10 § 12 (AB 1543), effective July 2, 2009.

§ 1358.20. Duties of issuer as to marketing procedures; Prohibited acts [Effective January 1, 2020]

(a) An issuer, directly or through solicitors or other representatives, shall do each of the following:

(1) Establish marketing procedures to ensure that any comparison of Medicare supplement coverage by its solicitors or other representatives will be fair and accurate.

(2) Establish marketing procedures to ensure that excessive coverage is not sold or issued.

(3) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and contract, the following:

"Notice to buyer: This Medicare supplement contract may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant for a Medicare supplement contract already has health care coverage and the types and amounts of that coverage.

(5) Provide, on the application form for Medicare supplement contracts, a statement that reads as follows: "A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Managed Health Care's consumer toll-free telephone number (1-888-466-2219), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Managed Health Care's internet website (www.dmhc.ca.gov)."

(6) Establish auditable procedures for verifying compliance with this subdivision.

(b) In addition to the practices prohibited by this code or any other law, the following acts and practices are prohibited:

(1) Twisting, which means knowingly making any misleading representation or incomplete or fraudulent comparison of any coverages or issuers for the purpose of inducing or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any coverage or to take out coverage with another plan or insurer.

(2) High pressure tactics, which means employing any method of marketing having the effect of or tending to induce the purchase of coverage through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of coverage.

(3) Cold lead advertising, which means making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is the solicitation of coverage and that contact will be made by a health care service plan or its representative.

(c) The terms "Medicare supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the contract is issued in compliance with this article.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2005 ch 206 § 15 (SB 375); Stats 2009 ch 10 § 12 (AB 1543), effective July 2, 2009; Stats 2019 ch 113 § 1 (AB 1802), effective January 1, 2020.

§ 1358.21. Appropriateness of recommended purchase or replacement; Multiple contracts; Issuance to individual enrolled in Part C

(a) In recommending the purchase or replacement of any Medicare supplement coverage, an issuer or its representative shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of a Medicare supplement contract that will provide an individual more than one Medicare supplement policy or certificate, or contract, is prohibited.

(c) An issuer shall not issue a Medicare supplement contract to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's coverage under Medicare Part C.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2005 ch 206 § 16 (SB 375), effective January 1, 2006.

§ 1358.22. Annual report

(a) On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement contract:

(1) Contract number.

(2) Date of issuance.

(b) The items set forth above shall be grouped by enrollee.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).

§ 1358.225. Annual filing of list of contracts in state; Contents

(a) Every issuer shall, by June 30 of each year, file with the director a list of its Medicare supplement contracts offered or issued or outstanding in this state as of the end of the previous calendar year.

(b) The list shall identify the filing issuer by name and address, shall identify each type of contract it offers by name and form number, if one is used, and shall differentiate between contracts filed with and approved by the director in years prior to the previous calendar year, and those filed and approved in the previous calendar year.

(c) The list shall specifically identify all of the following:

(1) Contracts that are issued and outstanding in this state but are no longer offered for sale.

(2) Contracts that, for any reason, were not filed and approved by the director.

(3) Contracts for which the director's approval was withdrawn within the previous calendar year.

(d) The director shall, on or before the first day of September of each year provide the secretary with a list identifying each contract by name and address and the information required to be submitted by this section.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).

§ 1358.23. Waiver of time periods for preexisting conditions

(a) If a Medicare supplement contract replaces another Medicare supplement policy or certificate, or contract, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement contract for similar benefits to the extent that time was spent under the original policy or certificate, or contract.

(b) If a Medicare supplement contract replaces another Medicare supplement policy or certificate, or contract, that has been in effect for at least six months, the replacing contract shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate, or contract.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).

§ 1358.24. Adherence to Genetic Information Nondiscrimination Act of 2008

This section applies to all contracts that become effective on or after May 21, 2009.

(a) In addition to the requirements set forth under Sections 1365.5 and 1374.7, an issuer of a Medicare supplement contract shall adhere to the requirements imposed by the federal Genetic Information Nondiscrimination Act of 2008 (Public Law 110-233), as follows:

(1) The issuer shall not deny or condition the issuance or effectiveness of the contract, including the imposition of any exclusion of benefits under the contract based on a preexisting condition, on the basis of the genetic information with respect to that individual or a family member of the individual.

(2) The issuer shall not discriminate in the pricing of the contract, including the adjustment of prepaid or periodic charges, of an individual on the basis of the genetic information with respect to that individual or a family member of the individual.

(b) Nothing in subdivision (a) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, to do any of the following:

(1) Deny or condition the issuance or effectiveness of the contract or increase the prepaid or periodic charge for a group based on the manifestation of a disease or disorder of an enrollee, subscriber, or applicant.

(2) Increase the prepaid or periodic charge for any contract issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the contract. For purposes of this paragraph, the manifestation of a disease or disorder in one individual shall not also be used as genetic information about other group members and to further increase the prepaid or periodic charge for the group.

(c) An issuer of a Medicare supplement contract shall not request or

require an individual or a family member of that individual to undergo a genetic test.

(d) Subdivision (c) shall not be construed to preclude an issuer of a Medicare supplement contract from obtaining and using the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying the regulations promulgated under Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time, and consistent with subdivision (a).

(e) For purposes of carrying out subdivision (d), an issuer of a Medicare supplement contract may request only the minimum amount of information necessary to accomplish the intended purpose.

(f) An issuer of a Medicare supplement contract shall not request, require, seek, or purchase genetic information for underwriting purposes.

(g) An issuer of a Medicare supplement contract shall not request, require, seek, or purchase genetic information with respect to any individual or a family member of that individual prior to the individual's enrollment under the contract in connection with that enrollment.

(h) If an issuer of a Medicare supplement contract obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual or a family member of that individual, the request, requirement, or purchase shall not be considered a violation of subdivision (g) if the request, requirement, or purchase is not in violation of subdivision (f). However, the issuer shall not use any genetic information obtained under this section for any prohibited purpose described in this section or in Sections 1365.5 and 1374.7.

(i) For the purposes of this section, the following definitions shall apply:

(1) "Issuer of a Medicare supplement contract" includes a third-party administrator, or other person acting for or on behalf of an issuer.

(2) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.

(3) "Genetic information" means, with respect to any individual, information about the individual's genetic tests, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in family members of the individual. The term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by the individual or any family member of the individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by that pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

(4) "Genetic services" means a genetic test, genetic education, genetic counseling, including obtaining, interpreting, or assessing genetic information.

(5) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(6) "Underwriting purposes" includes all of the following:

(A) Rules for, or determination of, eligibility, including enrollment and continued eligibility, for benefits under the contract.

(B) The computation of prepaid or periodic charges or contribution amounts under the contract.

(C) The application of any preexisting condition exclusion under the contract.

(D) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

HISTORY:
Added Stats 2009 ch 10 § 13 (AB 1543), effective July 2, 2009.

ARTICLE 4

Solicitation and Enrollment

Section

1359. Standards for solicitors and solicitor firms.
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Section
1366.2. Availability to group subscribers of termination date of health care contracts in geographic area; Definitions.
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1366.4. Nonphysician providers.
1366.6. Sale of products by health care service plans; Levels of coverage (Operative term contingent).
1366.6. Sale of products by health care service plans; Levels of coverage (Operative date contingent).

HISTORY: Added Stats 1975 ch 941 § 2, operative July 1, 1976.

§ 1359. Standards for solicitors and solicitor firms

(a) The director may require that solicitors and solicitor firms, and principal persons engaged in the supervision of solicitation for plans of solicitor firms, meet such reasonable and appropriate standards with respect to training, experience, and other qualifications as the director finds necessary and appropriate in the public interest or for the protection of subscribers, enrollees, and plans. For such purposes, the director may do the following:

(1) Appropriately classify such persons and individuals.

(2) Specify that all or any portion of such standards shall be applicable to any such class.

(3) Require individuals in any such class to pass examinations prescribed in accordance with such rules.

(b) The director may prescribe by rule reasonable fees and charges to defray the costs of carrying out this section, including, but not limited to, fees for any examination administered by the director or under his or her direction.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1979 ch 1083 § 7; Stats 1999 ch 525 § 85 (AB 78), operative July 1, 2000.

§ 1360. Untrue or misleading advertising or solicitations

(a) No plan, solicitor, solicitor firm, or representative shall use or permit the use of any advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this article:

(1) A written or printed statement or item of information shall be deemed untrue if it does not conform to fact in any respect which is, or may be significant to an enrollee or subscriber, or potential enrollee or subscriber in a plan.

(2) A written or printed statement or item of information shall be deemed misleading whether or not it may be literally true, if, in the total context in which the statement is made or such item of information is communicated, such statement or item of information may be understood by a person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage, or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee, or potential enrollee or subscriber, in a plan, and such is not the case.

(3) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person,

not possessing special knowledge of plans, and evidence of coverage therefor to expect benefits, service charges, or other advantages which the evidence of coverage does not provide or which the plan issuing such coverage or evidence of coverage does not regularly make available to enrollees or subscribers covered under such evidence of coverage.

(b) No plan, or solicitor, or representative shall use or permit the use of any verbal statement which is untrue, misleading, or deceptive or make any representations about coverage offered by the plan or its cost that does not conform to fact. All verbal statements are to be held to the same standards as those for printed matter provided in subdivision (a).

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976.

§ 1360.1. Representations respecting implications of licensing

It is unlawful for any person, including a plan, subject to this chapter to represent or imply in any manner that the person or plan has been sponsored, recommended, or approved, or that the person's or plan's abilities or qualifications have in any respect been passed upon, by the director. Nothing in this section prohibits a statement (other than in a paid advertisement) that a person or plan holds a license under this chapter, if such statement is true and if the effect of such licensing is not misrepresented.

HISTORY:
Added Stats 1979 ch 1083 § 7.5. Amended Stats 1983 ch 611 § 1; Stats 1999 ch 525 § 86 (AB 78), operative July 1, 2000.

§ 1360.5. Representing, constituting, providing services on behalf of Exchange; Unfair business practice

(a) For purposes of this section, "Exchange" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(b) It is an unfair business practice for a solicitor or solicitor firm to hold himself, herself, or itself out as representing, constituting, or otherwise providing services on behalf of the Exchange unless the solicitor or solicitor firm has a valid agreement with the Exchange to engage in those activities.

(c) It is an unfair business practice for a health care service plan to hold itself out as representing, constituting, or otherwise providing services on behalf of the Exchange unless the plan has a valid agreement with the Exchange to engage in those activities.

HISTORY:
Added Stats 2012 ch 876 § 2 (AB 1761), effective January 1, 2013.

§ 1361. New or revised advertisements; Filing

(a) Except as provided in subdivision (b), no plan shall publish or distribute, or allow to be published or distributed on its behalf, any advertisement not subject to Section 1352.1 unless (1) a true copy thereof has first been filed with the director, at least 30 days prior to any such use, or any shorter period as the

director by rule or order may allow, and (2) the director by notice has not found the advertisement, wholly or in part, to be untrue, misleading, deceptive, or otherwise not in compliance with this chapter or the rules thereunder, and specified the deficiencies, within the 30 days or any shorter time as the director by rule or order may allow.

(b) Except as provided in subdivision (c), a licensed plan which has been continuously licensed under this chapter for the preceding 18 months may publish or distribute or allow to be published or distributed on its behalf an advertisement not subject to Section 1352.1 without having filed the same for the director's prior approval, if the plan and the material comply with each of the following conditions:

(1) The advertisement or a material provision thereof has not been previously disapproved by the director by written notice to the plan and the plan reasonably believes that the advertisement does not violate any requirement of this chapter or the rules thereunder.

(2) The plan files a true copy of each new or materially revised advertisement, used by it or by any person acting on behalf of the plan, with the director not later than 10 business days after publication or distribution of the advertisement or within such additional period as the director may allow by rule or order.

(c) If the director finds that any advertisement of a plan has materially failed to comply with this chapter or the rules thereunder, the director may, by order, require the plan to publish in the same or similar medium, an approved correction or retraction of any untrue, misleading, or deceptive statement contained in the advertising, and may prohibit the plan from publishing or distributing, or allowing to be published or distributed on its behalf the advertisement or any new materially revised advertisement without first having filed a copy thereof with the director, 30 days prior to the publication or distribution thereof, or any shorter period specified in the order. An order issued under this subdivision shall be effective for 12 months from its issuance, and may be renewed by order if the advertisements submitted under this subdivision indicate difficulties of voluntary compliance with the applicable provisions of this chapter and the rules thereunder.

(d) A licensed plan or other person regulated under this chapter may, within 30 days after receipt of any notice or order under this section, file a written request for a hearing with the director.

(e) The director by rule or order may classify plans and advertisements and exempt certain classes, wholly or in part, either unconditionally or upon specified terms and conditions or for specified periods, from the application of subdivisions (a) and (b).

HISTORY:
Added Stats 1981 ch 662 § 4. Amended Stats 1986 ch 718 § 2; Stats 1999 ch 525 § 87 (AB 78), operative July 1, 2000.

§ 1361.1. Purchase of health care coverage products; Specified methods prohibited

(a) It is an unfair business practice for a solicitor, solicitor firm, or representative of a health care service plan to sell, solicit, or negotiate the purchase of health care coverage products by any of the following methods:

(1) The use of a marketing technique known as cold lead advertising when marketing a Medicare product. As used in this section, "cold lead advertising" means making use directly or indirectly of a method of marketing that fails to disclose in a conspicuous manner that a purpose of the marketing is health care service plan sales solicitation and that contact will be made by a solicitor, solicitor firm, or representative of a health care service plan.

(2) The use of an appointment that was made to discuss a particular Medicare product or to solicit the sale of a particular Medicare product in order to solicit the sale of another Medicare product or other health care coverage products, unless the consumer specifically agrees in advance of the appointment to discuss that other Medicare product or other types of health care coverage products during the same appointment.

(b) As used in this section, "Medicare product" includes Medicare Parts A, B, C, and D, and Medicare supplement plans.

HISTORY:
Added Stats 2008 ch 744 § 1 (AB 2842), effective January 1, 2009. Amended Stats 2009 ch 140 § 97 (AB 1164), effective January 1, 2010.

§ 1362. Definitions

As used in Sections 1363 and 1364:

(a) "Benefits and coverage" means the health care services available under a plan contract.

(b) "Exception" means any provision in a plan contract whereby coverage for a specified hazard or condition is entirely eliminated.

(c) "Reduction" means any provision in a plan contract which reduces the amount of a plan benefit to some amount or period less than would be otherwise payable for medically authorized expenses or services had such a reduction not been used.

(d) "Limitation" means any provision other than an exception or a reduction which restricts coverage under the plan.

(e) "Presenting for examination or sale" means either (1) publication and dissemination of any brochure, mailer, advertisement, or form which constitutes a presentation of the provisions of the plan and which provides a plan enrollment or application form, or (2) consultations or discussions between prospective plan members or their contract agents and solicitors or representatives of a plan, when such consultations or discussions include presentation of formal, organized information about the plan which is intended to influence or inform the prospective member or contract holder, such as brochures, summaries, charts, slides, or other modes of information.

(f) "Disclosure form" means the disclosure form, material, or information required pursuant to Section 1363.

(g) For the purposes of Sections 1363 and 1364, where the definition of the term "hospital" in the plan contract omits care in any "health facility" defined pursuant to subdivision (a) or (b) of Section 1250 of this code, the omitted coverage shall constitute a limitation; and where the definition of the term "nursing home" in the plan omits care in any "health facility" defined pursuant to subdivision (c) or (d) of Section 1250 of this code, the omitted coverage shall constitute a limitation.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976.

§ 1363. Disclosure forms or materials

(a) The director shall require the use by each plan of disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the director may require, so as to afford the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. The director may require that the materials be presented in a reasonably uniform manner so as to facilitate comparisons between plan contracts of the same or other types of plans. Nothing contained in this chapter shall preclude the director from permitting the disclosure form to be included with the evidence of coverage or plan contract.

The disclosure form shall provide for at least the following information, in concise and specific terms, relative to the plan, together with additional information as may be required by the director, in connection with the plan or plan contract:

(1) The principal benefits and coverage of the plan, including coverage for acute care and subacute care.

(2) The exceptions, reductions, and limitations that apply to the plan.

(3) The full premium cost of the plan.

(4) Any copayment, coinsurance, or deductible requirements that may be incurred by the member or the member's family in obtaining coverage under the plan.

(5) The terms under which the plan may be renewed by the plan member, including any reservation by the plan of any right to change premiums.

(6) A statement that the disclosure form is a summary only, and that the plan contract itself should be consulted to determine governing contractual provisions. The first page of the disclosure form shall contain a notice that conforms with all of the following conditions:

(A)(i) States that the evidence of coverage discloses the terms and conditions of coverage.

(ii) States, with respect to individual plan contracts, small group plan contracts, and any other group plan contracts for which health care services are not negotiated, that the applicant has a right to view the evidence of coverage prior to enrollment, and, if the evidence of coverage is not combined with the disclosure form, the notice shall specify where the evidence of coverage can be obtained prior to enrollment.

(B) Includes a statement that the disclosure and the evidence of coverage should be read completely and carefully and that individuals with special health care needs should read carefully those sections that apply to them.

(C) Includes the plan's telephone number or numbers that may be used by an applicant to receive additional information about the benefits of the plan or a statement where the telephone number or numbers are located in the disclosure form.

(D) For individual contracts, and small group plan contracts as defined in Article 3.1 (commencing with Section 1357), the disclosure

form shall state where the health plan benefits and coverage matrix is located.

(E) Is printed in type no smaller than that used for the remainder of the disclosure form and is displayed prominently on the page.

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

(8) To the extent that the plan permits a free choice of provider to its subscribers and enrollees, the statement shall disclose the nature and extent of choice permitted and the financial liability that is, or may be, incurred by the subscriber, enrollee, or a third party by reason of the exercise of that choice.

(9) A summary of the provisions required by subdivision (g) of Section 1373, if applicable.

(10) If the plan utilizes arbitration to settle disputes, a statement of that fact.

(11) A summary of, and a notice of the availability of, the process the plan uses to authorize, modify, or deny health care services under the benefits provided by the plan, pursuant to Sections 1363.5 and 1367.01.

(12) A description of any limitations on the patient's choice of primary care physician, specialty care physician, or nonphysician health care practitioner, based on service area and limitations on the patient's choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

(13) General authorization requirements for referral by a primary care physician to a specialty care physician or a nonphysician health care practitioner.

(14) Conditions and procedures for disenrollment.

(15) A description as to how an enrollee may request continuity of care as required by Section 1373.96 and request a second opinion pursuant to Section 1383.15.

(16) Information concerning the right of an enrollee to request an independent review in accordance with Article 5.55 (commencing with Section 1374.30).

(17) A notice as required by Section 1364.5.

(b)(1) As of July 1, 1999, the director shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence:

(A) Deductibles.

(B) Lifetime maximums.

(C) Professional services.

(D) Outpatient services.

(E) Hospitalization services.

(F) Emergency health coverage.

(G) Ambulance services.

(H) Prescription drug coverage.

(I) Durable medical equipment.

(J) Mental health services.

(K) Chemical dependency services.

(L) Home health services.

(M) Other.

(2) The following statement shall be placed at the top of the matrix in all capital letters in at least 10-point boldface type:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(3)(A) A health care service plan contract subject to Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15), shall satisfy the requirements of this subdivision by providing the uniform summary of benefits and coverage required under Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15) and any rules or regulations issued thereunder. A health care service plan that issues the uniform summary of benefits referenced in this paragraph shall do both of the following:

(i) Ensure that all applicable benefit disclosure requirements specified in this chapter and in Title 28 of the California Code of Regulations are met in other health plan documents provided to enrollees under the provisions of this chapter.

(ii) Consistent with applicable law, advise applicants and enrollees, in a prominent place in the plan documents referenced in subdivision (a), that enrollees are not financially responsible in payment of emergency care services, in any amount that the health care service plan is obligated to pay, beyond the enrollee's copayments, coinsurance, and deductibles as provided in the enrollee's health care service plan contract.

(B) Commencing October 1, 2016, the uniform summary of benefits and coverage referenced in this paragraph shall constitute a vital document for the purposes of Section 1367.04. Not later than July 1, 2016, the department shall develop written translations of the template uniform summary of benefits and coverage for all language groups identified by the State Department of Health Care Services in all plan letters as of August 27, 2014, for translation services pursuant to Section 14029.91 of the Welfare and Institutions Code, except for any language group for which the United States Department of Labor has already prepared a written translation. Not later than July 1, 2016, the department shall make available on its Internet Web site written translations of the template uniform summary of benefits and coverage developed by the department, and written translations prepared by the United States Department of Labor, if available, for any language group to which this subparagraph applies.

(C) Subdivision (c) shall not apply to a health care service plan contract subject to subparagraph (A).

(4) A health care service plan may satisfy the requirements of this subdivision for the dental services offered under a contract subject to Section 1363.04 by providing the uniform benefit disclosure benefits and coverage disclosure matrix consistent with the requirements of that section.

(c) Nothing in this section shall prevent a plan from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements in order to clarify any part of the matrix that may be unclear.

(d) All plans, solicitors, and representatives of a plan shall, when presenting any plan contract for examination or sale to an individual prospective plan member, provide the individual with a properly completed disclosure form, as prescribed by the director pursuant to this section for each plan so examined or sold.

(e) In the case of group contracts, the completed disclosure form and evidence of coverage shall be presented to the contractholder upon delivery of the completed health care service plan agreement.

(f) Group contractholders shall disseminate copies of the completed disclosure form to all persons eligible to be a subscriber under the group contract at the time those persons are offered the plan. If the individual group members are offered a choice of plans, separate disclosure forms shall be supplied for each plan available. Each group contractholder shall also disseminate or cause to be disseminated copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(g) In the case of conflicts between the group contract and the evidence of coverage, the provisions of the evidence of coverage shall be binding upon the plan notwithstanding any provisions in the group contract that may be less favorable to subscribers or enrollees.

(h) In addition to the other disclosures required by this section, every health care service plan and any agent or employee of the plan shall, when presenting a plan for examination or sale to any individual purchaser or the representative of a group consisting of 25 or fewer individuals, disclose in writing the ratio of premium costs to health services paid for plan contracts with individuals and with groups of the same or similar size for the plan's preceding fiscal year. A plan may report that information by geographic area, provided the plan identifies the geographic area and reports information applicable to that geographic area.

(i) Subdivision (b) shall not apply to any coverage provided by a plan for the Medi-Cal program or the Medicare Program pursuant to Title XVIII and Title XIX of the federal Social Security Act.

HISTORY:

Added Stats 1998 ch 994 § 2 (AB 1560), operative July 1, 1999. Amended Stats 1999 ch 525 § 88 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 31 (AB 2903); Stats 2001 ch 817 § 2 (AB 938), operative July 1, 2002; Stats 2013-2014 1st Ex Sess ch 2 § 8 (SBX1 2), effective September 30, 2013; Stats 2015 ch 655 § 1 (SB 388), effective January 1, 2016; Stats 2018 ch 933 § 1 (SB 1008), effective January 1, 2019.

§ 1363.01. Notice regarding use of formulary by plan; Information regarding drugs on formulary

(a) Every plan that covers prescription drug benefits shall provide notice in

the evidence of coverage and disclosure form to enrollees regarding whether the plan uses a formulary. The notice shall be in language that is easily understood and in a format that is easy to understand. The notice shall include an explanation of what a formulary is, how the plan determines which prescription drugs are included or excluded, and how often the plan reviews the contents of the formulary.

(b) Every plan that covers prescription drug benefits shall provide to members of the public, upon request, information regarding whether a specific drug or drugs are on the plan's formulary. Notice of the opportunity to secure this information from the plan, including the plan's telephone number for making a request of this nature and the Internet Web site where the formulary is posted under Section 1367.205, shall be included in the evidence of coverage and disclosure form to enrollees.

(c) Every plan shall notify enrollees, and members of the public who request formulary information, that the presence of a drug on the plan's formulary does not guarantee that an enrollee will be prescribed that drug by his or her prescribing provider for a particular medical condition.

HISTORY:
Added Stats 1998 ch 68 § 1 (AB 974). Amended Stats 1998 ch 994 § 3 (AB 1560), operative July 1, 1999; Stats 2014 ch 575 § 2 (SB 1052), effective January 1, 2015.

§ 1363.02. Findings; Requirements for service plan

(a) The Legislature finds and declares that the right of every patient to receive basic information necessary to give full and informed consent is a fundamental tenet of good public health policy and has long been the established law of this state. Some hospitals and other providers do not provide a full range of reproductive health services and may prohibit or otherwise not provide sterilization, infertility treatments, abortion, or contraceptive services, including emergency contraception. It is the intent of the Legislature that every patient be given full and complete information about the health care services available to allow patients to make well informed health care decisions.

(b) On or before July 1, 2001, a health care service plan that covers hospital, medical, and surgical benefits shall do both of the following:

(1) Include the following statement, in at least 12-point boldface type, at the beginning of each provider directory:

"Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health plan at (insert the health plan's membership services number or other appropriate number that individuals can call for assistance) to ensure that you can obtain the health care services that you need."

(2) Place the statement described in paragraph (1) in a prominent location on any provider directory posted on the health plan's website, if any, and

include this statement in a conspicuous place in the plan's evidence of coverage and disclosure forms.

(c) A health care service plan shall not be required to provide the statement described in paragraph (1) of subdivision (b) in a service area in which none of the hospitals, health facilities, clinics, medical groups, or independent practice associations with which it contracts limit or restrict any of the reproductive services described in the statement.

(d) This section shall not apply to specialized health care service plans or Medicare supplement plans.

HISTORY:
Added Stats 2000 ch 347 § 2 (AB 525).

§ 1363.03. Uniform prescription drug information card; Contents of card

(a) Every health care service plan that covers prescription drug benefits and that issues a card to enrollees for claims processing purposes shall issue to each of its enrollees a uniform card containing uniform prescription drug information. The uniform prescription drug information card shall, at a minimum, include the following information:

(1) The name or logo of the benefit administrator or health care service plan issuing the card, which shall be displayed on the front side of the card.

(2) The enrollee's identification number, or the subscriber's identification number when the enrollee is a dependent who accesses services using the subscriber's identification number, which shall be displayed on the front side of the card.

(3) A telephone number that pharmacy providers may call for assistance.

(4) Information required by the benefit administrator or health care service plan that is necessary to commence processing the pharmacy claim, except as provided for in paragraph (5).

(5) A health care service plan shall not be required to print any of the following information on a member card:

(A) Any number that is the same for all of its members, provided that the health care service plan provides this number to the pharmacy on an annual basis.

(B) Any information that may result in fraudulent use of the card.

(C) Any information that is otherwise prohibited from being included on the card.

(b) Beginning July 1, 2002, the new uniform prescription drug information card required by subdivision (a) shall be issued by a health care service plan to an enrollee upon enrollment or upon any change in the enrollee's coverage that impacts the data content or format of the card.

(c) Nothing in this section requires a health care service plan to issue a separate card for prescription drug coverage if the plan issues a card for health care coverage in general and the card is able to accommodate the information required by subdivision (a).

(d) This bill shall not apply to a nonprofit health care service plan with at least 3.5 million enrollees that owns or operates its own pharmacies and that provides health care services to enrollees in a specific geographic area through a mutually exclusive contract with a single medical group.

(e) "Card" as used in this section includes other technology that performs substantially the same function as a card.

(f) For purposes of this section, if a health care service plan delegates responsibility for issuing the uniform prescription drug information card to a contractor or agent, then the contract between the health care service plan and its contractor or agent shall require compliance with this section.

HISTORY:
Added Stats 2001 ch 622 § 1 (AB 207).

§ 1363.04. Dental services; Uniform benefits and coverage disclosure matrix

(a) For plan years on and after January 1, 2021, or 12 months after regulations are adopted under subdivision (f), whichever occurs later, a health care service plan that issues, sells, renews, or offers a contract that covers dental services in this state, in addition to any other applicable disclosure requirements, shall utilize a uniform benefits and coverage disclosure matrix, which shall be developed by the department, in conjunction with the Department of Insurance, and in consultation with stakeholders. At a minimum, the benefits and coverage disclosure matrix shall require the health care service plan to make available all of the following information relating to covered dental services, together with the corresponding copayments or coinsurance and limitations:

(1) The annual overall plan deductible.

(2) The annual benefit limit.

(3) Coverage for the following categories:

(A) Preventive and diagnostic services.

(B) Basic services.

(C) Major services.

(D) Orthodontia services.

(4) Dental plan reimbursement levels and estimated enrollee cost share for services.

(5) Waiting periods.

(6) Examples to illustrate coverage and estimated enrollee costs of commonly used benefits. The examples shall include at least one service from each of the following categories listed in paragraph (3):

(A) Preventive and diagnostic services.

(B) Basic services.

(C) Major services.

(b) All plans, solicitors, and representatives of a plan that issue, sell, renew, or offer a health care plan contract that covers dental services shall, when presenting any plan contract for examination or sale to an individual prospective plan member, make available to the individual a properly completed benefits and coverage disclosure matrix, as prescribed by the director pursuant to this section for each dental plan examined or sold.

(c) In the case of group contracts for dental services, the completed benefits and coverage disclosure matrix and evidence of coverage shall be made available to the contractholder upon delivery of the completed health care service plan agreement.

(d) Group contractholders shall make available the completed benefits and coverage disclosure matrix to all persons eligible to be a subscriber under the group contract at the time those persons are offered the dental plan. If the individual group members are offered a choice of dental plans, separate matrices shall be made available for each dental plan offered. Each group contractholder shall also make available copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(e) The health care service plan offering a dental product in the individual, small, or large group market shall make available the benefits and coverage disclosure matrix to all individuals newly enrolling for coverage, experiencing a special enrollment event, and renewing coverage, and shall make available the benefits and coverage disclosure matrix to all other enrollees upon request.

(f)(1) The department shall adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code to implement this section. The department shall consult with the Department of Insurance in adopting the emergency regulations, as appropriate. The adoption of regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, or safety.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted pursuant to this section shall not be subject to the review and approval of the Office of Administrative Law. The regulations shall become effective immediately upon filing with the Secretary of State. The regulations shall not remain in effect more than 120 days unless the adopting agency complies with all of the provisions of Chapter 3.5 (commencing with Section 11340) as required by subdivision (c) of Section 11346.1 of the Government Code.

(g) This section does not apply to Medi-Cal dental managed care contracts authorized under Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

HISTORY:
Added Stats 2018 ch 933 § 2 (SB 1008), effective January 1, 2019.

§ 1363.05. Statement to be included in plan's disclosure form; Modification; Notice to enrollees

(a) For every plan contract that provides or supplements Medicare benefits, a plan shall include within its disclosure form the following statement in at least 12-point type: "For additional information concerning covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, 1-800-434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California."

(b) For every plan contract that provides or supplements Medicare benefits,

a plan shall modify its disclosure forms to comply with subdivision (a) no later than January 1, 1998.

(c) Every health care service plan that provides or supplements Medicare benefits shall notify those current enrollees who enrolled prior to the modification of disclosure forms to include the disclosure statement required by subdivision (a) of the availability of the HICAP program. That notification shall include the same language as is required by subdivision (a). That notification may be by free standing document and shall be made no later than January 1, 1998.

HISTORY:
Added Stats 1996 ch 1113 § 1 (SB 1581).

§ 1363.06. Comparative benefit matrices (Inoperative; Operative date contingent)

(a) The Department of Managed Health Care and the Department of Insurance shall compile information as required by this section and Section 10127.14 of the Insurance Code into two comparative benefit matrices. The first matrix shall compare benefit packages offered pursuant to Section 1373.62 and Section 10127.15 of the Insurance Code. The second matrix shall compare benefit packages offered pursuant to Sections 1366.35, 1373.6, and 1399.804 and Sections 10785, 10901.2, and 12682.1 of the Insurance Code.

(b) The comparative benefit matrix shall include:

(1) Benefit information submitted by health care service plans pursuant to subdivision (d) and by health insurers pursuant to Section 10127.14 of the Insurance Code.

(2) The following statements in at least 12-point type at the top of the matrix:

(A) "This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact the health care service plan or health insurer."

(B) "The comparative benefit summary is updated annually, or more often if necessary to be accurate."

(C) "The most current version of this comparative benefit summary is available on (address of the plan's or insurer's Internet Web site)."

This subparagraph applies only to those plans or insurers that maintain an Internet Web site.

(3) The telephone number or numbers that may be used by an applicant to contact either the department or the Department of Insurance, as appropriate, for further assistance.

(c) The Department of Managed Health Care and the Department of Insurance shall jointly prepare two standardized templates for use by health care service plans and health insurers in submitting the information required pursuant to subdivision (d) and subdivision (d) of Section 10127.14 of the Insurance Code. The templates shall be exempt from the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) Health care service plans, except specialized health care service plans,

shall submit the following to the department by January 31, 2003, and annually thereafter:

(1) A summary explanation of the following for each product described in subdivision (a).

(A) Eligibility requirements.

(B) The full premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside.

(C) When and under what circumstances benefits cease.

(D) The terms under which coverage may be renewed.

(E) Other coverage that may be available if benefits under the described benefit package cease.

(F) The circumstances under which choice in the selection of physicians and providers is permitted.

(G) Lifetime and annual maximums.

(H) Deductibles.

(2) A summary explanation of coverage for the following, together with the corresponding copayments and limitations, for each product described in subdivision (a):

(A) Professional services.

(B) Outpatient services.

(C) Hospitalization services.

(D) Emergency health coverage.

(E) Ambulance services.

(F) Prescription drug coverage.

(G) Durable medical equipment.

(H) Mental health services.

(I) Residential treatment.

(J) Chemical dependency services.

(K) Home health services.

(L) Custodial care and skilled nursing facilities.

(3) The telephone number or numbers that may be used by an applicant to access a health care service plan customer service representative and to request additional information about the plan contract.

(4) Any other information specified by the department in the template.

(e) Each health care service plan shall provide the department with updates to the information required by subdivision (d) at least annually, or more often if necessary to maintain the accuracy of the information.

(f) The department and the Department of Insurance shall make the comparative benefit matrices available on their respective Internet Web sites and to the health care service plans and health insurers for dissemination as required by Section 1373.6 and Section 12682.1 of the Insurance Code, after confirming the accuracy of the description of the matrices with the health care service plans and health insurers.

(g) As used in this section and Section 1363.07, "benefit matrix" shall have the same meaning as benefit summary.

(h)(1) This section shall be inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act

(42 U.S.C. Sec. 300gg-91), this section shall become operative on the date of that repeal or amendment.

(3) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care Education and Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

HISTORY:
Added Stats 2002 ch 794 § 1 (AB 1401). Amended Stats 2013 ch 441 § 1 (AB 1180), effective October 1, 2013, inoperative January 1, 2014, operative date contingent.

§ 1363.07. Annual update of comparative benefit matrix by health care service plan; Copies to be mailed to solicitors and employers; Availability of link to matrix on Web site (Inoperative; Operative date contingent)

(a) Each health care service plan shall send copies of the comparative benefit matrix prepared pursuant to Section 1363.06 on an annual basis, or more frequently as the matrix is updated by the department and the Department of Insurance, to solicitors and solicitor firms and employers with whom the plan contracts.

(b) Each health care service plan shall require its representatives and solicitors and soliciting firms with which it contracts, to provide a copy of the comparative benefit matrix to individuals when presenting any benefit package for examination or sale.

(c) Each health care service plan that maintains an Internet Web site shall make a downloadable copy of the comparative benefit matrix described in Section 1363.06 available through a link on its site to the Internet Web sites of the department and the Department of Insurance.

(d)(1) This section shall be inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative on the date of that repeal or amendment.

(3) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care Education and Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

HISTORY:
Added Stats 2002 ch 794 § 2 (AB 1401). Amended Stats 2004 ch 164 § 1 (AB 1596); Stats 2013 ch 441 § 2 (AB 1180), effective October 1, 2013, inoperative January 1, 2014, operative date contingent.

§ 1363.1. Disclosure on binding arbitration

Any health care service plan that includes terms that require binding arbitration to settle disputes and that restrict, or provide for a waiver of, the right to a jury trial shall include, in clear and understandable language, a disclosure that meets all of the following conditions:

(a) The disclosure shall clearly state whether the plan uses binding arbitration to settle disputes, including specifically whether the plan uses binding arbitration to settle claims of medical malpractice.

(b) The disclosure shall appear as a separate article in the agreement issued to the employer group or individual subscriber and shall be prominently displayed on the enrollment form signed by each subscriber or enrollee.

(c) The disclosure shall clearly state whether the subscriber or enrollee is waiving his or her right to a jury trial for medical malpractice, other disputes relating to the delivery of service under the plan, or both, and shall be substantially expressed in the wording provided in subdivision (a) of Section 1295 of the Code of Civil Procedure.

(d) In any contract or enrollment agreement for a health care service plan, the disclosure required by this section shall be displayed immediately before the signature line provided for the representative of the group contracting with a health care service plan and immediately before the signature line provided for the individual enrolling in the health care service plan.

HISTORY:
Added Stats 1994 ch 653 § 3 (AB 3260).

§ 1363.2. Use of emergency response system

On or before July 1, 1999, the disclosure form required pursuant to Section 1363 shall also contain a statement that enrollees are encouraged to use appropriately the "911" emergency response system, in areas where the system is established and operating, when they have an emergency medical condition that requires an emergency response.

HISTORY:
Added Stats 1998 ch 979 § 2 (AB 984).

§ 1363.5. Disclosure of process used to authorize or deny services; Requirements for criteria used; Notice accompanying disclosure to public

(a) A plan shall disclose or provide for the disclosure to the director and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request. The disclosure to the director shall include the policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01.

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

(1) Be developed with involvement from actively practicing health care providers.

(2) Be consistent with sound clinical principles and processes.

(3) Be evaluated, and updated if necessary, at least annually.

(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.

(5) Be available to the public upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. A plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means.

(c) The disclosure required by paragraph (5) of subdivision (b) shall be accompanied by the following notice: "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

HISTORY:
Added Stats 1999 ch 539 § 3 (SB 59).
Amended Stats 2000 ch 1067 § 6 (SB 2094).

§ 1364. Supplemental disclosure information

Where the director finds it necessary in the interest of full and fair disclosure, all advertising and other consumer information disseminated by a plan for the purpose of influencing persons to become members of a plan shall contain such supplemental disclosure information as the director may require.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1999 ch 525 § 90 (AB 78), operative July 1, 2000.

§ 1364.1. Notice of reduction in emergency service

Within 30 days of receiving the notice required by Section 1255.1, a health care service plan shall notify, or provide for the notification of, enrollees who have selected a medical group or independent practice association that uses a hospital that the hospital will reduce or eliminate its emergency services. The plan may require that its contracting medical groups and independent practice associations that use the hospital provide this notice. The notice shall include a list of alternate hospitals that may be used by enrollees for emergency services.

HISTORY:
Added Stats 1998 ch 995 § 5 (AB 2103).

§ 1364.5. Filing of procedures to protect confidentiality; Statement for enrollees and subscribers; Notice of availability

(a) On or before July 1, 2001, every health care service plan shall file with the director a copy of their policies and procedures to protect the security of patient medical information to ensure compliance with the Confidentiality of

Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code). Any amendment to the policies and procedures shall be filed in accordance with Section 1352.

(b) On and after July 1, 2001, every health care service plan shall, upon request, provide to enrollees and subscribers a written statement that describes how the contracting organization or health care service plan maintains the confidentiality of medical information obtained by and in the possession of the contracting organization or the health care service plan.

(c) The statement required by subdivision (b) shall be in at least 12-point type and meet the following requirements:

(1) The statement shall describe how the contracting organization or health care service plan protects the confidentiality of medical information pursuant to this article and inform patients or enrollees and subscribers that any disclosure of medical information beyond the provisions of the law is prohibited.

(2) The statement shall describe the types of medical information that may be collected and the type of sources that may be used to collect the information, the purposes for which the contracting organization or plan will obtain medical information from other health care providers.

(3) The statement shall describe the circumstances under which medical information may be disclosed without prior authorization, pursuant to Section 56.10 of the Civil Code.

(4) The statement shall describe how patients or enrollees and subscribers may obtain access to medical information created by and in the possession of the contracting organization or health care service plan, including copies of medical information.

(d) On and after July 1, 2001, every health care service plan shall include in its evidence of coverage or disclosure form the following notice, in 12-point type: A STATEMENT DESCRIBING (NAME OR PLAN OR "OUR") POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

HISTORY:
Added Stats 1999 ch 526 § 10 (SB 19).
Amended Stats 2000 ch 1067 § 7 (SB 2094).

§ 1365. Cancellation and non-renewal of enrollment or subscription

(a) An enrollment or a subscription shall not be canceled or not renewed except for the following reasons:

(1)(A) Except as otherwise specified in subparagraph (C), for nonpayment of the required premiums by the individual, employer, or contractholder if the individual, employer, or contractholder has been duly notified and billed for the charge and at least a 30-day grace period has elapsed since the date of notification or, if longer, the period of time required for notice and any other requirements pursuant to Section 2703, 2712, or 2742 of the federal Public Health Service Act (42 U.S.C. Secs. 300gg-2, 300gg-12, and 300gg-42) and any subsequent rules or regulations has elapsed.

(B) Pursuant to subparagraph (A), a health care service plan shall continue to provide coverage as required by the individual's, employer's, or

contractholder's health care service plan contract during the 30-day period described in subparagraph (A).

(C)(i) For nonpayment of the required premiums by an individual who receives advance payments of the premium tax credit authorized by Section 100800 of the Government Code, or both, if the individual has been duly notified and billed for the charge and a grace period of three consecutive months has elapsed since the last day of paid coverage.

(ii) During the first month of the three-month grace period described in clause (i), a health care service plan shall continue to do both of the following:

(I) Collect advance payments of the federal premium tax credit or state advanced premium assistance subsidy, or both, on behalf of the enrollee.

(II) Provide coverage as required by the individual's health care service plan contract.

(iii) If the individual exhausts the three-month grace period described in clause (i) without paying all outstanding premiums due, the health care service plan shall return both of the following:

(I) Advance payments of the premium tax credit paid on behalf of the individual for the second and third months of the three-month grace period described in clause (i), pursuant to Section 156.270(e)(2) of Title 45 of the Code of Federal Regulations.

(II) The advanced premium assistance subsidy paid on behalf of the individual for the second and third months of the three-month grace period described in clause (i), pursuant to subdivision (a) of Section 100805 of the Government Code.

(iv) A health care service plan shall comply with all federal and state laws and regulations relating to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advance payments of the federal premium tax credit or state advanced premium assistance subsidy. For a health care service plan contract issued, amended, or renewed on or after January 1, 2020, all requirements applicable to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advance payments of premium tax credit authorized by Section 36B of the Internal Revenue Code shall apply to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advanced premium assistance subsidy authorized by Section 100800 of the Government Code.

(2) The plan demonstrates fraud or an intentional misrepresentation of material fact under the terms of the health care service plan contract by the individual contractholder or employer.

(3) In the case of an individual health care service plan contract, the individual subscriber no longer resides, lives, or works in the plan's service area, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(4) In the case of a group health care service plan contract, violation of a material contract provision relating to employer contribution or group participation rates by the contractholder or employer.

(5) If the plan ceases to provide or arrange for the provision of health benefits for new health care service plan contracts in the individual or group market, or all markets, in this state, provided, however, that the following conditions are satisfied:

(A) Notice of the decision to cease new or existing health benefit plans in the state is provided to the director, the individual or group contractholder or employer, and the enrollees covered under those contracts, at least 180 days prior to discontinuation of those contracts.

(B) Health benefit plans shall not be canceled for 180 days after the date of the notice required under subparagraph (A) and, for that business of a plan that remains in force, any plan that ceases to offer for sale new health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(C) Except as authorized under subdivision (b) of Section 1357.09 and Section 1357.10, a plan that ceases to write new health benefit plans in the individual or group market, or all markets, in this state shall be prohibited from offering for sale health benefit plans in that market or markets in this state for a period of five years from the date of the discontinuation of the last coverage not so renewed.

(6) If the plan withdraws a health benefit plan from the market, provided that all of the following conditions are satisfied:

(A) The plan notifies all affected subscribers, contractholders, employers, and enrollees and the director at least 90 days prior to the discontinuation of the plan.

(B) The plan makes available to the individual or group contractholder or employer all health benefit plans that it makes available to new individual or group business, respectively.

(C) In exercising the option to discontinue a health benefit plan under this paragraph and in offering the option of coverage under subparagraph (B), the plan acts uniformly without regard to the claims experience of the individual or contractholder or employer, or any health status-related factor relating to enrollees or potential enrollees.

(D) For small employer health care service plan contracts offered under Article 3.1 (commencing with Section 1357), the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1357.12. This subparagraph shall not apply after December 31, 2013.

(7) In the case of a group health benefit plan, if an individual or employer ceases to be a member of a guaranteed association, as defined in subdivision (n) of Section 1357, but only if that coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any enrollee.

(b)(1) An enrollee or subscriber who alleges that an enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed may request a review by the director pursuant to Section 1368.

(2) If the director determines that a proper complaint exists, the director shall notify the plan and the enrollee or subscriber who requested the review.

(3) If, after review, the director determines that the cancellation, rescission, or failure to renew is contrary to existing law, the director shall order

the plan to reinstate the enrollee or subscriber. Within 15 days after receipt of that order, the health care service plan shall request a hearing or reinstate the enrollee or subscriber.

(4) If an enrollee or subscriber requests a review of the health care service plan's determination to cancel or rescind or failure to renew the enrollee's or subscriber's health care service plan contract pursuant to this section, the health care service plan shall continue to provide coverage to the enrollee or subscriber under the terms of the contract until a final determination of the enrollee's or subscriber's request for review has been made by the director. This paragraph shall not apply if the health care service plan cancels or does not renew the enrollee's or subscriber's health care service plan contract for nonpayment of premiums pursuant to paragraph (1) of subdivision (a).

(5) A reinstatement pursuant to this subdivision shall be retroactive to the time of cancellation, rescission, or failure to renew and the plan shall be liable for the expenses incurred by the subscriber or enrollee for covered health care services from the date of cancellation, rescission, or nonrenewal to and including the date of reinstatement. The health care service plan shall reimburse the enrollee or subscriber for any expenses incurred pursuant to this paragraph within 30 days of receipt of the completed claim.

(c) This section shall not abrogate any preexisting contracts entered into prior to the effective date of this chapter between a subscriber or enrollee and a health care service plan or a specialized health care service plan, including, but not limited to, the financial liability of the plan, except that each plan shall, if directed to do so by the director, exercise its authority, if any, under those preexisting contracts to conform them to existing law.

(d) As used in this section, "health benefit plan" means any individual or group insurance policy or health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include accident only, credit, or disability income coverage, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, long-term care insurance, dental or vision coverage, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation law or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(e) On or before July 1, 2011, the director may issue guidance to health care service plans regarding compliance with this section and that guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Any guidance issued pursuant to this subdivision shall only be effective through December 31, 2013, or until the director adopts and effects regulations pursuant to the Administrative Procedure Act, whichever occurs first.

HISTORY:

Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1999 ch 525 § 91 (AB 78), operative July 1, 2000; Stats 2010 ch 658 § 4 (AB 2470), effective January 1, 2011; Stats 2011 ch 296 § 140 (AB 1023), effective January 1, 2012; Stats 2019 ch 38 § 15 (SB 78), effective June 27, 2019.

§ 1365.5. Modification of or refusal to enter contract on discriminatory basis

(a) No health care service plan or specialized health care service plan shall refuse to enter into any contract or shall cancel or decline to renew or reinstate any contract because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise.

(b) The terms of any contract shall not be modified, and the benefits or coverage of any contract shall not be subject to any limitations, exceptions, exclusions, reductions, copayments, coinsurance, deductibles, reservations, or premium, price, or charge differentials, or other modifications because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, potential contracting party, or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise; except that premium, price, or charge differentials because of the age of any individual when based on objective, valid, and up-to-date statistical and actuarial data are not prohibited.

(c) It shall be deemed a violation of subdivision (a) for any health care service plan to utilize marital status, living arrangements, occupation, sex, beneficiary designation, ZIP Codes or other territorial classification, or any combination thereof for the purpose of establishing sexual orientation. Nothing in this section shall be construed to alter in any manner the existing law prohibiting health care service plans from conducting tests for the presence of human immunodeficiency virus or evidence thereof.

(d) This section shall not be construed to limit the authority of the director to adopt or enforce regulations prohibiting discrimination because of sex, marital status, or sexual orientation.

(e) "Sex" as used in this section shall have the same meaning as "gender," as defined in Section 422.56 of the Penal Code.

(f) The changes made to this section by the act adding this subdivision shall only apply to contracts issued, amended, or renewed on or after January 1, 2011.

HISTORY:
Added Stats 1990 ch 1402 § 1 (AB 1721). Amended Stats 1999 ch 525 § 92 (AB 78), operative July 1, 2000; Stats 2005 ch 421 § 1 (AB 1586), effective January 1, 2006; Stats 2009 ch 365 § 1 (AB 119), effective January 1, 2010.

§ 1366. Name of plan

(a) No plan may use in its name, any of the words "insurance," "casualty," "surety," "mutual," or any other words descriptive of the insurance, casualty, or surety business or use any name similar to the name or description of any insurance or surety corporation doing business in this state unless such plan controls or is controlled by an entity licensed as an insurer pursuant to the provisions of the Insurance Code and the plan employs a name related to that of such controlled or controlling entity.

(b) Section 2415 of the Business and Professions Code, pertaining to

fictitious names, shall not apply to plans, except specialized health care service plans.

(c) No plan or solicitor firm may adopt a name style that is deceptive, or one that could cause the public to believe the plan is affiliated with, or recommended by any governmental or private entity unless such affiliation or endorsement exists.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1980 ch 1313 § 13.

§ 1366.1. Geographic accessibility standard; Applicability; Notice of material modification of plan and public hearing

(a) The department shall adopt regulations on or before July 1, 2003, that establish an extended geographic accessibility standard for access to health care providers served by a health care service plan in counties with a population of 500,000 or less, and that, as of January 1, 2002, have two or fewer health care service plans providing coverage to the entire county in the commercial market.

(b) This section shall not apply to specialized health care service plans or health care service plan contracts that provide benefits to enrollees through any of the following:

(1) Preferred provider contracting arrangements.

(2) The Medi-Cal program.

(3) The Healthy Families Program.

(4) The federal Medicare program.

(c) At least 30 days before a health care service plan files a notice of material modification of its license with the department to withdraw from a county with a population of 500,000 or less, the health care service plan shall hold a public meeting in the county from which it is intending to withdraw, and shall do all of the following:

(1) Provide notice announcing the public meeting at least 30 days prior to the public meeting to all affected enrollees, health care providers with which it contracts, the members of the board of supervisors of the affected county, the members of the city councils of cities in the affected county, and members of the Legislature who represent the affected county.

(2) Provide notice announcing the public meeting at least 15 days prior to the public meeting in a newspaper of general circulation within the affected county.

(3) At the public meeting, allow testimony, which may be limited to a certain length of time by the health care service plan, of all interested parties.

(4) File with the department for review, no less than 30 days prior to the date of mailing or publication, the notices required under paragraphs (1) and (2).

(d) The department may require a health care service plan that has filed to withdraw from a portion of a county with a population of less than 500,000, to hold a hearing for affected enrollees.

(e) A representative of the department shall attend the public meeting described in this section.

HISTORY:
Added Stats 2002 ch 549 § 1 (AB 1282), ch 928 § 1 (SB 398).

§ 1366.2. Availability to group subscribers of termination date of health care contracts in geographic area; Definitions

(a) A full health care service plan shall make available to a group subscriber, upon request, the termination date of all major health care provider contracts that are for services in the geographic area for which the group subscriber has secured coverage and that include a specified termination date.

(b) For purposes of this section, the following terms have the following meanings:

(1) "Enrollee" means a person who is enrolled in a health care service plan and who is a recipient of services from the plan.

(2) "Full health care service plan" means a plan that meets the definition set forth in subdivision (f) of Section 1345, and that has a total enrolled membership exceeding 499,999 enrollees.

(3) "Hospital" means a general acute care hospital.

(4) "Major health care provider contract" means a contract between a full service plan and provider group or hospital covering more than 25,000 of that plan's enrollees. "Major health care provider contract" does not mean a provider contract between a specialized health care service plan and a provider group or hospital.

(5) "Provider group" means a medical group, independent practice association, or other similar group of providers with a total enrolled membership exceeding 99,999 enrollees.

HISTORY:
Added Stats 2004 ch 411 § 1 (AB 321), effective September 9, 2004.

§ 1366.3. Plan ceasing to offer individual coverage; Regulations for implementation; Exceptions to applicability

(a) On and after January 1, 2005, a health care service plan issuing individual plan contracts that ceases to offer individual coverage in this state shall offer coverage to the subscribers who had been covered by those contracts at the time of withdrawal under the same terms and conditions as provided in paragraph (3) of subdivision (a), paragraphs (2) to (4), inclusive, of subdivision (b), subdivisions (c) to (e), inclusive, and subdivision (h) of Section 1373.6.

(b) A health care service plan that ceases to offer individual coverage in a service area shall offer the coverage required by subdivision (a) to subscribers who had been covered by those contracts at the time of withdrawal, if the plan continues to offer group coverage in that service area. This subdivision shall not apply to coverage provided pursuant to a preferred provider organization.

(c) The department may adopt regulations to implement this section.

(d) This section shall not apply when a plan participating in Medi-Cal, Healthy Families, Access for Infants and Mothers, or any other contract between the plan and a government entity no longer contracts with the government entity to provide health coverage in the state, or a specified area of the state, nor shall this section apply when a plan ceases entirely to market,

offer, and issue any and all forms of coverage in any part of this state after the effective date of this section.

(e)(1) On and after January 1, 2014, and except as provided in paragraph (2), the reference to Section 1373.6 in subdivision (a) shall not apply to any health plan contracts.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment.

HISTORY:
Added Stats 2004 ch 489 § 1 (AB 2759). Amended Stats 2013 ch 441 § 3 (AB 1180), effective October 1, 2013.

§ 1366.4. Nonphysician providers

(a) A medical group, physician, or independent practice association that contracts with a health care service plan may enter into contracts with licensed nonphysician providers to provide services, as defined in Section 1300.67(a)(1) of Title 28 of the California Code of Regulations, to plan enrollees covered by the contract between the plan and the group, physician, or association.

(b) The licensed nonphysician provider described in subdivision (a) that contracts with a medical group, physician, or independent practice association may directly bill, if direct billing is otherwise permitted by law, a health care service plan for covered services pursuant to a contract with the health care service plan that specifies direct billing. Direct billing pursuant to this subdivision is permitted only to the extent that the same services are not billed for by the medical group, physician, or independent practice association.

(c) A health care service plan may require the nonphysician provider to complete an appropriate credentialing process.

(d) Every health care service plan may either list licensed nonphysician providers that contract with medical groups, physicians, and independent practice associations pursuant to subdivision (b) in any listing or directory of plan health care providers that is provided to enrollees or to the public, or may include a notification in the plan's evidence of coverage or provider list that the health care service plan has contracts with nonphysician providers, pursuant to subdivision (b), and may list the types of contracted nonphysician providers. The notification may inform an enrollee that he or she may obtain a list of the nonphysician providers by contacting his or her primary or specialist medical group. The listing may indicate whether licensed nonphysician providers may be accessed directly by enrollees.

(e) Nothing in this section shall be construed to authorize, or otherwise require the director to approve, a risk-sharing arrangement between a plan and a provider.

HISTORY:
Added Stats 1996 ch 533 § 1 (SB 1798). Amended Stats 1999 ch 525 § 93 (AB 78), operative July 1, 2000; Stats 2009 ch 298 § 4 (AB 1540), effective January 1, 2010.

§ 1366.6. Sale of products by health care service plans; Levels of coverage (Operative term contingent)

(a) For purposes of this section, the following definitions shall apply:

(1) "Exchange" means the California Health Benefit Exchange established in Title 22 (commencing with Section 100500) of the Government Code.

(2) "Federal act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(3) "Qualified health plan" has the same meaning as that term is defined in Section 1301 of the federal act.

(4) "Small employer" has the same meaning as that term is defined in Section 1357.500.

(b)(1) Health care service plans participating in the individual market of the Exchange shall fairly and affirmatively offer, market, and sell in the individual market of the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act. Health care service plans participating in the Small Business Health Options Program (SHOP Program) of the Exchange, established pursuant to subdivision (m) of Section 100504 of the Government Code, shall fairly and affirmatively offer, market, and sell in the SHOP Program at least one product within each of the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(2) The board established under Section 100500 of the Government Code may require plans to sell additional products within each of the levels of coverage identified in paragraph (1).

(3) This subdivision shall not apply to a plan that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504 of the Government Code.

(4) This subdivision shall not apply to a bridge plan product that meets the requirements of Section 100504.5 of the Government Code to the extent approved by the appropriate federal agency.

(c)(1) Health care service plans participating in the Exchange that sell any products outside the Exchange shall do both of the following:

(A) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(B) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

(2) For purposes of this subdivision, "product" does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code between the Managed Risk Medical Insurance Board and health care service plans for enrolled Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the State

Department of Health Care Services and health care service plans for enrolled Medi-Cal beneficiaries, or for contracts with bridge plan products that meet the requirements of Section 100504.5 of the Government Code.

(d)(1) Commencing January 1, 2014, a health care service plan shall, with respect to individual plan contracts that cover hospital, medical, or surgical benefits, only sell the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act, except that a health care service plan that does not participate in the Exchange shall, with respect to individual plan contracts that cover hospital, medical, or surgical benefits, only sell the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(2) Commencing January 1, 2014, a health care service plan shall, with respect to small employer plan contracts that cover hospital, medical, or surgical expenses, only sell the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(e) Commencing January 1, 2014, a health care service plan that does not participate in the Exchange shall, with respect to individual or small employer plan contracts that cover hospital, medical, or surgical benefits, offer at least one standardized product that has been designated by the Exchange in each of the four levels of coverage contained in subsection (d) of Section 1302 of the federal act. This subdivision shall only apply if the board of the Exchange exercises its authority under subdivision (c) of Section 100504 of the Government Code. Nothing in this subdivision shall require a plan that does not participate in the Exchange to offer standardized products in the small employer market if the plan only sells products in the individual market. Nothing in this subdivision shall require a plan that does not participate in the Exchange to offer standardized products in the individual market if the plan only sells products in the small employer market. This subdivision shall not be construed to prohibit the plan from offering other products provided that it complies with subdivision (d).

(f) For purposes of this section, a bridge plan product shall mean an individual health benefit plan, as defined in subdivision (f) of Section 1399.845, that is offered by a health care service plan licensed under this chapter that contracts with the Exchange pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(g) This section shall become inoperative on the October 1 that is five years after the date that federal approval of the bridge plan option occurs, and, as of the second January 1 thereafter, is repealed, unless a later enacted statute that is enacted before that date deletes or extends the dates on which it becomes inoperative and is repealed.

HISTORY:
Added Stats 2010 ch 655 § 15 (AB 1602), effective January 1, 2011. Amended Stats 2013-2014 1st Ex Sess ch 5 § 8 (SBX1 3), effective September 30, 2013; Stats 2014 ch 572 § 5 (SB 959), effective January 1, 2015.

§ 1366.6. Sale of products by health care service plans; Levels of coverage (Operative date contingent)

(a) For purposes of this section, the following definitions shall apply:

(1) "Exchange" means the California Health Benefit Exchange estab-

lished in Title 22 (commencing with Section 100500) of the Government Code.

(2) "Federal act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(3) "Qualified health plan" has the same meaning as that term is defined in Section 1301 of the federal act.

(4) "Small employer" has the same meaning as that term is defined in Section 1357.500.

(b)(1) Health care service plans participating in the individual market of the Exchange shall fairly and affirmatively offer, market, and sell in the individual market of the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act. Health care service plans participating in the Small Business Health Options Program (SHOP Program) of the Exchange, established pursuant to subdivision (m) of Section 100504 of the Government Code, shall fairly and affirmatively offer, market, and sell in the SHOP Program at least one product within each of the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(2) The board established under Section 100500 of the Government Code may require plans to sell additional products within each of the levels of coverage identified in paragraph (1).

(3) This subdivision shall not apply to a plan that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504 of the Government Code.

(c)(1) Health care service plans participating in the Exchange that sell any products outside the Exchange shall do both of the following:

(A) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(B) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

(2) For purposes of this subdivision, "product" does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code between the Managed Risk Medical Insurance Board and health care service plans for enrolled Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the State Department of Health Care Services and health care service plans for enrolled Medi-Cal beneficiaries.

(d)(1) Commencing January 1, 2014, a health care service plan shall, with respect to individual plan contracts that cover hospital, medical, or surgical benefits, only sell the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act, except that a health care service plan that does not participate in the Exchange shall, with respect to individual plan contracts that cover hospital, medical, or surgical benefits, only sell the

four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(2) Commencing January 1, 2014, a health care service plan shall, with respect to small employer plan contracts that cover hospital, medical, or surgical expenses, only sell the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(e) Commencing January 1, 2014, a health care service plan that does not participate in the Exchange shall, with respect to individual or small employer plan contracts that cover hospital, medical, or surgical benefits, offer at least one standardized product that has been designated by the Exchange in each of the four levels of coverage contained in subdivision (d) of Section 1302 of the federal act. This subdivision shall only apply if the board of the Exchange exercises its authority under subdivision (c) of Section 100504 of the Government Code. Nothing in this subdivision shall require a plan that does not participate in the Exchange to offer standardized products in the small employer market if the plan only sells products in the individual market. Nothing in this subdivision shall require a plan that does not participate in the Exchange to offer standardized products in the individual market if the plan only sells products in the small employer market. This subdivision shall not be construed to prohibit the plan from offering other products provided that it complies with subdivision (d).

(f) This section shall become operative only if Section 8 of the act that added this section becomes inoperative pursuant to subdivision (g) of that Section 8.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 5 § 9 (SBX1 3), effective September 30, 2013.
Amended Stats 2014 ch 572 § 6 (SB 959), effective January 1, 2015.

ARTICLE 4.5

California COBRA Program

Section
1366.20. Citation; Intent; Adoption of emergency regulations.
1366.21. Definitions governing article.
1366.22. Inapplicability of requirements.
1366.23. Requirement to offer continuation coverage.
1366.24. Disclosures.
1366.25. Notification requirements; Contract with employer or administrator to perform administrative obligation; Coverage under American Recovery and Reinvestment Act of 2009.
1366.26. Rate limits.
1366.27. Termination of continuation coverage.
1366.28. Failures to comply.
1366.29. Continuing coverage for enrollees who have exhausted continuation coverage under COBRA.

HISTORY: Added Stats 1997 ch 665 § 1.

§ 1366.20. Citation; Intent; Adoption of emergency regulations

(a) This article shall be known as the California Continuation Benefits Replacement Act, or "Cal-COBRA."

(b) It is the intent of the Legislature that continued access to health insurance coverage is provided to employees, and their dependents, of employ-

ers with 2 to 19 eligible employees who are not currently offered continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985.

(c) It is the intent of the Legislature that any federal assistance that is or may become available to qualified beneficiaries under this article be effectively and promptly implemented by the department.

(d) The director, in consultation with the Insurance Commissioner, may adopt emergency regulations to implement this article in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code by making a finding of emergency and demonstrating the need for immediate action in the event that any federal assistance is or becomes available to qualified beneficiaries under this article. The adoption of these regulations shall be considered by the Office of Administrative Law to be necessary to avoid serious harm to the public peace, health, safety, or general welfare. Any regulations adopted pursuant to this subdivision shall be substantially similar to those adopted by the Insurance Commissioner under subdivision (d) of Section 10128.50 of the Insurance Code.

HISTORY:
Added Stats 1997 ch 665 § 1 (SB 719).
Amended Stats 2009 ch 3 § 1 (AB 23), effective May 12, 2009.

§ 1366.21. Definitions governing article

The definitions contained in this section govern the construction of this article.

(a) "Continuation coverage" means extended coverage under the group benefit plan in which an eligible employee or eligible dependent is currently enrolled, or, in the case of a termination of the group benefit plan or an employer open enrollment period, extended coverage under the group benefit plan currently offered by the employer.

(b) "Group benefit plan" means any health care service plan contract provided pursuant to Article 3.1 (commencing with Section 1357) to an employer with 2 to 19 eligible employees, as defined in Section 1357, as well as a specialized health care service plan contract provided to an employer with 2 to 19 eligible employees, as defined in Section 1357.

(c)(1) "Qualified beneficiary" means any individual who, on the day before the qualifying event, is an enrollee in a group benefit plan offered by a health care service plan pursuant to Article 3.1 (commencing with Section 1357) and has a qualifying event, as defined in subdivision (d).

(2) "Qualified beneficiary eligible for premium assistance under ARRA" means a qualified beneficiary, as defined in paragraph (1), who (A) was or is eligible for continuation coverage as a result of the involuntary termination of the covered employee's employment during the period specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, (B) elects continuation coverage, and (C) meets the definition of "qualified beneficiary" set forth in paragraph (3) of Section 1167 of Title 29 of the United States Code, as used in subparagraph (E) of paragraph (10) of subdivision (a) of Section 3001 of ARRA or any subsequent rules or regulations issued pursuant to that law.

(3) "ARRA" means Title III of Division B of the federal American Recovery and Reinvestment Act of 2009 or any amendment to that federal law extending federal premium assistance to qualified beneficiaries.

(d) "Qualifying event" means any of the following events that, but for the election of continuation coverage under this article, would result in a loss of coverage under the group benefit plan to a qualified beneficiary:

(1) The death of the covered employee.

(2) The termination of employment or reduction in hours of the covered employee's employment, except that termination for gross misconduct does not constitute a qualifying event.

(3) The divorce or legal separation of the covered employee from the covered employee's spouse.

(4) The loss of dependent status by a dependent enrolled in the group benefit plan.

(5) With respect to a covered dependent only, the covered employee's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).

(e) "Employer" means any employer that meets the definition of "small employer" as set forth in Section 1357 and (1) employed 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar year, or, if the employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar quarter, (2) has contracted for health care coverage through a group benefit plan offered by a health care service plan, and (3) is not subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

(f) "Core coverage" means coverage of basic health care services, as defined in subdivision (b) of Section 1345, and other hospital, medical, or surgical benefits provided by the group benefit plan that a qualified beneficiary was receiving immediately prior to the qualifying event, other than noncore coverage.

(g) "Noncore coverage" means coverage for vision and dental care.

HISTORY:
Added Stats 1997 ch 665 § 1 (SB 719). Amended Stats 1998 ch 107 § 6 (AB 112), effective July 6, 1998; Stats 2009 ch 3 § 2 (AB 23), effective May 12, 2009; Stats 2010 ch 24 § 1 (SB 838), effective June 3, 2010.

§ 1366.22. Inapplicability of requirements

The continuation coverage requirements of this article do not apply to the following individuals:

(a) Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits pursuant to Title XVIII of the United States Social Security Act, as amended or superseded. Entitlement to Medicare Part A only constitutes entitlement to benefits under Medicare.

(b) Individuals who have other hospital, medical, or surgical coverage or who are covered or become covered under another group benefit plan, including a self-insured employee welfare benefit plan, that provides coverage for individuals and that does not impose any exclusion or limitation with respect to any preexisting condition of the individual, other than a preexisting condition limitation or exclusion that does not apply to or is satisfied by the qualified beneficiary pursuant to Sections 1357 and 1357.06. A group

conversion option under any group benefit plan shall not be considered as an arrangement under which an individual is or becomes covered.

(c) Individuals who are covered, become covered, or are eligible for federal COBRA coverage pursuant to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

(d) Individuals who are covered, become covered, or are eligible for coverage pursuant to Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq.

(e) Qualified beneficiaries who fail to meet the requirements of subdivision (b) of Section 1366.24 or subdivision (h) of Section 1366.25 regarding notification of a qualifying event or election of continuation coverage within the specified time limits.

(f) Except as provided in Section 3001 of ARRA, qualified beneficiaries who fail to submit the correct premium amount required by subdivision (b) of Section 1366.24 and Section 1366.26, in accordance with the terms and conditions of the plan contract, or fail to satisfy other terms and conditions of the plan contract.

HISTORY:
Added Stats 1997 ch 665 § 1 (SB 719). Amended Stats 1998 ch 107 § 7 (AB 112), effective July 6, 1998; Stats 2009 ch 3 § 3 (AB 23), effective May 12, 2009; Stats 2010 ch 24 § 2 (SB 838), effective June 3, 2010.

§ 1366.23. Requirement to offer continuation coverage

(a) Every health care service plan, including a specialized health care service plan contract, that provides coverage under a group benefit plan to an employer, as defined in Section 1366.21, shall offer continuation coverage, pursuant to this section, to a qualified beneficiary under the contract upon a qualifying event without evidence of insurability. The qualified beneficiary shall, upon election, be able to continue his or her coverage under the group benefit plan, subject to the contract's terms and conditions, and subject to the requirements of this article. Except as otherwise provided in this article, continuation coverage shall be provided under the same terms and conditions that apply to similarly situated individuals under the group benefit plan.

(b) Every health care service plan shall also offer the continuation coverage to a qualified beneficiary who (1) elects continuation coverage under a group benefit plan, as defined in this article or in Section 10128.51 of the Insurance Code, but whose continuation coverage is terminated pursuant to subdivision (b) of Section 1366.27, prior to any other termination date specified in Section 1366.27, or (2) who elects coverage through the health care service plan during any employer open enrollment, and the employer has contracted with the health care service plan to provide coverage to the employer' s active employees. This continuation coverage shall be provided only for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan had the employer not terminated the group contract with the previous health care service plan or insurer.

(c) Every health care service plan or specialized health care service plan shall offer a qualified beneficiary the ability to elect the same core, noncore, or core and noncore coverage that the qualified beneficiary had immediately prior to the qualifying event.

(d) Any child who is born to a former employee who is a qualified beneficiary who has elected continuation coverage pursuant to this article or a child who is placed for adoption with a former employee who is a qualified beneficiary who has elected continuation coverage pursuant to this article during the period of continuation coverage provided by this article shall be considered a qualified beneficiary entitled to receive benefits pursuant to this article for the remainder of the period that the former employee is covered pursuant to this article, if the child is enrolled under a group benefit plan as a dependent of that former employee who is a qualified beneficiary within 30 days of the child's birth or placement for adoption.

(e) An individual who becomes a qualified beneficiary pursuant to this article shall continue to receive coverage pursuant to this article until continuation coverage is terminated at the qualified beneficiary's election or pursuant to Section 1366.27, whichever comes first, even if the employer that sponsored the group benefit plan that is continued subsequently becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1161 et seq.

(f) A qualified beneficiary electing coverage pursuant to this section shall be considered part of the group contract and treated as similarly situated employees for contract purposes, unless otherwise specified in this article.

HISTORY:
Added Stats 1997 ch 665 § 1 (SB 719). Amended Stats 1998 ch 107 § 8 (AB 112), effective July 6, 1998.

§ 1366.24. Disclosures

(a) Every health care service plan evidence of coverage, provided for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject to this article the ability to continue coverage pursuant to this article, as required by this section.

(b) This disclosure shall state that all enrollees who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 1366.21, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the health care service plan, or the employer if the employer contracts to perform the administrative services as provided for in Section 1366.25, of all qualifying events as specified in paragraphs (1), (3), (4), and (5) of subdivision (d) of Section 1366.21 within 60 days of the date of the qualifying event. This disclosure shall inform enrollees that failure to make the notification to the health care service plan, or to the employer when under contract to provide the administrative services, within the required 60 days will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article. The disclosure shall further state that a qualified beneficiary who wishes to continue coverage under the group benefit plan pursuant to this article must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 1366.25, within the 60-day period following the later of (1) the date that the enrollee's

coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the enrollee was sent notice pursuant to subdivision (e) of Section 1366.25 of the ability to continue coverage under the group benefit plan. The disclosure required by this section shall also state that a qualified beneficiary electing continuation shall pay to the health care service plan, in accordance with the terms and conditions of the plan contract, which shall be set forth in the notice to the qualified beneficiary pursuant to subdivision (d) of Section 1366.25, the amount of the required premium payment, as set forth in Section 1366.26. The disclosure shall further require that the qualified beneficiary's first premium payment required to establish premium payment be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the employer has contracted with the plan to perform the administrative services pursuant to subdivision (d) of Section 1366.25, within 45 days of the date the qualified beneficiary provided written notice to the health care service plan or the employer, if the employer has contracted to perform the administrative services, of the election to continue coverage in order for coverage to be continued under this article. This disclosure shall also state that the first premium payment must equal an amount sufficient to pay any required premiums and all premiums due, and that failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

(c) The disclosure required by this section shall also describe separately how qualified beneficiaries whose continuation coverage terminates under a prior group benefit plan pursuant to subdivision (b) of Section 1366.27 may continue their coverage for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan, including the requirements for election and payment. The disclosure shall clearly state that continuation coverage shall terminate if the qualified beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.

(d) Prior to August 1, 1998, every health care service plan shall provide to all covered employees of employers subject to this article a written notice containing the disclosures required by this section, or shall provide to all covered employees of employers subject to this section a new or amended evidence of coverage that includes the disclosures required by this section. Any specialized health care service plan that, in the ordinary course of business, maintains only the addresses of employer group purchasers of benefits and does not maintain addresses of covered employees, may comply with the notice requirements of this section through the provision of the notices to its employer group purchasers of benefits.

(e) Every plan disclosure form issued, amended, or renewed on and after January 1, 1999, for a group benefit plan subject to this article shall provide a notice that, under state law, an enrollee may be entitled to continuation of group coverage and that additional information regarding eligibility for this coverage may be found in the plan's evidence of coverage.

(f) Every disclosure issued, amended, or renewed on and after July 1, 2006, for a group benefit plan subject to this article shall include the following notice:

"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

HISTORY:
Added Stats 1997 ch 665 § 1 (SB 719). Amended Stats 1998 ch 107 § 8.5 (AB 112), effective July 6, 1998; Stats 2005 ch 526 § 2 (AB 356), effective January 1, 2006.

§ 1366.25. Notification requirements; Contract with employer or administrator to perform administrative obligation; Coverage under American Recovery and Reinvestment Act of 2009

(a) Every group contract between a health care service plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify the plan, in writing, of any employee who has had a qualifying event, as defined in paragraph (2) of subdivision (d) of Section 1366.21, within 30 days of the qualifying event. The group contract shall also require the employer to notify the plan, in writing, within 30 days of the date, when the employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1161 et seq.

(b) Every group contract between a plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered, as specified in Section 1366.27, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later.

Every health care service plan and specialized health care service plan shall provide to the employer replacing a health care service plan contract issued by the plan, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the plan reasonably required to administer the notification requirements of this subdivision and subdivision (c).

(c) Notwithstanding subdivision (a), the group contract between the health care service plan and the employer shall require the employer to notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator, may provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by subdivision (c) of Section 1366.24 and subdivision (e) of this section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified beneficiaries who are enrolled in the plan and those qualified beneficiaries who have been notified, pursuant to Section 1366.24, of their ability to continue their coverage and may still elect

coverage within the specified 60-day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the employer by the health care service plan or disability insurer currently providing continuation coverage to the qualified beneficiary. The successor plan shall not be obligated to provide this information to qualified beneficiaries if the employer or prior plan or insurer fails to comply with this section.

(d) A health care service plan may contract with an employer, or an administrator, to perform the administrative obligations of the plan as required by this article, including required notifications and collecting and forwarding premiums to the health care service plan. Except for the requirements of subdivisions (a), (b), and (c), this subdivision shall not be construed to permit a plan to require an employer to perform the administrative obligations of the plan as required by this article as a condition of the issuance or renewal of coverage.

(e) Every health care service plan, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, within 14 days of receiving a notice of a qualifying event, provide to the qualified beneficiary the necessary benefits information, premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 1366.24 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.

(f) Every health care service plan, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, during the 180-day period ending on the date that continuation coverage is terminated pursuant to paragraphs (1), (3), and (5) of subdivision (a) of Section 1366.27, notify a qualified beneficiary who has elected continuation coverage pursuant to this article of the date that his or her coverage will terminate, and shall notify the qualified beneficiary of any conversion coverage available to that qualified beneficiary. This requirement shall not apply when the continuation coverage is terminated because the group contract between the plan and the employer is being terminated.

(g)(1) A health care service plan shall provide to a qualified beneficiary who has a qualifying event during the period specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, a written notice containing information on the availability of premium assistance under ARRA. This notice shall be sent to the qualified beneficiary's last known address. The notice shall include clear and easily understandable language to inform the qualified beneficiary that changes in federal law provide a new opportunity to elect continuation coverage with a 65-percent premium subsidy and shall include all of the following:

(A) The amount of the premium the person will pay. For qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, if a health care service plan is unable to provide the correct premium amount in the notice, the notice may contain the last known premium amount and an opportunity for the qualified beneficiary to request, through a toll-free telephone number, the correct premium that would apply to the beneficiary.

(B) Enrollment forms and any other information required to be included pursuant to subdivision (e) to allow the qualified beneficiary to elect

continuation coverage. This information shall not be included in notices sent to qualified beneficiaries currently enrolled in continuation coverage.

(C) A description of the option to enroll in different coverage as provided in subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA. This description shall advise the qualified beneficiary to contact the covered employee's former employer for prior approval to choose this option.

(D) The eligibility requirements for premium assistance in the amount of 65 percent of the premium under Section 3001 of ARRA.

(E) The duration of premium assistance available under ARRA.

(F) A statement that a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days of the date of the notice.

(G) A statement that a qualified beneficiary eligible for premium assistance under ARRA who rejected or discontinued continuation coverage prior to receiving the notice required by this subdivision has the right to withdraw that rejection and elect continuation coverage with the premium assistance.

(H) A statement that reads as follows:

"IF YOU ARE HAVING ANY DIFFICULTIES READING OR UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name of health plan] at [insert appropriate telephone number]."

(2) With respect to qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, the notice described in this subdivision shall be provided by the later of May 26, 2009, or seven business days after the date the plan receives notice of the qualifying event.

(3) With respect to qualified beneficiaries who had or have a qualifying event between May 13, 2009, and the later date specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, inclusive, the notice described in this subdivision shall be provided within the period of time specified in subdivision (e).

(4) Nothing in this section shall be construed to require a health care service plan to provide the plan's evidence of coverage as a part of the notice required by this subdivision, and nothing in this section shall be construed to require a health care service plan to amend its existing evidence of coverage to comply with the changes made to this section by the enactment of Assembly Bill 23 of the 2009-10 Regular Session or by the act amending this section during the second year of the 2009-10 Regular Session.

(5) The requirement under this subdivision to provide a written notice to a qualified beneficiary and the requirement under paragraph (1) of subdivision (h) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health care service plan previously provided a written notice and additional election opportunity under Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.

(h)(1) Notwithstanding any other provision of law, a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days after the date of the notice required by subdivision (g).

(2) For a qualified beneficiary who elects to continue coverage pursuant to this subdivision, the period beginning on the date of the qualifying event and ending on the effective date of the continuation coverage shall be disregarded for purposes of calculating a break in coverage in determining whether a preexisting condition provision applies under subdivision (c) of Section 1357.06 or subdivision (e) of Section 1357.51.

(3) For a qualified beneficiary who had a qualifying event between September 1, 2008, and February 16, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the continuation coverage shall commence on the first day of the month following the election.

(4) For a qualified beneficiary who had a qualifying event between February 17, 2009, and May 12, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the effective date of the continuation coverage shall be either of the following, at the option of the beneficiary, provided that the beneficiary pays the applicable premiums:

(A) The date of the qualifying event.

(B) The first day of the month following the election.

(5) Notwithstanding any other provision of law, a qualified beneficiary who is eligible for the special election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA may elect continuation coverage no later than 60 days after the date of the notice required under subdivision (j). For a qualified beneficiary who elects coverage pursuant to this paragraph, the continuation coverage shall be effective as of the first day of the first period of coverage after the date of termination of employment, except, if federal law permits, coverage shall take effect on the first day of the month following the election. However, for purposes of calculating the duration of continuation coverage pursuant to Section 1366.27, the period of that coverage shall be determined as though the qualifying event was a reduction of hours of the employee.

(6) Notwithstanding any other provision of law, a qualified beneficiary who is eligible for any other special election opportunity under ARRA may elect continuation coverage no later than 60 days after the date of the special election notice required under ARRA.

(i) A health care service plan shall provide a qualified beneficiary eligible for premium assistance under ARRA written notice of the extension of that premium assistance as required under Section 3001 of ARRA.

(j) A health care service plan, or an administrator or employer if administrative obligations have been assumed by those entities pursuant to subdivision (d), shall give the qualified beneficiaries described in subparagraph (C) of paragraph (17) of subdivision (a) of Section 3001 of ARRA the written notice required by that paragraph by implementing the following procedures:

(1) The health care service plan shall, within 14 days of the effective date of the act adding this subdivision, send a notice to employers currently contracting with the health care service plan for a group benefit plan subject to this article. The notice shall do all of the following:

(A) Advise the employer that employees whose employment is terminated on or after March 2, 2010, who were previously enrolled in any group health care service plan or health insurance policy offered by the employer may be entitled to special health coverage rights, including a subsidy paid by the federal government for a portion of the premium.

(B) Ask the employer to provide the health care service plan with the name, address, and date of termination of employment for any employee whose employment is terminated on or after March 2, 2010, and who was at any time covered by any health care service plan or health insurance policy offered to their employees on or after September 1, 2008.

(C) Provide employers with a format and instructions for submitting the information to the health care service plan, or their administrator or employer who has assumed administrative obligations pursuant to subdivision (d), by telephone, fax, electronic mail, or mail.

(2) Within 14 days of receipt of the information specified in paragraph (1) from the employer, the health care service plan shall send the written notice specified in paragraph (17) of subdivision (a) of Section 3001 of ARRA to those individuals.

(3) If an individual contacts his or her health care service plan and indicates that he or she experienced a qualifying event that entitles him or her to the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other special election provision of ARRA, the plan shall provide the individual with the written notice required under paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other applicable provision of ARRA, regardless of whether the plan receives information from the individual's previous employer regarding that individual pursuant to Section 24100. The plan shall review the individual's application for coverage under this special election notice to determine if the individual qualifies for the special election period and the premium assistance under ARRA. The plan shall comply with paragraph (5) if the individual does not qualify for either the special election period or premium assistance under ARRA.

(4) The requirement under this subdivision to provide the written notice described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to a qualified beneficiary and the requirement under paragraph (5) of subdivision (h) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health care service plan previously provided the written notice and additional election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.

(5) If an individual does not qualify for either a special election period or the premium assistance under ARRA, the health care service plan shall provide a written notice to that individual that shall include information on the right to appeal as set forth in Section 3001 of ARRA.

(6) A health care service plan shall provide information on its publicly accessible Internet Web site regarding the premium assistance made available under ARRA and any special election period provided under that law. A plan may fulfill this requirement by linking or otherwise directing consumers to the information regarding COBRA continuation coverage premium assistance located on the Internet Web site of the United States Department of Labor. The information required by this paragraph shall be located in a section of the plan's Internet Web site that is readily accessible to consumers, such as the Web site's Frequently Asked Questions section.

(k) For purposes of implementing federal premium assistance for continuation coverage, the department may designate a model notice or notices that may be used by health care service plans. Use of the model notice or notices shall not require prior approval of the department. Any model notice or notices designated by the department for purposes of this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(*l*) Notwithstanding any other provision of law, a qualified beneficiary eligible for premium assistance under ARRA may elect to enroll in different coverage subject to the criteria provided under subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA.

(m) A qualified beneficiary enrolled in continuation coverage as of February 17, 2009, who is eligible for premium assistance under ARRA may request application of the premium assistance as of March 1, 2009, or later, consistent with ARRA.

(n) A health care service plan that receives an election notice from a qualified beneficiary eligible for premium assistance under ARRA, pursuant to subdivision (h), shall be considered a person entitled to reimbursement, as defined in Section 6432(b)(3) of the Internal Revenue Code, as amended by paragraph (12) of subdivision (a) of Section 3001 of ARRA.

(o)(1) For purposes of compliance with ARRA, in the absence of guidance from, or if specifically required for state-only continuation coverage by, the United States Department of Labor, the Internal Revenue Service, or the Centers for Medicare and Medicaid Services, a health care service plan may request verification of the involuntary termination of a covered employee's employment from the covered employee's former employer or the qualified beneficiary seeking premium assistance under ARRA.

(2) A health care service plan that requests verification pursuant to paragraph (1) directly from a covered employee's former employer shall do so by providing a written notice to the employer. This written notice shall be sent by mail or facsimile to the covered employee's former employer within seven business days from the date the plan receives the qualified beneficiary's election notice pursuant to subdivision (h). Within 10 calendar days of receipt of written notice required by this paragraph, the former employer shall furnish to the health care service plan written verification as to whether the covered employee's employment was involuntarily terminated.

(3) A qualified beneficiary requesting premium assistance under ARRA may furnish to the health care service plan a written document or other information from the covered employee's former employer indicating that the covered employee's employment was involuntarily terminated. This document or information shall be deemed sufficient by the health care service plan to establish that the covered employee's employment was involuntarily terminated for purposes of ARRA, unless the plan makes a reasonable and timely determination that the documents or information provided by the qualified beneficiary are legally insufficient to establish involuntary termination of employment.

(4) If a health care service plan requests verification pursuant to this subdivision and cannot verify involuntary termination of employment within 14 business days from the date the employer receives the verification

request or from the date the plan receives documentation or other information from the qualified beneficiary pursuant to paragraph (3), the health care service plan shall either provide continuation coverage with the federal premium assistance to the qualified beneficiary or send the qualified beneficiary a denial letter which shall include notice of his or her right to appeal that determination pursuant to ARRA.

(5) No person shall intentionally delay verification of involuntary termination of employment under this subdivision.

(p) The provision of information and forms related to the premium assistance available pursuant to ARRA to individuals by a health care service plan shall not be considered a violation of this chapter provided that the plan complies with all of the requirements of this article.

HISTORY:
Added Stats 1997 ch 665 § 1 (SB 719). Amended Stats 1998 ch 107 § 9 (AB 112), effective July 6, 1998; Stats 2009 ch 3 § 4 (AB 23), effective May 12, 2009; Stats 2010 ch 24 § 3 (SB 838), effective June 3, 2010.

§ 1366.26. Rate limits

A qualified beneficiary electing continuation coverage shall pay to the health care service plan, on or before the due date of each payment but not more frequently than on a monthly basis, not more than 110 percent of the applicable rate charged for a covered employee or, in the case of dependent coverage, not more than 110 percent of the applicable rate charged to a similarly situated individual under the group benefit plan being continued under the group contract. In the case of a qualified beneficiary who is determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act, the qualified beneficiary shall be required to pay to the health care service plan an amount no greater than 150 percent of the group rate after the first 18 months of continuation coverage provided pursuant to this section. In no case shall a health care service plan charge an employer an additional fee for administering Cal-COBRA other than those incorporated in the risk adjusted employee risk rate as provided for in subdivision (i) of Section 1357.

HISTORY:
Added Stats 1997 ch 665 § 1 (SB 719). Amended Stats 1998 ch 107 § 10 (AB 112), effective July 6, 1998.

§ 1366.27. Termination of continuation coverage

(a) The continuation coverage provided pursuant to this article shall terminate at the first to occur of the following:

(1) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 1366.21, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event.

(2) Except as provided in Section 3001 of ARRA, the end of the period for which premium payments were made, if the qualified beneficiary ceases to make payments or fails to make timely payments of a required premium, in accordance with the terms and conditions of the plan contract. In the case of nonpayment of premiums, reinstatement shall be governed by the terms and conditions of the plan contract and by Section 3001 of ARRA, if applicable.

(3) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (1), (3), (4), or (5) of subdivision (d) of Section 1366.21, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event.

(4) The requirements of this article no longer apply to the qualified beneficiary pursuant to the provisions of Section 1366.22.

(5) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 1366.21, and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first 60 days of continuation coverage, and the spouse or dependent who has elected coverage pursuant to this article, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event. The qualified beneficiary shall notify the plan, or the employer or administrator that contracts to perform administrative services, of the social security determination within 60 days of the date of the determination letter and prior to the end of the original 36-month continuation coverage period in order to be eligible for coverage pursuant to this subdivision. If the qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act, the benefits provided in this paragraph shall terminate on the later of the date provided by paragraph (1), or the month that begins more than 31 days after the date of the final determination under Title II or Title XVI of the United States Social Security Act that the qualified beneficiary is no longer disabled. A qualified beneficiary eligible for 36 months of continuation coverage as a result of a disability shall notify the plan, or the employer or administrator that contracts to perform the notice and administrative services, within 30 days of a determination that the qualified beneficiary is no longer disabled.

(6) In the case of a qualified beneficiary who is initially eligible for and elects continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 1366.21, but who has another qualifying event, as described in paragraph (1), (3), (4), or (5) of subdivision (d) of Section 1366.21, within 36 months of the date of the first qualifying event, and the qualified beneficiary has notified the plan, or the employer or administrator under contract to provide administrative services, of the second qualifying event within 60 days of the date of the second qualifying event, the date 36 months after the date of the first qualifying event.

(7) The employer, or any successor employer or purchaser of the employer, ceases to provide any group benefit plan to his or her employees.

(8) The qualified beneficiary moves out of the plan's service area or the qualified beneficiary commits fraud or deception in the use of plan services.

(b) If the group contract between the plan and the employer is terminated prior to the date the qualified beneficiary's continuation coverage would terminate pursuant to this section, coverage under the prior plan shall terminate and the qualified beneficiary may elect continuation coverage under the subsequent group benefit plan, if any, pursuant to the requirements of subdivision (b) of Section 1366.23 and subdivision (c) of Section 1366.24.

(c) The amendments made to this section by Assembly Bill 1401 of the

2001-02 Regular Session shall apply to individuals who begin receiving continuation coverage under this article on or after January 1, 2003.

HISTORY:
Added Stats 1997 ch 665 § 1 (SB 719). Amended Stats 1998 ch 107 § 11 (AB 112), effective July 6, 1998; Stats 2002 ch 794 § 3 (AB 1401); Stats 2010 ch 24 § 4 (SB 838), effective June 3, 2010.

§ 1366.28. Failures to comply

A health care service plan subject to this article shall not be obligated to provide continuation coverage to a qualified beneficiary pursuant to this article if an enrollee fails to make the notification required by Section 1366.24, or if the employer of the enrollee fails to comply with Section 1366.25.

HISTORY:
Added Stats 1997 ch 665 § 1 (SB 719).

§ 1366.29. Continuing coverage for enrollees who have exhausted continuation coverage under COBRA

(a) A health care service plan shall offer an enrollee who has exhausted continuation coverage under COBRA the opportunity to continue coverage for up to 36 months from the date the enrollee's continuation coverage began, if the enrollee is entitled to less than 36 months of continuation coverage under COBRA. The health care service plan shall offer coverage pursuant to the terms of this article, including the rate limitations contained in Section 1366.26.

(b) Notification of the coverage available under this section shall be included in the notice of the pending termination of COBRA coverage that is required to be provided to COBRA beneficiaries and that is required to be provided under Section 1366.24.

(c) For purposes of this section, "COBRA" means Section 4980B of Title 26 of the United States Code, Sections 1161 et seq. of Title 29 of the United States Code, and Section 300bb of Title 42 of the United States Code.

(d) This section shall not apply to specialized health care service plans providing noncore coverage, as defined in subdivision (g) of Section 1366.21.

(e) This section shall become operative on September 1, 2003, and shall apply to individuals who begin receiving COBRA coverage on or after January 1, 2003.

HISTORY:
Added Stats 2002 ch 794 § 4 (AB 1401), operative September 1, 2003.

ARTICLE 4.6

Coverage for Federally Eligible Defined Individuals

Section
1366.35. Required coverage (Inoperative; Operative date contingent).
1366.50. Notice of eligibility for reduced-cost coverage through California Health Benefit Exchange or no-cost coverage through Medi-Cal [Effective until January 1, 2020].
1366.50. Notice of eligibility for reduced-cost coverage through California Health Benefit Exchange or no-cost coverage through Medi-Cal [Effective January 1, 2020].

HISTORY: Added Stats 2000 ch 810 § 1.

§ 1366.35. Required coverage (Inoperative; Operative date contingent)

(a) A health care service plan providing coverage for hospital, medical, or surgical benefits under an individual health care service plan contract may not, with respect to a federally eligible defined individual desiring to enroll in individual health insurance coverage, decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion with respect to the coverage.

(b) For purposes of this section, "federally eligible defined individual" means an individual who, as of the date on which the individual seeks coverage under this section, meets all of the following conditions:

(1) Has had 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002).

(2) Is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have other health insurance coverage.

(3) Was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud.

(4) If offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.

(c) Every health care service plan shall comply with applicable federal statutes and regulations regarding the provision of coverage to federally eligible defined individuals, including any relevant application periods.

(d) A health care service plan shall offer the following health benefit plan contracts under this section that are designed for, made generally available to, are actively marketed to, and enroll, individuals: (1) either the two most popular products as defined in Section 300gg-41(c)(2) of Title 42 of the United States Code and Section 148.120(c)(2) of Title 45 of the Code of Federal Regulations or (2) the two most representative products as defined in Section 300gg-41(c)(3) of the United States Code and Section 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as determined by the plan in compliance with federal law. A health care service plan that offers only one health benefit plan contract to individuals, excluding health benefit plans offered to Medi-Cal or Medicare beneficiaries, shall be deemed to be in compliance with this article if it offers that health benefit plan contract to federally eligible defined individuals in a manner consistent with this article.

(e)(1) In the case of a health care service plan that offers health insurance coverage in the individual market through a network plan, the plan may do both of the following:

(A) Limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service area for the network plan.

(B) Within the service area of the plan, deny coverage to individuals if the plan has demonstrated to the director that the plan will not have the capacity to deliver services adequately to additional individual enrollees

because of its obligations to existing group contractholders and enrollees and individual enrollees, and that the plan is applying this paragraph uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A health care service plan, upon denying health insurance coverage in any service area in accordance with subparagraph (B) of paragraph (1), may not offer coverage in the individual market within that service area for a period of 180 days after the coverage is denied.

(f)(1) A health care service plan may deny health insurance coverage in the individual market to a federally eligible defined individual if the plan has demonstrated to the director both of the following:

(A) The plan does not have the financial reserves necessary to underwrite additional coverage.

(B) The plan is applying this subdivision uniformly to all individuals in the individual market and without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A health care service plan, upon denying individual health insurance coverage in any service area in accordance with paragraph (1), may not offer that coverage in the individual market within that service area for a period of 180 days after the date the coverage is denied or until the issuer has demonstrated to the director that the plan has sufficient financial reserves to underwrite additional coverage, whichever is later.

(g) The requirement pursuant to federal law to furnish a certificate of creditable coverage shall apply to health insurance coverage offered by a health care service plan in the individual market in the same manner as it applies to a health care service plan in connection with a group health benefit plan.

(h) A health care service plan shall compensate a life agent or fire and casualty broker-agent whose activities result in the enrollment of federally eligible defined individuals in the same manner and consistent with the renewal commission amounts as the plan compensates life agents or fire and casualty broker-agents for other enrollees who are not federally eligible defined individuals and who are purchasing the same individual health benefit plan contract.

(i) Every health care service plan shall disclose as part of its COBRA or Cal-COBRA disclosure and enrollment documents, an explanation of the availability of guaranteed access to coverage under the Health Insurance Portability and Accountability Act of 1996, including the necessity to enroll in and exhaust COBRA or Cal-COBRA benefits in order to become a federally eligible defined individual.

(j) No health care service plan may request documentation as to whether or not a person is a federally eligible defined individual other than is permitted under applicable federal law or regulations.

(k) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.

(*l*) This section shall apply to health care service plan contracts offered, delivered, amended, or renewed on or after January 1, 2001.

(m)(1) This section shall be inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), this section shall become operative on the date of that repeal or amendment.

(3) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care Education and Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

HISTORY:
Added Stats 2000 ch 810 § 1 (SB 265). Amended Stats 2013 ch 441 § 4 (AB 1180), effective October 1, 2013, inoperative January 1, 2014, operative date contingent.

§ 1366.50. Notice of eligibility for reduced-cost coverage through California Health Benefit Exchange or no-cost coverage through Medi-Cal [Effective until January 1, 2020]

(a) On and after January 1, 2014, a health care service plan providing individual or group health care coverage shall provide to enrollees or subscribers who cease to be enrolled in coverage a notice informing them that they may be eligible for reduced-cost coverage through the California Health Benefit Exchange established under Title 22 (commencing with Section 100500) of the Government Code or no-cost coverage through Medi-Cal. The notice shall include information on obtaining coverage pursuant to those programs, shall be in no less than 12-point type, and shall be developed by the department, no later than July 1, 2013, in consultation with the Department of Insurance and the California Health Benefit Exchange.

(b) The notice described in subdivision (a) may be incorporated into or sent simultaneously with and in the same manner as any other notices sent by the health care service plan.

(c) This section shall not apply with respect to a specialized health care service plan contract or a Medicare supplemental plan contract.

HISTORY:
Added Stats 2012 ch 851 § 3 (AB 792), effective January 1, 2013.

§ 1366.50. Notice of eligibility for reduced-cost coverage through California Health Benefit Exchange or no-cost coverage through Medi-Cal [Effective January 1, 2020]

(a)(1) On and after January 1, 2014, a health care service plan providing individual or group health care coverage shall provide to enrollees or subscribers who cease to be enrolled in coverage a notice informing them that they may be eligible for reduced-cost coverage through the California Health Benefit Exchange (Exchange) established under Title 22 (commencing with Section 100500) of the Government Code or no-cost coverage through Medi-Cal. The notice shall include information on obtaining coverage pursuant to those programs, shall be in no less than 12-point type, and

shall be developed by the department, no later than July 1, 2013, in consultation with the Department of Insurance and the Exchange. The notice shall also include information that individuals eligible for the Medicare Program should examine their options carefully, as delaying Medicare enrollment may result in substantial financial implications, as well as information on how to find enrollment advice or assistance.

(2) The notice described in paragraph (1) may be incorporated into or sent simultaneously with and in the same manner as any other notices sent by the health care service plan.

(b)(1) A health care service plan providing individual or group health care coverage shall annually notify an enrollee or subscriber that if the enrollee or subscriber ceases to be enrolled in coverage, the health care service plan will provide information, including the enrollee's or subscriber's name, address, and other contact information, such as email address, to the Exchange so that the enrollee or subscriber may obtain other coverage. An enrollee or subscriber may opt out of this transfer of information to the Exchange. This notice may be incorporated into or sent simultaneously with other notices sent by the health care service plan.

(2) Beginning January 1, 2021, a health care service plan providing individual or group health care coverage that has notified its enrollees or subscribers consistent with paragraph (1) shall provide to the Exchange the name, address, and other contact information of an enrollee or subscriber who ceased to be enrolled in coverage and who did not opt out of the information transfer. The information shall be provided in a manner prescribed by the Exchange.

(3) The Exchange may use any contact method to communicate with and inform an enrollee or subscriber who ceases to be enrolled in coverage of available coverage options.

(c) This section does not apply to a specialized health care service plan contract or a Medicare supplemental plan contract.

HISTORY:
Added Stats 2012 ch 851 § 3 (AB 792), effective January 1, 2013. Amended Stats 2019 ch 845 § 2 (SB 260), effective January 1, 2020.

ARTICLE 5

Standards

Section

1367. Requirements for health care service plans.
1367.001. Compliance with specified federal law, rules and regulations, and state laws required; Applicability.
1367.002. Compliance with provisions regarding coverage of, and cost-sharing for, preventive services and rules or regulations.
1367.003. Rebate on pro rata basis; Conditions; Minimum medical loss ratios; Total amount of rebate; Adoption of regulations; Applicability.
1367.004. Plans covering dental services; MLR annual report requirement; Examination by director; Use of data by Legislature; Compliance guidance exempt from APA.
1367.005. Individual or small group health care service plan to cover essential health benefits; Provisions.
1367.006. Nongrandfathered individual and group health care service plans that cover essential health benefits; Limit on annual out-of-pocket expenses for covered essential health benefits.
1367.0065. [Section repealed 2016.]

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1367.007. Limitation on deductible for small employer health care service plan.
1367.008. Levels of coverage for nongrandfathered individual market; Determination of actuarial value for nongrandfathered individual health care service plans; Catastrophic plan.
1367.0085. Actuarial value for nongrandfathered bronze level high deductible health plan.
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1367.010. Minimum value of sixty percent for large group health care service plan contract.
1367.012. Renewal of small employer health care service plan contract; Notice; Exemptions; Amendments for compliance.
1367.015. Decisions to deny requests by providers for authorization or claim reimbursement for mental health services.
1367.016. Premium payments from third-party entities; Reimbursement; Dispute resolution [Effective January 1, 2020].
1367.02. Filing relating to any economic profiling policies or procedures; Availability to public; "Economic profiling".
1367.03. Development of standards for timely access to health care services.
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1367.035. Standards for timely access to health care services; Required inclusion of network adequacy data.
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1367.041. Required non-English insurance documents.
1367.042. Information made available by health care service plan.
1367.05. Contract with dental college.
1367.06. Service plan to cover outpatient prescription drug benefits to provide coverage for inhaler spacers, nebulizers, and peak flow meters when medically necessary for treatment of pediatric asthma.
1367.07. Report by health care service plan on cultural appropriateness in specified contexts.
1367.08. Compensation disclosure.
1367.09. Return to skilled nursing.
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1367.2. Coverage for alcoholism; Notice of coverage.
1367.3. Coverage plan for comprehensive preventive care of children.
1367.35. Comprehensive preventive care of children of specified ages.
1367.36. Costs of required immunization of children.
1367.4. Effect of blindness on coverage.
1367.41. Pharmacy and therapeutics committee.
1367.42. Enrollee access to prescription drug benefits at in-network retail pharmacy; Effect on cost-sharing.
1367.43. Prorated cost for partial fill of prescription.
1367.45. Coverage for approved AIDS vaccine; Cost effective price.
1367.46. Coverage for HIV testing required.
1367.47. Maximum amount health care service plan may require enrollee to pay at point of sale for covered prescription drug.
1367.49. Information to be furnished to consumers or purchasers concerning cost range of procedure or full course of treatment, or quality of services performed by provider or supplier; Review of methodology and data; Online posting; Definitions.
1367.5. Health service plan contract restrictions.
1367.50. Disclosure of claims data to qualified entity.
1367.51. Coverage of equipment and supplies for treatment of diabetes; Prescription items; Outpatient self-management and training.
1367.54. California Prenatal Screening Program.
1367.6. Coverage for breast cancer screening, diagnosis, and treatment; Denial of enrollment or coverage on grounds related to breast cancer; Prosthetic devices or reconstructive surgery.
1367.61. Coverage for prosthetic devices to restore method of speaking incident to laryngectomy.
1367.62. Restrictions on limiting inpatient hospital care following childbirth; Proscription on specified treatment and coverage practices; Notice of required coverage.
1367.625. Maternal mental health program.
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1367.64. Coverage for screening and diagnosis of prostate cancer.

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1367.65. Coverage for mammography for screening and diagnostic purposes.
1367.656. Healthcare coverage for orally administered anticancer medication [Effective until January 1, 2024; Repealed effective January 1, 2024].
1367.66. Coverage for annual cervical cancer screening test.
1367.665. Coverage for cancer screening tests.
1367.67. Coverage for osteoporosis.
1367.68. Coverage for surgical procedure for conditions affecting upper or lower jawbone.
1367.69. Obstetrician-gynecologists as eligible primary care physicians.
1367.695. Requirement for enrollee's choice of obstetrical or gynecological services provider [Effective until January 1, 2020].
1367.695. Requirement for enrollee's choice of obstetrical or gynecological services provider [Effective January 1, 2020].
1367.7. Coverage for prenatal diagnosis of genetic disorders of fetus.
1367.71. General anesthesia and associated facility charges for dental procedures.
1367.8. Coverage for handicapped persons.
1367.9. Coverage for conditions attributable to diethylstilbestrol.
1367.10. Disclosure of effect of participation in plan on choice of provider.
1367.11. Direct reimbursement to providers of covered medical transportation services.
1367.12. Number of forms to be submitted per claim for payment or reimbursement.
1367.15. Closure of "block of business".
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1367.205. Formularies to be posted on Internet Web site; Required updates; Template.
1367.21. Limitation or exclusion of coverage for drug prescribed for use different from which drug was approved.
1367.215. Coverage of pain management medications for terminally ill patients.
1367.22. Plan's obligations relating to drug previously approved for enrollee's medical condition.
1367.23. Plan provision requiring notification of group contractholders and subscribers of cancellation.
1367.24. Process for authorization of medically necessary nonformulary prescription drug; Required recordkeeping by plan; Review of plan's provision of prescription drug benefits.
1367.241. Prior authorization for prescription drugs.
1367.243. Prescription drug reporting requirements for health service plans reporting rate information; Legislative report on drug cost impact on health care premiums.
1367.244. Request for exception to plan's step therapy process for prescription drugs.
1367.25. Contraceptive coverage.
1367.26. [Section repealed 2016.]
1367.27. Provider directory.
1367.29. Issuance of identification card to assist enrollee with accessing health benefits coverage information; Contents of identification card.
1367.30. Group health care service plan contracts; Applicable law.
1367.31. Referral requirement prohibited for receiving reproductive and sexual health care coverage or services.
1368. Grievance systems.
1368.01. Time period in which to resolve grievances; Expedited review for cases involving serious threat to patient's health.
1368.015. Online grievance procedure [Effective until January 1, 2020].
1368.015. Online grievance procedure [Effective January 1, 2020].
1368.016. Establishment of Internet Web site; Link to specified information required; Updates; Applicability of section.
1368.02. Toll-free telephone number for complaints [Effective until January 1, 2020].
1368.02. Toll-free telephone number for complaints [Effective January 1, 2020].
1368.03. Participation in plan's grievance process before complaint with department.
1368.04. Enforcement by director; Violations; Administrative penalty.
1368.05. Direct consumer assistance activities by Department of Managed Health Care; Contracts with community-based consumer assistance organizations.
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1368.7. State of emergency; Access to medically necessary health care services; Disruption to operation of health care service plan.
1369. Participation by subscribers and enrollees.
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1370.1. Review subcommittees.
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1370.4. Independent external review process for coverage decisions on experimental or investigational therapies.
1370.6. Coverage relating to cancer clinical trials [Repealed effective January 1, 2020].
1370.6. Coverage for approved clinical trials [Effective January 1, 2020].
1371. Reimbursement of claims; Contested claims [Effective until January 1, 2020].
1371. Reimbursement of claims; Contested claims [Effective January 1, 2020].
1371.1. Notification to provider of overpayment; Reimbursement; Contested claims; Accrual of interest.
1371.2. Prohibited request for reimbursement or reduction of level of payment.
1371.22. Acceptance of lowest payment rate charged by provider to patient or third-party; Inapplicability of policy provision to cash payments made to provider by patient without private or public health care.
1371.25. Liability.
1371.3. Assignment of right to reimbursement.
1371.30. Independent dispute resolution process for noncontracting individual health professional.
1371.31. Reimbursement rate for noncontracting individual health professional; Reporting requirements; Exemptions.
1371.35. Time limits for reimbursement, contest, or denial of certain claims; What constitutes complete claim; Claims excepted from time limits.
1371.36. Denial of payment based on authorization.
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1371.38. Regulations and reports.
1371.39. Instances of unfair payment patterns.
1371.4. Authorization for emergency services.
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1371.55. Services received from noncontracting air ambulance provider; "In-network cost-sharing amount" [Effective January 1, 2020].
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1371.9. "In-network cost-sharing amount" for services provided by noncontracting individual health professional; Exemptions.
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1373. Required or prohibited contract provisions.
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1373.2. Conversion rights of dependent spouse upon change of status.
1373.3. Selection of primary care physician.
1373.4. Limitation on copayments and deductibles for specified maternity services.
1373.5. Coverage of spouses covered under terms of same master contract; Maximum contractual benefits.
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1373.621. Additional benefits for former employee meeting tenure and age requirements and for employee's spouse or former spouse; Applicability.
1373.622. Provision of coverage after termination of pilot program; Applicable rules.
1373.65. Termination of contract with provider group or general acute care hospital; Written notice; Right of enrollee to keep provider for designated time period [Effective until January 1, 2020].
1373.65. Termination of contract with provider group or general acute care hospital; Written notice; Right of enrollee to keep provider for designated time period [Effective January 1, 2020].
1373.7. Out of state contracts; Psychologist licensure requirements.
1373.8. Contractees' right to select licensed professionals in California to perform contract services.
1373.9. Duty to give reasonable consideration to proposals for affiliation.
1373.95. Written policy on continuity of care from health care service plan.
1373.96. Completion of covered services [Effective until January 1, 2020].
1373.96. Completion of covered services [Effective January 1, 2020].

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1373.10. Acupuncture.
1373.11. Affiliation with podiatrists.
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1373.13. Discrimination against licensed dentists; Legislative intent.
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1373.18. Calculation of enrollee copayments for specified contracts of health care service plan.
1373.19. Selection of arbitrator.
1373.20. Arbitration requirements.
1373.21. Written arbitration decisions.
1374. Coverage less favorable for employees than spouses.
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1374.51. Voluntariness of psychiatric admission not to be used when determining eligibility for reimbursement.
1374.55. Coverage for treatment of infertility; "Subsidiary".
1374.551. Standard fertility preservation services; Basic health care service [Effective January 1, 2020].
1374.56. Coverage for testing and treatment of phenylketonuria (PKU).
1374.57. Exclusion of dependent child.
1374.58. Group health care service plan to offer coverage for registered domestic partner equal to that provided to spouse.
1374.7. Discrimination on basis of genetic characteristics.
1374.75. Discrimination by health care service plan providers against victims of domestic violence.
1374.8. Disclosure to employer that employee is receiving services.
1374.9. Administrative penalties for discrimination on basis of genetic characteristics.
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1374.13. Telehealth; Restrictions; Construction [Effective until January 1, 2020].
1374.13. Telehealth; Restrictions; Construction [Effective January 1, 2020].
1374.14. Telehealth services reimbursement [Effective January 1, 2020].
1374.15. Disclosure of method used in calculating contract payment rates.
1374.16. Standing referral to specialist.
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1374.193. Service plan or contract covering dental services; Third party access to provider network contract, dental services, or contractual discounts [Effective January 1, 2020].
1374.195. Covered dental services; Contracts; Charge for services; Evidence of coverage and disclosure form; Required statement.

HISTORY: Added Stats 1975 ch 941 § 2, operative July 1, 1976.

§ 1367. Requirements for health care service plans

A health care service plan and, if applicable, a specialized health care service plan shall meet the following requirements:

(a) Facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Public Health, where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(b) Personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

(c) Equipment required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law.

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

(e)(1) All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.

(2) To the extent that telehealth services are appropriately provided through telehealth, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, these services shall be considered in determining compliance with Section 1300.67.2 of Title 28 of the California Code of Regulations.

(3) The plan shall make all services accessible and appropriate consistent with Section 1367.04.

(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

(h)(1) Contracts with subscribers and enrollees, including group contracts, and contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.

(2) A health care service plan shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.

(3) On and after January 1, 2002, a health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes.

(i) A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service

that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service consistent with Section 1367.006 or 1367.007, provided that the copayments, deductibles, or other cost sharing are reported to the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363. Nothing in this chapter shall prohibit a health care service plan from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

(j) A health care service plan shall not require registration under the federal Controlled Substances Act (21 U.S.C. Sec. 801 et seq.) as a condition for participation by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 of the Business and Professions Code.

Nothing in this section shall be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services.

The director's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.

The obligation of the plan to comply with this chapter shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.

HISTORY:

Added Stats 1978 ch 285 § 4, effective June 23, 1978, operative July 1, 1978. Amended Stats 1992 ch 1128 § 7 (AB 1672), operative July 1, 1993; Stats 1995 ch 774 § 1 (AB 1840), ch 788 § 1 (SB 454); Stats 1996 ch 864 § 5 (SB 1665); Stats 1997 ch 17 § 60 (SB 947), ch 120 § 1 (SB 497) (ch 120 prevails); Stats 1999 ch 525 § 94 (AB 78), operative July 1, 2000; Stats 2000 ch 825 § 2 (SB 1177), ch 827 § 2 (AB 1455); Stats 2002 ch 797 § 3 (AB 2179); Stats 2003 ch 713 § 1 (SB 853); Stats 2013 ch 316 § 2 (SB 639), effective January 1, 2014.

§ 1367.001. Compliance with specified federal law, rules and regulations, and state laws required; Applicability

(a) To the extent required by federal law, every health care service plan that issues, sells, renews, or offers contracts for health care coverage in this state shall comply with the requirements of Section 2711 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-11) and any rules or regulations issued under that section, in addition to any state laws or regulations that do not prevent the application of those requirements.

(b) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of

the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

HISTORY:
Added Stats 2011 ch 644 § 1 (SB 51), effective January 1, 2012.

§ 1367.002. Compliance with provisions regarding coverage of, and cost-sharing for, preventive services and rules or regulations

To the extent required by federal law, a group or individual health care service plan contract issued, amended, renewed, or delivered on or after September 23, 2010, shall comply with Section 2713 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-13), as added by Section 1001 of the federal Patient Protection and Affordable Care Act (P.L. 111-148), and any rules or regulations issued under that section.

HISTORY:
Added Stats 2010 ch 657 § 1 (AB 2345), effective January 1, 2011. Amended Stats 2011 ch 296 § 141 (AB 1023), effective January 1, 2012.

§ 1367.003. Rebate on pro rata basis; Conditions; Minimum medical loss ratios; Total amount of rebate; Adoption of regulations; Applicability

(a) A health care service plan that issues, sells, renews, or offers health care service plan contracts for health care coverage in this state, including a grandfathered health plan, but not including specialized health care service plan contracts that provide only dental or vision services, shall provide an annual rebate to each enrollee under that coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health care service plan on the costs for reimbursement for clinical services provided to enrollees under that coverage and for activities that improve health care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:

(1) With respect to a health care service plan offering coverage in the large group market, 85 percent.

(2) With respect to a health care service plan offering coverage in the small group market or in the individual market, 80 percent.

(b) A health care service plan that issues, sells, renews, or offers health care service plan contracts for health care coverage in this state, including a grandfathered health plan, shall comply with the following minimum medical loss ratios:

(1) With respect to a health care service plan offering coverage in the large group market, 85 percent.

(2) With respect to a health care service plan offering coverage in the small group market or in the individual market, 80 percent.

(c)(1) The total amount of an annual rebate required under this section shall be calculated in an amount equal to the product of the following:

(A) The amount by which the percentage described in paragraph (1) or (2) of subdivision (a) exceeds the ratio described in paragraph (1) or (2) of subdivision (a).

(B) The total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.

(2) A health care service plan shall provide a rebate owing to an enrollee no later than September 30 of the calendar year following the year for which the ratio described in subdivision (a) was calculated.

(d) The director may adopt regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) that are necessary to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations issued under that section.

(e) The requirements of this section shall be implemented as described in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91) and the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under those sections as in effect on January 1, 2017.

(f) This section does not apply to provisions of this chapter pertaining to financial statements, assets, liabilities, and other accounting items to which subdivision (s) of Section 1345 applies.

(g) This section does not apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

HISTORY:
Added Stats 2011 ch 644 § 2 (SB 51), effective January 1, 2012. Amended Stats 2018 ch 678 § 1 (AB 2499), effective January 1, 2019.

§ 1367.004. Plans covering dental services; MLR annual report requirement; Examination by director; Use of data by Legislature; Compliance guidance exempt from APA

(a) A health care service plan that issues, sells, renews, or offers a contract covering dental services shall file a report with the department by July 31 of each year, which shall be known as the MLR annual report. The MLR annual report shall be organized by market and product type and shall contain the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418). The department shall post a health care service plan's MLR annual report on its Internet Web site within 45 days after receiving the report.

(b) The MLR reporting year shall be for the calendar year during which dental coverage is provided by the plan. As applicable, all terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with Section 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.

(c) If the director decides to conduct a financial examination, as described in Section 1382, because the director finds it necessary to verify the health care service plan's representations in the MLR annual report, the department shall provide the health care service plan with a notification 30 days before the commencement of the financial examination.

(d) The health care service plan shall have 30 days from the date of notification to electronically submit to the department all requested records, books, and papers specified in subdivision (a) of Section 1381. The director may extend the time for a health care service plan to comply with this subdivision upon a finding of good cause.

(e) The department shall make available to the public all of the data provided to the department pursuant to this section.

(f) This section does not apply to a health care service plan contract issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code), the Medi-Cal Access Program (Chapter 2 commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code), or the California Major Risk Medical Insurance Program (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(g) The department may issue guidance to specialized health care service plans subject to this section regarding compliance with this section. The guidance shall not be subject to the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), and shall be effective only until the department adopts regulations pursuant to that act. The department shall consult with the Department of Insurance in issuing the guidance specified in this section.

HISTORY:
Added Stats 2014 ch 567 § 1 (AB 1962), effective January 1, 2015. Amended Stats 2015 ch 303 § 252 (AB 731), effective January 1, 2016; Stats 2018 ch 933 § 3 (SB 1008), effective January 1, 2019.

§ 1367.005. Individual or small group health care service plan to cover essential health benefits; Provisions

(a) An individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2017, shall, at a minimum, include coverage for essential health benefits pursuant to PPACA and as outlined in this section. For purposes of this section, "essential health benefits" means all of the following:

(1) Health benefits within the categories identified in Section 1302(b) of PPACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

(2)(A) The health benefits covered by the Kaiser Foundation Health Plan

Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2014, as follows, regardless of whether the benefits are specifically referenced in the evidence of coverage or plan contract for that plan:

(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 and in Section 1300.67 of Title 28 of the California Code of Regulations.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha-fetoprotein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

(iii) Any other benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in those statutes.

(iv) The health benefits covered by the plan that are not otherwise required to be covered under this chapter, to the extent required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the California Code of Regulations.

(v) Any other health benefits covered by the plan that are not otherwise required to be covered under this chapter.

(B) If there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under this chapter that were enacted prior to December 31, 2011, the requirements of this chapter shall be controlling, except as otherwise specified in this section.

(C) Notwithstanding subparagraph (B) or any other provision of this section, the home health services benefits covered under the plan identified in subparagraph (A) shall be deemed to not be in conflict with this chapter.

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law

110-343) shall apply to a contract subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, or guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(3) With respect to habilitative services, in addition to any habilitative services and devices identified in paragraph (2), coverage shall also be provided as required by federal rules, regulations, and guidance issued pursuant to Section 1302(b) of PPACA. Habilitative services and devices shall be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract. Limits on habilitative and rehabilitative services and devices shall not be combined.

(4) With respect to pediatric vision care, the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2014. The pediatric vision care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (2).

(5) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental benefit received by children under the Medi-Cal program as of 2014, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).

(b) Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

(c) Except as provided in subdivision (d), nothing in this section shall be construed to permit a health care service plan to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

(d) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, a plan may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) as long as the coverage for prescription drugs complies with the sections referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision (a) that apply to prescription drugs.

(e) A health care service plan, or its agent, solicitor, or representative, shall not issue, deliver, renew, offer, market, represent, or sell any product, contract, or discount arrangement as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section.

(f) This section applies regardless of whether the plan contract is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

(g) This section shall not be construed to exempt a plan or a plan contract from meeting other applicable requirements of law.

(h) This section shall not be construed to prohibit a plan contract from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

(i) Subdivision (a) does not apply to any of the following:

(1) A specialized health care service plan contract.

(2) A Medicare supplement plan.

(3) A plan contract that qualifies as a grandfathered health plan under Section 1251 of PPACA or any rules, regulations, or guidance issued pursuant to that section.

(j) This section shall not be implemented in a manner that conflicts with a requirement of PPACA.

(k) This section shall be implemented only to the extent essential health benefits are required pursuant to PPACA.

(*l*) An essential health benefit is required to be provided under this section only to the extent that federal law does not require the state to defray the costs of the benefit.

(m) This section does not obligate the state to incur costs for the coverage of benefits that are not essential health benefits as defined in this section.

(n) A plan is not required to cover, under this section, changes to health benefits that are the result of statutes enacted on or after December 31, 2011.

(o)(1) The department may adopt emergency regulations implementing this section. The department may, on a one-time basis, readopt any emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(3) The initial adoption of emergency regulations implementing this section made during the 2015-16 Regular Session of the Legislature and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(4) The director shall consult with the Insurance Commissioner to ensure

consistency and uniformity in the development of regulations under this subdivision.

(5) This subdivision shall become inoperative on July 1, 2018.

(p) For purposes of this section, the following definitions apply:

(1) "Habilitative services" means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

(2)(A) "Health benefits," unless otherwise required to be defined pursuant to federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a behavioral health condition.

(B) "Health benefits" does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(4) "Small group health care service plan contract" means a group health care service plan contract issued to a small employer, as defined in Section 1357.500.

HISTORY:
Added Stats 2015 ch 648 § 2 (SB 43), effective January 1, 2016, operative January 1, 2017.
Amended Stats 2016 ch 86 § 177 (SB 1171), effective January 1, 2017.

§ 1367.006. Nongrandfathered individual and group health care service plans that cover essential health benefits; Limit on annual out-of-pocket expenses for covered essential health benefits

(a) This section shall apply to nongrandfathered individual and group health care service plan contracts that provide coverage for essential health benefits, as defined in Section 1367.005, and that are issued, amended, or renewed on or after January 1, 2015.

(b)(1) For nongrandfathered health care service plan contracts in the individual or small group markets, a health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits in Section 1367.005, including out-of-network emergency care consistent with Section 1371.4.

(2) For nongrandfathered health care service plan contracts in the large group market, a health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for covered benefits, including out-of-network emergency care

consistent with Section 1371.4. This limit shall only apply to essential health benefits, as defined in Section 1367.005, that are covered under the plan to the extent that this provision does not conflict with federal law or guidance on out-of-pocket maximums for nongrandfathered health care service plan contracts in the large group market.

(c)(1) The limit described in subdivision (b) shall not exceed the limit described in Section 1302(c) of PPACA, and any subsequent rules, regulations, or guidance issued under that section.

(2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all covered essential health benefits equal to the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.

(3) For family coverage, an individual within a family shall not have a maximum out-of-pocket limit that is greater than the maximum out-of-pocket limit for individual coverage for that product.

(d) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible enrollees described in Section 1402 of PPACA, and any subsequent rules, regulations, or guidance issued under that section.

(e) If an essential health benefit is offered or provided by a specialized health care service plan, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the limit in subdivision (b). This section shall not apply to a specialized health care service plan that does not offer an essential health benefit as defined in Section 1367.005.

(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits in Section 1367.005.

(g)(1)(A) Except as provided in paragraph (2), if a health care service plan contract for family coverage includes a deductible, an individual within a family shall not have a deductible that is greater than the deductible limit for individual coverage for that product.

(B) Except as provided in paragraph (2), if a large group market health care service plan contract for family coverage that is issued, amended, or renewed on or after January 1, 2017, includes a deductible, an individual within a family shall not have a deductible that is more than the deductible limit for individual coverage for that product.

(2)(A) If a health care service plan contract for family coverage includes a deductible and is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the plan contract shall include a deductible for each individual covered by the plan that is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the plan contract, whichever is greater.

(B) If a large group market health care service plan contract for family coverage that is issued, amended, or renewed on or after January 1, 2017, includes a deductible and is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the plan contract shall include a deductible for each individual covered by the plan that is equal to either the amount set forth in Section

223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the plan contract, whichever is greater.

(h) For nongrandfathered health plan contracts in the group market, "plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health plan contracts sold in the individual market, "plan year" means the calendar year.

(i) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

HISTORY:

Added Stats 2013 ch 316 § 3 (SB 639), effective January 1, 2014. Amended Stats 2014 ch 71 § 84 (SB 1304), effective January 1, 2015, ch 572 § 8 (SB 959), effective January 1, 2015 (ch 572 prevails); Stats 2015 ch 641 § 1 (AB 1305), effective January 1, 2016.

§ 1367.0065. [Section repealed 2016.]

HISTORY:

Added Stats 2013 ch 316 § 4 (SB 639), effective January 1, 2014, repealed January 1, 2016, by its own terms. The repealed section related to limitation on annual out-of-pocket expenses for covered essential health benefits for nongrandfathered individual and group health care service plans that cover essential health benefits and were issued, amended, or renewed for the 2014 plan year.

§ 1367.007. Limitation on deductible for small employer health care service plan

(a)(1) For a small employer health care service plan contract offered, sold, or renewed on or after January 1, 2014, the deductible under the plan shall not exceed:

(A) Two thousand dollars ($2,000) in the case of a plan contract covering a single individual.

(B) Four thousand dollars ($4,000) in the case of any other plan contract.

(2) The dollar amounts in this section shall be indexed consistent with Section 1302(c)(4)of PPACA and any federal rules or guidance pursuant to that section.

(3) The limitation in this subdivision shall be applied in a manner that does not affect the actuarial value of any small employer health care service plan contract.

(4) For small group products at the bronze level of coverage, as defined in Section 1367.008, the department may permit plans to offer a higher deductible in order to meet the actuarial value requirement of the bronze level. In making this determination, the department shall consider affordability of cost sharing for enrollees and shall also consider whether enrollees may be deterred from seeking appropriate care because of higher cost sharing.

(b) Nothing in this section shall be construed to allow a plan contract to have a deductible that applies to preventive services as defined in Section 1367.002.

(c) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

HISTORY:
Added Stats 2013 ch 316 § 5 (SB 639), effective January 1, 2014. Amended Stats 2015 ch 641 § 2 (AB 1305), effective January 1, 2016.

§ 1367.008. Levels of coverage for nongrandfathered individual market; Determination of actuarial value for nongrandfathered individual health care service plans; Catastrophic plan

(a) Levels of coverage for the nongrandfathered individual market are defined as follows:

(1) Bronze level: A health care service plan contract in the bronze level shall provide a level of coverage that is actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan contract.

(2) Silver level: A health care service plan contract in the silver level shall provide a level of coverage that is actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan contract.

(3) Gold level: A health care service plan contract in the gold level shall provide a level of coverage that is actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan contract.

(4) Platinum level: A health care service plan contract in the platinum level shall provide a level of coverage that is actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan contract.

(b) Actuarial value for nongrandfathered individual health care service plan contracts shall be determined in accordance with the following:

(1) Actuarial value shall not vary by more than plus or minus 2 percent.

(2) Actuarial value shall be determined on the basis of essential health benefits as defined in Section 1367.005 and as provided to a standard, nonelderly population. For this purpose, a standard population shall not include those receiving coverage through the Medi-Cal or Medicare programs.

(3) The department may use the actuarial value methodology developed consistent with Section 1302(d) of PPACA.

(4) The actuarial value for pediatric dental benefits, whether offered by a full service plan or a specialized plan, shall be consistent with federal law and guidance applicable to the plan type.

(5) The department, in consultation with the Department of Insurance and the Exchange, shall consider whether to exercise state-level flexibility with respect to the actuarial value calculator in order to take into account the unique characteristics of the California health care coverage market, including the prevalence of health care service plans, total cost of care paid for by the plan, price of care, patterns of service utilization, and relevant demographic factors.

(c)(1) A catastrophic plan is a health care service plan contract that provides no benefits for any plan year until the enrollee has incurred cost-sharing expenses in an amount equal to the annual limit on out-of-pocket costs as specified in Section 1367.006 except that it shall provide coverage for at least three primary care visits. A carrier that is not participating in the Exchange shall not offer, market, or sell a catastrophic plan in the individual market.

(2) A catastrophic plan may be offered only in the individual market and only if consistent with this paragraph. Catastrophic plans may be offered only if either of the following apply:

(A) The individual purchasing the plan has not yet attained 30 years of age before the beginning of the plan year.

(B) The individual has a certificate of exemption from Section 5000(A) of the Internal Revenue Code because the individual is not offered affordable coverage or because the individual faces hardship.

(d) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

HISTORY:
Added Stats 2013 ch 316 § 6 (SB 639), effective January 1, 2014.

§ 1367.0085. Actuarial value for nongrandfathered bronze level high deductible health plan

Notwithstanding paragraph (1) of subdivision (b) of Section 1367.008 and paragraph (1) of subdivision (b) of Section 1367.009, the actuarial value for a nongrandfathered bronze level high deductible health plan, as defined in Section 223(c)(2) of Title 26 of the United States Code, may range from plus 4 percent to minus 2 percent.

HISTORY:
Added Stats 2019 ch 38 § 16 (SB 78), effective June 27, 2019.

§ 1367.009. Levels of coverage for nongrandfathered small group market; Determination of actuarial value for nongrandfathered small employer health care service plans

(a) Levels of coverage for the nongrandfathered small group market are defined as follows:

(1) Bronze level: A health care service plan contract in the bronze level shall provide a level of coverage that is actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan contract.

(2) Silver level: A health care service plan contract in the silver level shall provide a level of coverage that is actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan contract.

(3) Gold level: A health care service plan contract in the gold level shall provide a level of coverage that is actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan contract.

(4) Platinum level: A health care service plan contract in the platinum level shall provide a level of coverage that is actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan contract.

(b) Actuarial value for nongrandfathered small employer health care service plan contracts shall be determined in accordance with the following:

(1) Actuarial value shall not vary by more than plus or minus 2 percent.

(2) Actuarial value shall be determined on the basis of essential health benefits as defined in Section 1367.005 and as provided to a standard, nonelderly population. For this purpose, a standard population shall not

include those receiving coverage through the Medi-Cal or Medicare programs.

(3) The department may use the actuarial value methodology developed consistent with Section 1302(d) of PPACA.

(4) The actuarial value for pediatric dental benefits, whether offered by a full service plan or a specialized plan, shall be consistent with federal law and guidance applicable to the plan type.

(5) The department, in consultation with the Department of Insurance and the Exchange, shall consider whether to exercise state-level flexibility with respect to the actuarial value calculator in order to take into account the unique characteristics of the California health care coverage market, including the prevalence of health care service plans, total cost of care paid for by the plan, price of care, patterns of service utilization, and relevant demographic factors.

(6) Employer contributions toward health reimbursement accounts and health savings accounts shall count toward the actuarial value of the product in the manner specified in federal rules and guidance.

(c) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

HISTORY:
Added Stats 2013 ch 316 § 7 (SB 639), effective January 1, 2014.

§ 1367.01. Written policies and procedures for review and approval, modification, delay or denial of services; Medical director to ensure compliance; Compliance review

(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to

providers and enrollees upon request, and by the plan to the public upon request.

(c) A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the time period for review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this

determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours or, if shorter, the period of time required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional

responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

(k) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan

undertaken pursuant to Section 1380, and shall include a discussion of compliance with this section as part of its report issued pursuant to that section.

(*l*) This section shall not apply to decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion as set forth in subdivision (a) of Section 1270.

(m) Nothing in this section shall cause a health care service plan to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

HISTORY:
Added Stats 1999 ch 539 § 4 (SB 59). Amended Stats 2000 ch 1067 § 8 (SB 2094); Stats 2004 ch 491 § 3 (SB 1347); Stats 2007 ch 196 § 3 (SB 192), effective January 1, 2008; Stats 2008 ch 607 § 3 (SB 1379), effective September 30, 2008; Stats 2010 ch 658 § 5 (AB 2470), effective January 1, 2011.

§ 1367.010. Minimum value of sixty percent for large group health care service plan contract

(a)(1) A nongrandfathered health care service plan, except a health care service plan offering a specialized health care service plan contract, that offers, amends, or renews a large group health care service plan contract shall not market, offer, amend, or renew a large group plan contract that provides a minimum value of less than 60 percent.

(2) This section shall not apply to limited wraparound coverage, consistent with Section 146.145(b) of Title 45 of the Code of Federal Regulations.

(b) For purposes of this section, a plan shall provide a minimum value of at least 60 percent, as described in Section 36B(c)(2)(C) of the federal Internal Revenue Code and any regulation or guidance adopted under that section.

(c) The following definitions apply for purposes of this section:

(1) "Large group health care service plan contract" means a group health care service plan contract other than a contract issued to a "small employer," as defined in Section 1357, 1357.500, or 1357.600.

(2) "Plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations.

HISTORY:
Added Stats 2015 ch 617 § 2 (AB 248), effective January 1, 2016.

§ 1367.012. Renewal of small employer health care service plan contract; Notice; Exemptions; Amendments for compliance

(a)(1) A small employer health care service plan contract in effect on December 31, 2013, and still in effect as of the effective date of this section, that does not qualify as a grandfathered health plan under Section 1251 of PPACA may be renewed until January 1, 2015, and may continue to be in force until December 31, 2015, subject to applicable federal law, and any other requirements imposed by this chapter.

(2) A small employer health care service plan contract described in paragraph (1) may continue to be in force after December 31, 2015, if the

contract is amended to comply with all of the provisions listed in subdivision (e) by January 1, 2016, and complies with all other applicable provisions of law.

(b)(1) If a health care service plan offers for renewal a small employer health care service plan contract pursuant to paragraph (1) of subdivision (a), the health care service plan shall provide notice to the group contractholder regarding the option to renew coverage pursuant to subdivision (a) using the relevant notice attached to the guidance entitled "Insurance Standards Bulletin Series - Extension of Transition Policy through October 1, 2016," issued by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services on March 5, 2014.

(2) A health care service plan shall include the following notice with the notice issued pursuant to paragraph (1):

"New health care coverage options are available in California. You currently have health care coverage that is not required to comply with many new laws. A new health care service plan contract may be more affordable and/or offer more comprehensive benefits. New plans may also have limits on deductibles and out-of-pocket costs, while your existing plan may have no such limits.

You have the option to remain with your current coverage for one more year or switch to new coverage that complies with the new laws. Covered California, the state's new health insurance marketplace, offers small employers health insurance from a number of companies through its Small Business Health Options Program (SHOP). Federal tax credits are available through the SHOP to those small employers that qualify. Talk to Covered California (1-877-453-9198), your plan representative, or your insurance agent to discuss your options."

(3) A health care service plan shall include with the notices issued pursuant to paragraphs (1) and (2), the premium, cost sharing, and benefits associated with the plan's standard benefit designs approved consistent with subdivision (c) of Section 100504 of the Government Code for the geographic region of the small employer.

(4) A health care service plan that offers for renewal a small employer health care service plan contract pursuant to paragraph (1) of subdivision (a) shall offer renewal to all employers whose health care service plan contract with that health care service plan was in effect on December 31, 2013.

(c)(1) A small employer health care service plan contract in effect on December 31, 2013, and still in effect as of the effective date of this section, that does not qualify as a grandfathered health plan under Section 1251 of PPACA that is renewed on or before January 1, 2015, and that continues to be in force until no later than December 31, 2015, is exempt from the following provisions:

(A) Paragraphs (1) and (2) of subdivision (a) of, and subdivisions (e) and (i) of, Section 1357.503.

(B) Section 1357.512.

(C) Sections 1367.005 and 1357.508.

(D) Section 1367.0065.

(E) Section 1367.006.

(F) Section 1367.007.

(G) Section 1367.009.

(2) Notwithstanding paragraphs (1) and (2) of subdivision (a) of, and subdivision (e) of, Section 1357.503, a small employer health care service plan contract subject to this section shall only be offered, marketed, and sold to an employer whose health care service plan contract with that health care service plan was in effect on December 31, 2013.

(d) A small employer health care service plan contract described in paragraph (1) of subdivision (a) shall be subject to Sections 1357.12 and 1357.13, and shall continue to be subject to Article 3.16 (commencing with Section 1357.500), except as provided in subdivision (c), and to all otherwise applicable provisions of this chapter.

(e) No later than January 1, 2016, a small employer health care service plan contract described in paragraph (1) of subdivision (a) may be amended to comply with all of the following:

(1) Paragraphs (1) and (2) of subdivision (a) of, and subdivisions (e) and (i) of, Section 1357.503.

(2) Section 1357.512.

(3) Sections 1357.508 and 1367.005.

(4) Section 1367.006.

(5) Section 1367.007.

(6) Section 1367.009.

(f) This section shall be implemented only to the extent permitted by PPACA.

(g) For purposes of this section, the following definitions shall apply:

(1) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

(2) "Small employer health care service plan contract" means a group health care service plan contract, other than a specialized health care service plan contract, issued to a small employer, as defined in subdivision (s) of Section 1357.500.

HISTORY:
Added Stats 2014 ch 84 § 1 (SB 1446), effective July 7, 2014.

§ 1367.015. Decisions to deny requests by providers for authorization or claim reimbursement for mental health services

In addition to complying with subdivision (h) of Section 1367.01, in determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to Section 1367.01 shall not base decisions to deny requests by providers for authorization for mental health services or to deny claim reimbursement for mental health services on either of the following:

(a) Whether admission was voluntary or involuntary.

(b) The method of transportation to the health facility.

HISTORY:
Added Stats 2008 ch 722 § 1 (SB 1553), effective January 1, 2009.

§ 1367.016. Premium payments from third-party entities; Reimbursement; Dispute resolution [Effective January 1, 2020]

(a) A health care service plan shall accept premium payments from the following third-party entities without the need to comply with subdivision (c):

(1) A Ryan White HIV/AIDS Program under Title XXVI of the federal Public Health Service Act.

(2) An Indian tribe, tribal organization, or urban Indian organization.

(3) A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf.

(4) A member of the individual's family, defined for purposes of this section to include the individual's spouse, domestic partner, child, parent, grandparent, and siblings, unless the true source of funds used to make the premium payment originates with a financially interested entity.

(b) A financially interested entity that is not specified in subdivision (a) and is making third-party premium payments shall comply with all of the following requirements:

(1) It shall provide assistance for the full plan year and notify the enrollee prior to an open enrollment period, if applicable, if financial assistance will be discontinued. Notification shall include information regarding alternative coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans, if applicable. Assistance may be discontinued at the request of an enrollee who obtains other health coverage, or if the enrollee dies during the plan year.

(2) It shall agree not to condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device.

(3) It shall inform an applicant of financial assistance, and shall inform a recipient annually, of all available health coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans, if applicable.

(4) It shall agree not to steer, direct, or advise the patient into or away from a specific coverage program option or health care service plan contract.

(5) It shall agree that financial assistance shall not be conditioned on the use of a specific facility, health care provider, or coverage type.

(6) It shall agree that financial assistance shall be based on financial need in accordance with criteria that are uniformly applied and publicly available.

(c) A financially interested entity shall not make a third-party premium payment unless the entity complies with both of the following requirements:

(1) Annually provides a statement to the health care service plan that it meets the requirements set forth in subdivision (b), as applicable.

(2) Discloses to the health care service plan, prior to making the initial payment, the name of the enrollee for each health care service plan contract on whose behalf a third-party premium payment described in this section will be made.

(d)(1) Reimbursement for enrollees for whom a nonprofit financially interested entity described in paragraph (2) of subdivision (h) that was already

making premium payments to a health care service plan on the enrollee's behalf prior to October 1, 2019, is not subject to subdivisions (e) and (f) and the financially interested entity is not required to comply with the disclosure requirements described in subdivision (c) for those enrollees.

(2) Notwithstanding paragraph (1), a financially interested entity shall comply with the disclosure requirements of subdivision (c) for an enrollee on whose behalf the financially interested entity was making premium payments to a health care service plan on the enrollee's behalf prior to October 1, 2019, if the enrollee changes health care service plans on or after March 1, 2020.

(3) The amount of reimbursement for services paid to a financially interested provider shall be governed by the terms of the enrollee's health care service plan contract, except for an enrollee who has changed health care service plans pursuant to paragraph (2), in which case, commencing January 1, 2022, the reimbursement amount shall be determined in accordance with subdivisions (e) and (f).

(e) Commencing January 1, 2022, if a financially interested entity makes a third-party premium payment to a health care service plan on behalf of an enrollee, reimbursement to a provider who is also a financially interested entity for covered services provided shall be determined by the following:

(1) For a contracted financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the enrollee shall be the higher of the Medicare reimbursement or the rate determined pursuant to the process described in this subdivision, if a rate determination pursuant to that process is sought by either the provider or the health care service plan. Financially interested providers shall neither bill the enrollee nor seek reimbursement from the enrollee for services provided, except for cost sharing pursuant to the terms and conditions of the enrollee's health care service plan contract. If an enrollee's contract imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health care service plan pursuant to this paragraph.

(2) For a noncontracting financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the enrollee shall be governed by the terms and conditions of the enrollee's health care service plan contract or the rate determined pursuant to the process described in this subdivision, whichever is lower, if a rate determination pursuant to that process is sought by either the provider or the health care service plan. Financially interested providers shall neither bill the enrollee nor seek reimbursement from the enrollee for services provided, except for cost sharing pursuant to the terms and conditions of the enrollee's health care service plan contract. If an enrollee's contract imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health care service plan pursuant to this paragraph. A claim submitted to a health care

service plan by a noncontracting financially interested provider may be considered an incomplete claim and contested by the health care service plan pursuant to Section 1371 or 1371.35 if the financially interested provider has not provided the information as required in subdivision (c).

(f)(1) By October 1, 2021, the department shall establish an independent dispute resolution process for the purpose of determining if the amount required to be reimbursed by subdivision (e) is appropriate.

(2) If either the provider or health care service plan submits a claim to the department's independent dispute resolution process, the other party shall participate in the independent dispute resolution process.

(3) In making its determination, the independent organization shall consider information submitted by either party regarding the actual cost to provide services, patient eligibility for Medicare or Medi-Cal, and the rate that would be paid by Medicare or Medi-Cal for patients eligible for those programs.

(4) The health care service plan shall implement the determination obtained through the independent dispute resolution process. The independent organization's determination of the amount required to be reimbursed shall apply for the duration of the plan year for that enrollee. If dissatisfied, either party may pursue any right, remedy, or penalty established under any other applicable law.

(5) In establishing the independent dispute resolution process, the department shall permit the bundling of claims submitted to the same plan or the same delegated entity for the same or similar services. The department shall permit claims on behalf of multiple enrollees from the same provider to the same health care service plan to be combined into a single independent dispute resolution process.

(6) The department shall establish uniform written procedures for the submission, receipt, processing, and resolution of claim payment disputes pursuant to this section and any other guidelines for implementing this section.

(7) The department shall establish reasonable and necessary fees not to exceed the reasonable costs of administering this subdivision.

(8) The department may contract with one or more independent organizations to conduct the proceedings. The independent organization handling a dispute shall be independent of either party to the dispute.

(9) The department shall use conflict-of-interest standards consistent with the standards pursuant to subdivisions (c) and (d) of Section 1374.32.

(10) The department may contract with the same independent organization or organizations as the Department of Insurance.

(11) The independent organization retained to conduct proceedings shall be deemed to be consultants for purposes of Section 43.98 of the Civil Code.

(12) Contracts entered into pursuant to the authority in this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(13) This subdivision does not alter a health care service plan's obligations under Section 1371.

(14) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-plan letters or similar instructions, without taking regulatory action, until regulations are adopted.

(g) For the purposes of this section, third-party premium payments only include health care service plan premium payments made directly by a provider or other third party, made indirectly through payments to the individual for the purpose of making health care service plan premium payments, or provided to one or more intermediaries with the intention that the funds be used to make health care service plan premium payments for the individuals.

(h) The following definitions apply for purposes of this section:

(1) "Enrollee" means an individual whose health care service plan premiums are paid by a financially interested entity.

(2) "Financially interested" includes any of the following entities:

(A) A provider of health care services that receives a direct or indirect financial benefit from a third-party premium payment.

(B) An entity that receives the majority of its funding from one or more financially interested providers of health care services, parent companies of providers of health care services, subsidiaries of health care service providers, or related entities.

(C) A chronic dialysis clinic that is operated, owned, or controlled by a parent entity or related entity that meets the definition of a large dialysis clinic organization (LDO) under the federal Centers for Medicare and Medicaid Services Comprehensive ESRD Care Model as of January 1, 2019. A chronic dialysis clinic that does not meet the definition of an LDO or has no more than 10 percent of California's market share of licensed chronic dialysis clinics shall not be considered financially interested for purposes of this section.

(3) "Health care service plan contract" means an individual or group health care service plan contract that provides medical, hospital, and surgical benefits, except a specialized health care service plan contract. The term does not include coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, long-term care insurance, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation law or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(4) "Provider" means a professional person, organization, health facility, or other person or institution that delivers or furnishes health care services.

(i) The following shall occur if a health care service plan subsequently discovers that a financially interested entity fails to provide disclosure pursuant to subdivision (c):

(1) The health care service plan shall be entitled to recover 120 percent of the difference between a payment made to a provider and the payment to which the provider would have been entitled pursuant to subdivision (e), including interest on that difference.

(2) The health care service plan shall notify the department of the amount by which the provider was overpaid and shall remit to the department any amount exceeding the difference between the payment made to the provider and the payment to which the provider would have been entitled pursuant to subdivision (e), including interest on that difference that was recovered pursuant to paragraph (1).

(j) Commencing January 1, 2022, each health care service plan licensed by the department and subject to this section shall provide to the department information regarding premium payments by financially interested entities and reimbursement for services to providers under subdivision (e). The information shall be provided at least annually at the discretion of the department and shall include, to the best of the health care service plan's knowledge, the number of enrollees whose premiums were paid by financially interested entities, disclosures provided to the plan pursuant to subdivision (c), the identities of any providers whose reimbursement rate was governed by subdivision (e), the identities of any providers who failed to provide disclosure as described in subdivision (c), and, at the discretion of the department, additional information necessary for the implementation of this section.

(k) This section does not limit the authority of the Attorney General to take action to enforce this section.

(*l*) This section does not affect a contracted payment rate for a provider who is not financially interested.

(m) This section does not alter any of a health care service plan's obligations and requirements under this chapter, including, but not limited to, the following:

(1) The obligation of a health care service plan to fairly and affirmatively offer, market, sell, and issue a health benefit plan to any individual, consistent with Article 11.8 (commencing with Section 1399.845), or small employer, consistent with Article 3.1 (commencing with Section 1357).

(2) The obligations of a health care service plan with respect to cancellation or nonrenewal as provided in this chapter, including, but not limited to, Section 1365.

(3) A health care service plan may not deny coverage to an enrollee whose premiums are paid by a third party.

(n) This section does not supersede or modify any privacy and information security requirements and protections in federal and state law regarding protected health information or personally identifiable information, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg).

(o) Notwithstanding clause (iii) of subparagraph (A) of paragraph (1) of subdivision (d) of Section 1399.849, an enrollee's loss of coverage due to a financially interested entity's failure to pay premiums on a timely basis shall be deemed a triggering event for special enrollment pursuant to subparagraph (A) of paragraph (1) of subdivision (d) of Section 1399.849.

HISTORY:

Added Stats 2019 ch 862 § 3 (AB 290), effective January 1, 2020.

§ 1367.02. Filing relating to any economic profiling policies or procedures; Availability to public; "Economic profiling"

(a) On or before July 1, 1999, for purposes of public disclosure, every health care service plan shall file with the department a description of any policies and procedures related to economic profiling utilized by the plan and its medical groups and individual practice associations. The filing shall describe how these policies and procedures are used in utilization review, peer review, incentive and penalty programs, and in provider retention and termination decisions. The filing shall also indicate in what manner, if any, the economic profiling system being used takes into consideration risk adjustments that reflect case mix, type and severity of patient illness, age of patients, and other enrollee characteristics that may account for higher or lower than expected costs or utilization of services. The filing shall also indicate how the economic profiling activities avoid being in conflict with subdivision (g) of Section 1367, which requires each plan to demonstrate that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. Any changes to the policies and procedures shall be filed with the director pursuant to Section 1352. Nothing in this section shall be construed to restrict or impair the department, in its discretion, from utilizing the information filed pursuant to this section for purposes of ensuring compliance with this chapter.

(b) The director shall make each plan's filing available to the public upon request. The director shall not publicly disclose any information submitted pursuant to this section that is determined by the director to be confidential pursuant to state law.

(c) Each plan that uses economic profiling shall, upon request, provide a copy of economic profiling information related to an individual provider, contracting medical group, or individual practice association to the profiled individual, group, or association. In addition, each plan shall require as a condition of contract that its medical groups and individual practice associations that maintain economic profiles of individual providers shall, upon request, provide a copy of individual economic profiling information to the individual providers who are profiled. The economic profiling information provided pursuant to this section shall be provided upon request until 60 days after the date upon which the contract between the plan and the individual provider, medical group, or individual practice association terminates, or until 60 days after the date the contract between the medical group or individual practice association and the individual provider terminates, whichever is applicable.

(d) For the purposes of this article, "economic profiling" shall mean any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.

HISTORY:
Added Stats 1998 ch 893 § 1 (SB 984).
Amended Stats 1999 ch 525 § 95 (AB 78), operative July 1, 2000.

§ 1367.03. Development of standards for timely access to health care services

(a) Not later than January 1, 2004, the department shall develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner. In developing these regulations, the department shall develop indicators of timeliness of access to care and, in so doing, shall consider the following as indicators of timeliness of access to care:

(1) Waiting times for appointments with physicians, including primary care and specialty physicians.

(2) Timeliness of care in an episode of illness, including the timeliness of referrals and obtaining other services, if needed.

(3) Waiting time to speak to a physician, registered nurse, or other qualified health professional acting within his or her scope of practice who is trained to screen or triage an enrollee who may need care.

(b) In developing these standards for timeliness of access, the department shall consider the following:

(1) Clinical appropriateness.

(2) The nature of the specialty.

(3) The urgency of care.

(4) The requirements of other provisions of law, including Section 1367.01 governing utilization review, that may affect timeliness of access.

(c) The department may adopt standards other than the time elapsed between the time an enrollee seeks health care and obtains care. If the department chooses a standard other than the time elapsed between the time an enrollee first seeks health care and obtains it, the department shall demonstrate why that standard is more appropriate. In developing these standards, the department shall consider the nature of the plan network.

(d) The department shall review and adopt standards, as needed, concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care, so that consumers have timely access to care. In so doing, the department shall consider the nature of physician practices, including individual and group practices as well as the nature of the plan network. The department shall also consider various circumstances affecting the delivery of care, including urgent care, care provided on the same day, and requests for specific providers. If the department finds that health care service plans and health care providers have difficulty meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature pursuant to subdivision (i).

(e) In developing standards under subdivision (a), the department shall consider requirements under federal law, requirements under other state programs, standards adopted by other states, nationally recognized accrediting organizations, and professional associations. The department shall further consider the needs of rural areas, specifically those in which health facilities are more than 30 miles apart and any requirements imposed by the State Department of Health Care Services on health care service plans that contract with the State Department of Health Care Services to provide Medi-Cal managed care.

(f)(1) Contracts between health care service plans and health care providers shall ensure compliance with the standards developed under this section. These contracts shall require reporting by health care providers to health care service plans and by health care service plans to the department to ensure compliance with the standards.

(2) Health care service plans shall report annually to the department on compliance with the standards in a manner specified by the department. The reported information shall allow consumers to compare the performance of plans and their contracting providers in complying with the standards, as well as changes in the compliance of plans with these standards.

(3) The department may develop standardized methodologies for reporting that shall be used by health care service plans to demonstrate compliance with this section and any regulations adopted pursuant to it. The methodologies shall be sufficient to determine compliance with the standards developed under this section for different networks of providers if a health care service plan uses a different network for Medi-Cal managed care products than for other products or if a health care service plan uses a different network for individual market products than for small group market products. The development and adoption of these methodologies shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until January 1, 2020. The department shall consult with stakeholders in developing standardized methodologies under this paragraph.

(g)(1) When evaluating compliance with the standards, the department shall focus more upon patterns of noncompliance rather than isolated episodes of noncompliance.

(2) The director may investigate and take enforcement action against plans regarding noncompliance with the requirements of this section. Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director may, by order, assess administrative penalties subject to appropriate notice of, and the opportunity for, a hearing in accordance with Section 1397. The plan may provide to the director, and the director may consider, information regarding the plan's overall compliance with the requirements of this section. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(3) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:

(A) Repeated failure to act promptly and reasonably to assure timely access to care consistent with this chapter.

(B) Repeated failure to act promptly and reasonably to require contracting providers to assure timely access that the plan is required to perform

under this chapter and that have been delegated by the plan to the contracting provider when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(C) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

(4) The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(h) The department shall work with the patient advocate to assure that the quality of care report card incorporates information provided pursuant to subdivision (f) regarding the degree to which health care service plans and health care providers comply with the requirements for timely access to care.

(i) The department shall annually review information regarding compliance with the standards developed under this section and shall make recommendations for changes that further protect enrollees. Commencing no later than December 1, 2015, and annually thereafter, the department shall post its final findings from the review on its Internet Web site.

(j) The department shall post on its Internet Web site any waivers or alternative standards that the department approves under this section on or after January 1, 2015.

HISTORY:
Added Stats 2002 ch 797 § 4 (AB 2179). Amended Stats 2005 ch 77 § 28 (SB 64), effective January 1, 2006; Stats 2008 ch 607 § 4 (SB 1379), effective September 30, 2008; Stats 2014 ch 573 § 1 (SB 964), effective January 1, 2015.

§ 1367.031. Information regarding standards for timely access to health care services

(a) A health care service plan contract that is issued, renewed, or amended on or after July 1, 2017, shall provide information to an enrollee regarding the standards for timely access to care adopted pursuant to Section 1367.03 and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(b) A health care service plan at a minimum shall provide information regarding appointment wait times for urgent care, nonurgent primary care, nonurgent specialty care, and telephone screening established pursuant to Section 1367.03 to enrollees and contracting providers. The information shall also include notice of the availability of interpreter services at the time of the appointment pursuant to Section 1367.04. A health care service plan may indicate that exceptions to appointment wait times may apply if the department has found exceptions to be permissible.

(c) The information required to be provided pursuant to this section shall be provided to an enrollee with individual coverage upon initial enrollment and annually thereafter upon renewal, and to enrollees and subscribers with group coverage upon initial enrollment and annually thereafter upon renewal. A health care service plan may include this information with other materials sent to the enrollee. The information shall also be provided in the following manner:

(1) In a separate section of the evidence of coverage titled "Timely Access to Care."

(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the plan's enrollees.

(3) Commencing January 1, 2018, in a separate section of the provider directory published and maintained by the health care service plan pursuant to Section 1367.27. The separate section shall be titled "Timely Access to Care."

(4) On the Internet Web site published and maintained by the health care service plan, in a manner that allows enrollees and prospective enrollees to easily locate the information.

(d)(1) A health care service plan shall provide the information required by this section to contracting providers on no less than an annual basis.

(2) A health care service plan shall also inform a contracting provider of all of the following:

(A) Information about a health care service plan's obligation under California law to provide or arrange for timely access to care.

(B) How a contracting provider or enrollee can contact the health care service plan to obtain assistance if a patient is unable to obtain a timely referral to an appropriate provider.

(C) The toll-free telephone number for the Department of Managed Health Care where providers and enrollees can file a complaint if they are unable to obtain a timely referral to an appropriate provider.

(3) A health care service plan may comply with this subdivision by including the information with an existing communication with a contracting provider.

(e) This section shall apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

HISTORY:
Added Stats 2016 ch 500 § 1 (SB 1135), effective January 1, 2017.

§ 1367.035. Standards for timely access to health care services; Required inclusion of network adequacy data

(a) As part of the reports submitted to the department pursuant to subdivision (f) of Section 1367.03 and regulations adopted pursuant to that section, a health care service plan shall submit to the department, in a manner specified by the department, data regarding network adequacy, including, but not limited to, the following:

(1) Provider office location.

(2) Area of specialty.

(3) Hospitals where providers have admitting privileges, if any.

(4) Providers with open practices.

(5) The number of patients assigned to a primary care provider or, for providers who do not have assigned enrollees, information that demonstrates the capacity of primary care providers to be accessible and available to enrollees.

(6) Grievances regarding network adequacy and timely access that the health care service plan received during the preceding calendar year.

(b) A health care service plan that uses a network for its Medi-Cal managed care product line that is different from the network used for its other product lines shall submit the data required under subdivision (a) for its Medi-Cal managed care product line separately from the data submitted for its other product lines.

(c) A health care service plan that uses a network for its individual market product line that is different from the network used for its small group market product line shall submit the data required under subdivision (a) for its individual market product line separate from the data submitted for its small group market product line.

(d) The department shall review the data submitted pursuant to this section for compliance with this chapter.

(e) In submitting data under this section, a health care service plan that provides services to Medi-Cal beneficiaries pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code shall provide the same data to the State Department of Health Care Services pursuant to Section 14456.3 of the Welfare and Institutions Code.

(f) In developing the format and requirements for reports, data, or other information provided by plans pursuant to subdivision (a), the department shall not create duplicate reporting requirements, but, instead, shall take into consideration all existing relevant reports, data, or other information provided by plans to the department. This subdivision does not limit the authority of the department to request additional information from the plan as deemed necessary to carry out and complete any enforcement action initiated under this chapter.

(g) If the department requests additional information or data to be reported pursuant to subdivision (a), which is different or in addition to the information required to be reported in paragraphs (1) to (6), inclusive, of subdivision (a), the department shall provide health care service plans notice of that change by November 1 of the year prior to the change.

(h) A health care service plan may include in the provider contract provisions requiring compliance with the reporting requirements of Section 1367.03 and this section.

HISTORY:
Added Stats 2014 ch 573 § 2 (SB 964), effective January 1, 2015. Amended Stats 2015 ch 303 § 253 (AB 731), effective January 1, 2016.

§ 1367.04. Language assistance in obtaining health care services; Adoption of regulations and standards; Considerations; Reports; Public input; Contracts

(a) Not later than January 1, 2006, the department shall develop and adopt regulations establishing standards and requirements to provide health care service plan enrollees with appropriate access to language assistance in obtaining health care services.

(b) In developing the regulations, the department shall require every health care service plan and specialized health care service plan to assess the

linguistic needs of the enrollee population, excluding Medi-Cal enrollees, and to provide for translation and interpretation for medical services, as indicated. A health care service plan that participates in the Healthy Families Program may assess the Healthy Families Program enrollee population separately from the remainder of its enrollee population for purposes of subparagraph (A) of paragraph (1). A health care service plan that chooses to separate its Healthy Families Program enrollment from the remainder of its enrollee population shall treat the Healthy Families Program population separately for purposes of determining whether subparagraph (A) of paragraph (1) is applicable, and shall also treat the Healthy Families Program population separately for purposes of applying the percentage and numerical thresholds in subparagraph (A) of paragraph (1). The regulations shall include the following:

(1) Requirements for the translation of vital documents that include the following:

(A) A requirement that all vital documents, as defined pursuant to subparagraph (B), be translated into an indicated language, as follows:

(i) A health care service plan with an enrollment of 1,000,000 or more shall translate vital documents into the top two languages other than English as determined by the needs assessment as required by this subdivision and any additional languages when 0.75 percent or 15,000 of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.

(ii) A health care service plan with an enrollment of 300,000 or more but less than 1,000,000 shall translate vital documents into the top one language other than English as determined by the needs assessment as required by this subdivision and any additional languages when 1 percent or 6,000 of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.

(iii) A health care service plan with an enrollment of less than 300,000 shall translate vital documents into a language other than English when 3,000 or more or 5 percent of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.

(B) Specification of vital documents produced by the plan that are required to be translated. The specification of vital documents shall not exceed that of the United States Department of Health and Human Services (HHS) Office for Civil Rights (OCR) Policy Guidance (65 Federal Register 52762 (August 30, 2000)), but shall include all of the following:

(i) Applications.

(ii) Consent forms.

(iii) Letters containing important information regarding eligibility and participation criteria.

(iv) Notices pertaining to the denial, reduction, modification, or

termination of services and benefits, and the right to file a grievance or appeal.

(v) Notices advising limited-English-proficient persons of the availability of free language assistance and other outreach materials that are provided to enrollees.

(vi) Translated documents shall not include a health care service plan's explanation of benefits or similar claim processing information that is sent to enrollees, unless the document requires a response by the enrollee.

(C)(i) For those documents described in subparagraph (B) that are not standardized but contain enrollee specific information, health care service plans shall not be required to translate the documents into the threshold languages identified by the needs assessment as required by this subdivision, but rather shall include with the documents a written notice of the availability of interpretation services in the threshold languages identified by the needs assessment as required by this subdivision. A health care service plan subject to the requirements in Section 1367.042 shall also include with the documents a written notice of the availability of interpretation services in the top 15 languages spoken by limited-English-proficient (LEP) individuals in California as determined by the State Department of Health Care Services.

(ii) Upon request, the enrollee shall receive a written translation of the documents described in clause (i). The health care service plan shall have up to, but not to exceed, 21 days to comply with the enrollee's request for a written translation. If an enrollee requests a translated document, all timeframes and deadline requirements related to the document that apply to the health care service plan and enrollees under the provisions of this chapter and under any regulations adopted pursuant to this chapter shall begin to run upon the health care service plan's issuance of the translated document.

(iii) For grievances that require expedited plan review and response in accordance with subdivision (b) of Section 1368.01, the health care service plan may satisfy this requirement by providing notice of the availability and access to oral interpretation services.

(D) A requirement that health care service plans advise limited-English-proficient enrollees of the availability of interpreter services.

(2) Standards to ensure the quality and accuracy of the written translations and that a translated document meets the same standards required for the English language version of the document. The English language documents shall determine the rights and obligations of the parties, and the translated documents shall be admissible in evidence only if there is a dispute regarding a substantial difference in the material terms and conditions of the English language document and the translated document.

(3) Requirements for surveying the language preferences and needs assessments of health care service plan enrollees within one year of the effective date of the regulations that permit health care service plans to utilize various survey methods, including, but not limited to, the use of existing enrollment and renewal processes, subscriber newsletters, or other mailings. Health care service plans shall update the needs assessment,

demographic profile, and language translation requirements every three years.

(4) Requirements for individual enrollee access to interpretation services that include the following:

(A) A requirement that an interpreter meets, at a minimum, all of the following qualifications:

(i) Demonstrated proficiency in both English and the target language.

(ii) Knowledge in both English and the target language of health care terminology and concepts relevant to health care delivery systems.

(iii) Adheres to generally accepted interpreter ethics principles, including client confidentiality.

(B) A requirement that the enrollee with limited English proficiency shall not be required to provide his or her own interpreter or rely on a staff member who does not meet the qualifications described in subparagraph (A) to communicate directly with the limited-English-proficient enrollee.

(C) A requirement that the enrollee with limited English proficiency shall not be required to rely on an adult or minor child accompanying the enrollee to interpret or facilitate communication except under either of the following circumstances:

(i) In an emergency, as described in Section 1317.1, if a qualified interpreter is not immediately available for the enrollee with limited English proficiency.

(ii) If the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.

(5) Standards to ensure the quality and timeliness of oral interpretation services provided by health care service plans.

(c) In developing the regulations, standards, and requirements, the department shall consider the following:

(1) Publications and standards issued by federal agencies, such as the Culturally and Linguistically Appropriate Services (CLAS) in Health Care issued by the United States Department of Health and Human Services Office of Minority Health in December 2000, and the United States Department of Health and Human Services (HHS) Office for Civil Rights (OCR) Policy Guidance (65 Federal Register 52762 (August 30, 2000)).

(2) Other cultural and linguistic requirements under state programs, such as Medi-Cal Managed Care Policy Letters, cultural and linguistic requirements imposed by the State Department of Health Care Services on health care service plans that contract to provide Medi-Cal managed care services, and cultural and linguistic requirements imposed by the Managed Risk Medical Insurance Board on health care service plans that contract to provide services in the Healthy Families Program.

(3) Standards adopted by other states pertaining to language assistance requirements for health care service plans.

(4) Standards established by California or nationally recognized accrediting, certifying, or licensing organizations and medical and health care interpreter professional associations regarding interpretation services.

(5) Publications, guidelines, reports, and recommendations issued by state agencies or advisory committees, such as the report card to the public on the comparative performance of plans and reports on cultural and linguistic services issued by the Office of Patient Advocate and the report to the Legislature from the Task Force on Culturally and Linguistically Competent Physicians and Dentists established by former Section 852 of the Business and Professions Code.

(6) Examples of best practices relating to language assistance services by health care providers and health care service plans, including existing practices.

(7) Information gathered from complaints to the HMO Helpline and consumer assistance centers regarding language assistance services.

(8) The cost of compliance and the availability of translation and interpretation services and professionals.

(9) Flexibility to accommodate variations in plan networks and method of service delivery. The department shall allow for health care service plan flexibility in determining compliance with the standards for oral and written interpretation services.

(d) The department shall work to ensure that the biennial reports required by this section, and the data collected for those reports, are consistent with reports required by government-sponsored programs and do not require duplicative or conflicting data collection or reporting.

(e) The department shall seek public input from a wide range of interested parties through advisory bodies established by the director.

(f) A contract between a health care service plan and a health care provider shall require compliance with the standards developed under this section. In furtherance of this section, the contract shall require providers to cooperate with the plan by providing any information necessary to assess compliance.

(g) The department shall report biennially to the Legislature and advisory bodies established by the director regarding plan compliance with the standards, including results of compliance audits made in conjunction with other audits and reviews. The reported information shall also be included in the publication required under subparagraph (B) of paragraph (1) of subdivision (b) of Section 136000. The department shall also utilize the reported information to make recommendations for changes that further enhance standards pursuant to this section. The department may also delay or otherwise phase-in implementation of standards and requirements in recognition of costs and availability of translation and interpretation services and professionals.

(h)(1) Except for contracts with the State Department of Health Care Services Medi-Cal program, the standards developed under this section shall be considered the minimum required for compliance.

(2) The regulations shall provide that a health plan is in compliance if the plan is required to meet the same or similar standards by the Medi-Cal program, either by contract or state law, if the standards provide as much access to cultural and linguistic services as the standards established by this section for an equal or higher number of enrollees and therefore meet or exceed the standards of the regulations established pursuant to this section, and the department determines that the health care service plan is in compliance with the standards required by the Medi-Cal program. To meet

this requirement, the department shall not be required to perform individual audits. The department shall, to the extent feasible, rely on audits, reports, or other oversight and enforcement methods used by the State Department of Health Care Services.

(3) The determination pursuant to paragraph (2) shall only apply to the enrollees covered by the Medi-Cal program standards. A health care service plan subject to paragraph (2) shall comply with the standards established by this section with regard to enrollees not covered by the Medi-Cal program.

(i) This section does not prohibit a government purchaser from including in their contracts additional translation or interpretation requirements, to meet linguistic or cultural needs, beyond those set forth pursuant to this section.

HISTORY:
Added Stats 2003 ch 713 § 2 (SB 853). Amended Stats 2004 ch 183 § 188 (AB 3082); Stats 2005 ch 77 § 29 (SB 64), effective January 1, 2006; Stats 2017 ch 771 § 1 (SB 223), effective January 1, 2018; Stats 2018 ch 92 § 131 (SB 1289), effective January 1, 2019.

§ 1367.041. Required non-English insurance documents

(a) A health care service plan that advertises or markets products in the individual or small group health care service plan markets, or allows any other person or business to market or advertise on its behalf in the individual or small group health care service plan markets, in a non-English language that does not meet the requirements set forth in Sections 1367.04 and 1367.07, shall provide the following documents in the same non-English language:

(1) Welcome letters or notices of initial coverage, if provided.

(2) Applications for enrollment and any information pertinent to eligibility or participation.

(3) Notices advising limited-English-proficient persons of the availability of no-cost translation and interpretation services.

(4) Notices pertaining to the right and instructions on how an enrollee may file a grievance.

(5) The uniform summary of benefits and coverage required pursuant to subparagraph (A) of paragraph (3) of subdivision (b) of Section 1363.

(b) A health care service plan shall use a trained and qualified translator for all written translations of marketing and advertising materials relating to health care service plan products, and for all of the documents specified in subdivision (a).

(c) This section shall not apply to a specialized health care service plan that does not offer an essential health benefit as defined in Section 1367.005.

HISTORY:
Added Stats 2013 ch 447 § 1 (SB 353), effective January 1, 2014.

§ 1367.042. Information made available by health care service plan

(a) A health care service plan shall notify enrollees and members of the public of all of the following information:

(1) The availability of language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner pursuant to Section 1367.04, and how to access these services. This

information shall be available in the top 15 languages spoken by limited-English-proficient individuals in California as determined by the State Department of Health Care Services.

(2) The availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

(3) The health plan does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

(4) The availability of the grievance procedure described in Section 1368, how to file a grievance, including the name of the plan representative and the telephone number, address, and email address of the plan representative who may be contacted about the grievance, and how to submit the grievance to the department for review after completing the grievance process or participating in the process for at least 30 days.

(5) How to file a discrimination complaint with the United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

(b) The information required to be provided pursuant to this section shall be provided to an enrollee with individual coverage upon initial enrollment and annually thereafter upon renewal, and to enrollees and subscribers with group coverage upon initial enrollment and annually thereafter upon renewal. A health care service plan may include this information with other materials sent to the enrollee. The information shall also be provided in the following manner:

(1) In a conspicuously visible location in the evidence of coverage.

(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the plan's enrollees.

(3) On the Internet Web site published and maintained by the health care service plan, in a manner that allows enrollees, prospective enrollees, and members of the public to easily locate the information.

(c)(1) A specialized health care plan that is not a covered entity, as defined in Section 92.4 of Title 45 of the Code of Federal Regulations, subject to Section 1557 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18116) may request an exemption from the requirements under this section.

(2) The department shall not grant an exemption under this subdivision to a specialized health care service plan that arranges for mental health benefits, except for employee assistance program plans.

(3) The department shall provide information on its Internet Web site about any exemptions granted under this subdivision.

(d) This section does not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

HISTORY:
Added Stats 2017 ch 771 § 2 (SB 223), effective January 1, 2018. Amended Stats 2018 ch 92 § 132 (SB 1289), effective January 1, 2019.

§ 1367.05. Contract with dental college

(a) Nothing in this chapter shall prohibit a health care service plan from entering into a contract with a dental college approved by the Board of Dental Examiners of California under which the dental college provides for or arranges for the provision of dental care to enrollees of the plan through the practice of dentistry by either of the following:

(1) Bona fide students of dentistry or dental hygiene operating under subdivision (b) of Section 1626 of the Business and Professions Code.

(2) Bona fide clinicians or instructors operating under subdivision (c) of Section 1626 of the Business and Professions Code.

(b) A plan that contracts with a dental college for the delivery of dental care pursuant to subdivision (a) shall disclose to enrollees in the disclosure form and the evidence of coverage, or the combined evidence of coverage and disclosure form, and, if the plan provides a listing of providers to the enrollees, in the listing of providers, that the dental care provided by the dental college will be provided by students of dentistry or dental hygiene and clinicians or instructors of the dental college.

HISTORY:
Added Stats 1996 ch 492 § 7 (SB 511).

§ 1367.06. Service plan to cover outpatient prescription drug benefits to provide coverage for inhaler spacers, nebulizers, and peak flow meters when medically necessary for treatment of pediatric asthma

(a) A health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2005, that covers outpatient prescription drug benefits shall include coverage for inhaler spacers when medically necessary for the management and treatment of pediatric asthma.

(b) If a subscriber has coverage for outpatient prescription drugs, a health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2005, shall include coverage for the following equipment and supplies when medically necessary for the management and treatment of pediatric asthma:

(1) Nebulizers, including face masks and tubing.

(2) Peak flow meters.

(c) The quantity of the equipment and supplies required to be covered pursuant to subdivisions (a) and (b) may be limited by the health care service plan if the limitations do not inhibit appropriate compliance with treatment as prescribed by the enrollee's physician and surgeon. A health care service plan shall provide for an expeditious process for approving additional or replacement inhaler spacers, nebulizers, and peak flow meters when medically necessary for an enrollee to maintain compliance with his or her treatment regimen. The process required by Section 1367.24 may be used to satisfy the requirements of this section for an inhaler spacer.

(d) Education for pediatric asthma, including education to enable an en-

rollee to properly use the device identified in subdivisions (a) and (b), shall be consistent with current professional medical practice.

(e) The coverage required by this section shall be provided under the same general terms and conditions, including copayments and deductibles, applicable to all other benefits provided by the plan.

(f) A health care service plan shall disclose the benefits under this section in its evidence of coverage and disclosure forms.

(g) A health care service plan may not reduce or eliminate coverage as a result of the requirements of this section.

(h) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter, if a plan provides coverage for prescription drugs.

HISTORY:
Added Stats 2004 ch 711 § 1 (AB 2185).

§ 1367.07. Report by health care service plan on cultural appropriateness in specified contexts

Within one year after a health care service plan's assessment pursuant to subdivision (b) of Section 1367.04, the health care service plan shall report to the department, in a format specified by the department, regarding internal policies and procedures related to cultural appropriateness in each of the following contexts:

(a) Collection of data regarding the enrollee population pursuant to the health care service plan's assessment conducted in accordance with subdivision (b) of Section 1367.04.

(b) Education of health care service plan staff who have routine contact with enrollees regarding the diverse needs of the enrollee population.

(c) Recruitment and retention efforts that encourage workforce diversity.

(d) Evaluation of the health care service plan's programs and services with respect to the plan's enrollee population, using processes such as an analysis of complaints and satisfaction survey results.

(e) The periodic provision of information regarding the ethnic diversity of the plan's enrollee population and any related strategies to plan providers. Plans may use existing means of communication.

(f) The periodic provision of educational information to plan enrollees on the plan's services and programs. Plans may use existing means of communication.

HISTORY:
Added Stats 2003 ch 713 § 3 (SB 853). Amended Stats 2007 ch 577 § 12 (AB 1750), effective October 13, 2007; Stats 2008 ch 179 § 139 (SB 1498), effective January 1, 2009.

§ 1367.08. Compensation disclosure

A health care service plan shall annually disclose to the governing board of a public agency that is the subscriber of a group contract, the name and address of, and amount paid to, any agent, broker, or individual to whom the plan paid fees or commissions related to the public agency's group contract. As part of this disclosure, the health care service plan shall include the name, address, and amounts paid to the specific agents, brokers, or individuals

involved in transactions with the public agency. The compensation disclosure required by this section is in addition to any other compensation disclosure requirements that exist under law.

HISTORY:
Added Stats 2008 ch 331 § 1 (AB 2589), effective January 1, 2009.

§ 1367.09. Return to skilled nursing

(a) An enrollee with coverage for Medicare benefits who is discharged from an acute care hospital shall be allowed to return to a skilled nursing facility in which the enrollee resided prior to hospitalization, or the skilled nursing unit of a continuing care retirement community or multilevel facility in which the enrollee is a resident for continuing treatment related to the acute care hospital stay, if all of the following conditions are met:

(1) The enrollee is a resident of a continuing care retirement community, as defined in paragraph (10) of subdivision (a) of Section 1771, or is a resident of a multilevel facility, as defined in paragraph (9) of subdivision (d) of Section 15432 of the Government Code, or has resided for at least 60 days in a skilled nursing facility, as defined in Section 1250, that serves the needs of special populations, including religious and cultural groups.

(2) The primary care physician, and the treating physician if appropriate, in consultation with the patient, determines that the medical care needs of the enrollee, including continuity of care, can be met in the skilled nursing facility, or the skilled nursing unit of the continuing care retirement community, or multilevel facility. If a determination not to return the patient to the facility is made, the physician shall document reasons in the patient's medical record and share that written explanation with the patient.

(3) The skilled nursing facility, continuing care retirement facility, or multilevel facility is within the service area and agrees to abide by the plan's standards and terms and conditions related to the following:

(A) Utilization review, quality assurance, peer review, and access to health care services.

(B) Management and administrative procedures, including data and financial reporting that may be required by the plan.

(C) Licensing and certification as required by Section 1367.

(D) Appropriate certification of the facility by the Health Care Financing Administration or other federal and state agencies.

(4)(A) The skilled nursing facility, multilevel facility, or continuing care retirement community agrees to accept reimbursement from the health care service plan for covered services at either of the following rates:

(i) The rate applicable to similar skilled nursing coverage for facilities participating in the plan.

(ii) Upon mutual agreement, at a rate negotiated in good faith by the health care service plan or designated agent on an individual, per enrollee, contractual basis.

(B) Reimbursement shall not necessarily be based on actual costs and may be comparable to similar skilled nursing facility reimbursement methods available for other plan contracted facilities available to the individual member.

(b) The health care service plan, or designated agent, shall be required to reimburse the skilled nursing facility, continuing care retirement facility, or multilevel facility at the rate agreed to in paragraph (4) of subdivision (a).

(c) No skilled nursing facility, multilevel facility, or continuing care retirement community shall collect, or attempt to collect, or maintain any action of law, against a subscriber or enrollee to collect reimbursement owed by the health care service plan for health care services provided pursuant to this section, or for any amount in excess of the payment amount that the facility has agreed to accept in its agreement with the health care service plan.

(d) Reimbursement by the health care service plan or designated agent shall be for those services included in the Medicare risk contract between the health care service plan and enrollee.

(e) Nothing in this section requires a skilled nursing facility, continuing care retirement facility, or multilevel facility to accept as a skilled nursing unit patient anyone other than a resident of the facility.

(f) This section shall apply to a health care service plan contract that is issued, amended, or renewed on or after January 1, 1999.

HISTORY:
Added Stats 1998 ch 124 § 2 (AB 742).

§ 1367.1. Application to transitionally licensed plans

Subdivision (i) of Section 1367 shall apply to transitionally licensed plans only insofar as it relates to contracts entered into, amended, delivered, or renewed in this state on or after October 1, 1977.

HISTORY:
Added Stats 1977 ch 818 § 8, effective September 16, 1977.

§ 1367.2. Coverage for alcoholism; Notice of coverage

(a) On and after January 1, 1990, every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall offer coverage for the treatment of alcoholism under such terms and conditions as may be agreed upon between the group subscriber and the health care service plan. Every plan shall communicate the availability of such coverage to all group subscribers and to all prospective group subscribers with whom they are negotiating.

(b) If the group subscriber or policyholder agrees to such coverage or to coverage for treatment of chemical dependency, or nicotine use, the treatment may take place in facilities licensed to provide alcoholism or chemical dependency services under Chapter 2 (commencing with Section 1250) of Division 2.

HISTORY:
Added Stats 1978 ch 829 § 1. Amended Stats 1985 ch 722 § 1; Stats 1989 ch 688 § 1.

§ 1367.3. Coverage plan for comprehensive preventive care of children

(a) Every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall offer benefits for the comprehensive preventive

care of children. This section shall apply to children 17 and 18 years of age, except as provided in subparagraph (D) of paragraph (2) of subdivision (b). Every plan shall communicate the availability of these benefits to all group contractholders and to all prospective group contractholders with whom they are negotiating. This section shall apply to a plan that, by rule or order of the director, has been exempted from subdivision (i) of Section 1367, insofar as that section and the rules thereunder relate to the provision of the preventive health care services described herein.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The most recent Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics.

(B) The most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians, unless the State Department of Public Health determines, within 45 days of the published date of the schedule, that the schedule is not consistent with the purposes of this section.

(2) Provide for the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

(D) Screening for blood lead levels in children of any age who are at risk for lead poisoning, as determined by a physician and surgeon affiliated with the plan, if the screening is prescribed by a health care provider affiliated with the plan.

(c) For purposes of this section, a health care provider is any of the following:

(1) A person licensed to practice medicine pursuant to Article 3 (commencing with Section 2050) of Chapter 5 of Division 2 of the Business and Professions Code.

(2) A nurse practitioner licensed to practice pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.

(3) A physician assistant licensed to practice pursuant to Article 3 (commencing with Section 3513) of Chapter 7.7 of Division 2 of the Business and Professions Code.

HISTORY:

Added Stats 1979 ch 965 § 1. Amended Stats 1986 ch 274 § 1; Stats 1989 ch 845 § 2; Stats 1991 ch 797 § 1 (AB 1979); Stats 1992 ch 1134 § 1 (SB 371); Stats 1996 ch 556 § 1 (SB 686); Stats 1999 ch 525 § 96 (AB 78), operative July 1, 2000; Stats 2017 ch 507 § 1 (AB 1316), effective January 1, 2018.

§ 1367.35. Comprehensive preventive care of children of specified ages

(a) On and after January 1, 1993, every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall provide benefits for the comprehensive preventive care of children 16 years of age or younger under terms and conditions agreed upon between the group subscriber and the

plan. Every plan shall communicate the availability of these benefits to all group contractholders and to all prospective group contractholders with whom they are negotiating. This section shall apply to each plan that, by rule or order of the director, has been exempted from subdivision (i) of Section 1367, insofar as that section and the rules thereunder relate to the provision of the preventive health care services described in this section.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics in September of 1987.

(B) The most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians, unless the State Department of Health Services determines, within 45 days of the published date of the schedule, that the schedule is not consistent with the purposes of this section.

(2) Provide for all of the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

HISTORY:
Added Stats 1992 ch 1134 § 2 (SB 371), as H & S C § 1367.5. Renumbered by Stats 1994 ch 146 § 98 (AB 3601). Amended Stats 1996 ch 556 § 2 (SB 686); Stats 1999 ch 525 § 97 (AB 78), operative July 1, 2000.

§ 1367.36. Costs of required immunization of children

(a) A risk-based contract between a health care service plan and a physician or physician group that is issued, amended, delivered, or renewed in this state on or after January 1, 2001, shall not include a provision that requires a physician or a physician group to assume financial risk for the acquisition costs of required immunizations for children as a condition of accepting the risk-based contract. A physician or physician group shall not be required to assume financial risk for immunizations that are not part of the current contract.

(b) Beginning January 1, 2001, with respect to immunizations for children that are not part of the current contract between a health care service plan and a physician or physician group, the health care service plan shall reimburse a physician or physician group at the lowest of the following, until the contract is renegotiated: (1) the physician's actual acquisition cost, (2) the "average wholesale price" as published in the Drug Topics Red Book, or (3) the lowest acquisition cost through sources made available to the physician by the health care service plan. Reimbursements shall be made within 45 days of receipt by the plan of documents from the physician demonstrating that the immunizations were performed, consistent with Section 1371 or through an alternative funding mechanism mutually agreed to by the health care service plan and the physician or physician group. The alternative funding mechanism shall be based on reimbursements consistent with this subdivision.

(c) Physicians and physician groups may assume financial risk for providing

required immunizations, if the immunizations have experiential data that has been negotiated and agreed upon by the health care service plan and the physician risk-bearing organization. However, a health care service plan shall not require a physician risk-bearing organization to accept financial risk or impose additional risk on a physician risk-bearing organization in violation of subdivision (a).

(d) A health care service plan shall not include the acquisition costs associated with required immunizations for children in the capitation rate of a physician who is individually capitated.

HISTORY:
Added Stats 2000 ch 845 § 1 (SB 168).

§ 1367.4. Effect of blindness on coverage

No plan issuing, providing, or administering any contract of individual or group coverage providing medical, surgical, or dental expense benefits applied for and issued on or after January 1, 1986, shall refuse to cover, or refuse to continue to cover, or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of blindness or partial blindness.

"Blindness or partial blindness" means central visual acuity of not more than 20/200 in the better eye, after correction, or visual acuity greater than 20/200 but with a limitation in the fields of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees, certified by a licensed physician and surgeon who specializes in diseases of the eye or a licensed optometrist.

HISTORY:
Added Stats 1985 ch 971 § 1.

§ 1367.41. Pharmacy and therapeutics committee

(a) Commencing January 1, 2017, a health care service plan shall maintain a pharmacy and therapeutics committee that shall be responsible for developing, maintaining, and overseeing any drug formulary list. If the plan delegates responsibility for the formulary to any entity, the obligation of the plan to comply with this chapter shall not be waived.

(b) The pharmacy and therapeutics committee board membership shall conform with both of the following:

(1) Represent a sufficient number of clinical specialties to adequately meet the needs of enrollees.

(2) Consist of a majority of individuals who are practicing physicians, practicing pharmacists, and other practicing health professionals who are licensed to prescribe drugs.

(c) Members of the board shall abstain from voting on any issue in which the member has a conflict of interest with respect to the issuer or a pharmaceutical manufacturer.

(d) At least 20 percent of the board membership shall not have a conflict of interest with respect to the issuer or any pharmaceutical manufacturer.

(e) The pharmacy and therapeutics committee shall meet at least quarterly

and shall maintain written documentation of the rationale for its decisions regarding the development of, or revisions to, the formulary drug list.

(f) The pharmacy and therapeutics committee shall do all of the following:

(1) Develop and document procedures to ensure appropriate drug review and inclusion.

(2) Base clinical decisions on the strength of the scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other related information.

(3) Consider the therapeutic advantages of drugs in terms of safety and efficacy when selecting formulary drugs.

(4) Review policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, and therapeutic interchange.

(5) Evaluate and analyze treatment protocols and procedures related to the plan's formulary at least annually.

(6) Review and approve all clinical prior authorization criteria, step therapy protocols, and quantity limit restrictions applied to each covered drug.

(7) Review new United States Food and Drug Administration-approved drugs and new uses for existing drugs.

(8) Ensure that the plan's formulary drug list or lists cover a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states and do not discourage enrollment by any group of enrollees.

(9) Ensure that the plan's formulary drug list or lists provide appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time.

(g) This section shall be interpreted consistent with federal guidance issued under paragraph (3) of subdivision (a) of Section 156.122 of Title 45 of the Code of Federal Regulations. This section shall apply to the individual, small group, and large group markets.

HISTORY:
Added Stats 2015 ch 619 § 3 (AB 339), effective January 1, 2016.

§ 1367.42. Enrollee access to prescription drug benefits at in-network retail pharmacy; Effect on cost-sharing

(a) For plan years commencing on or after January 1, 2017, a plan that provides essential health benefits shall allow an enrollee to access prescription drug benefits at an in-network retail pharmacy unless the prescription drug is subject to restricted distribution by the United States Food and Drug Administration or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

(b) A nongrandfathered individual or small group health plan contract may charge an enrollee a different cost sharing for obtaining a covered drug at a retail pharmacy, but all cost sharing shall count toward the plan's annual limitation on cost sharing consistent with Section 1367.006.

HISTORY:
Added Stats 2015 ch 619 § 4 (AB 339), effective January 1, 2016.

§ 1367.43. Prorated cost for partial fill of prescription

Commencing January 1, 2019, a health care service plan shall prorate an enrollee's cost sharing for a partial fill of a prescription dispensed pursuant to Section 4052.10 of the Business and Professions Code. This section shall only apply to oral, solid dosage forms of prescription drugs.

HISTORY:
Added Stats 2017 ch 615 § 3 (AB 1048), effective January 1, 2018.

§ 1367.45. Coverage for approved AIDS vaccine; Cost effective price

(a) Every individual or group health care service plan contract that is issued, amended, or renewed on or after January 1, 2002, that covers hospital, medical, or surgery expenses shall provide coverage for a vaccine for acquired immune deficiency syndrome (AIDS) that is approved for marketing by the federal Food and Drug Administration and that is recommended by the United States Public Health Service.

(b) This section may not be construed to require a health care service plan to provide coverage for any clinical trials relating to an AIDS vaccine or for any AIDS vaccine that has been approved by the federal Food and Drug Administration in the form of an investigational new drug application.

(c) A health care service plan that contracts directly with an individual provider or provider organization may not delegate the risk adjusted treatment cost of providing services under this section unless the requirements of Section 1375.5 are met.

(d) Nothing in this section is to be construed in any manner to limit or impede a health care service plan's power or responsibility to negotiate the most cost-effective price for vaccine purchases.

(e) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.

HISTORY:
Added Stats 2001 ch 634 § 2 (SB 446).
Amended Stats 2002 ch 791 § 5 (SB 842).

§ 1367.46. Coverage for HIV testing required

Every individual or group health care service plan contract that is issued, amended, or renewed on or after January 1, 2009, that covers hospital, medical, or surgery expenses shall provide coverage for human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

HISTORY:
Added Stats 2008 ch 631 § 1 (AB 1894), effective January 1, 2009.

§ 1367.47. Maximum amount health care service plan may require enrollee to pay at point of sale for covered prescription drug

(a) The maximum amount a health care service plan may require an enrollee to pay at the point of sale for a covered prescription drug is the lesser of the following:

(1) The applicable cost-sharing amount for the prescription drug.

(2) The retail price.

(b) A health care service plan shall not require a pharmacist or pharmacy to charge or collect from an enrollee a cost-sharing amount that exceeds the total retail price for the prescription drug.

(c) The payment rendered shall constitute the applicable cost sharing and shall apply to the deductible, if any, and also to the maximum out-of-pocket limit in the same manner as if the enrollee had purchased the prescription drug by paying the cost-sharing amount.

HISTORY:
Added Stats 2018 ch 770 § 2 (AB 2863), effective January 1, 2019.

§ 1367.49. Information to be furnished to consumers or purchasers concerning cost range of procedure or full course of treatment, or quality of services performed by provider or supplier; Review of methodology and data; Online posting; Definitions

(a) A contract issued, amended, renewed, or delivered on or after January 1, 2015, by or on behalf of a health care service plan and a provider or supplier shall not contain any provision that restricts the ability of the health care service plan to furnish consumers or purchasers information concerning any of the following:

(1) The cost range of a procedure or a full course of treatment, including, but not limited to, facility, professional, and diagnostic services, prescription drugs, durable medical equipment, and other items and services related to the treatment.

(2) The quality of services performed by the provider or supplier.

(b) Any contractual provision inconsistent with this section shall be void and unenforceable.

(c) A health care service plan shall provide the provider or supplier an advance opportunity of 30 days to review the methodology and data developed and compiled by the health care service plan, and used pursuant to subdivision (a), before cost or quality information is provided to consumers or purchasers, including material revisions or additions of new information. At the time the health care service plan provides a provider or supplier with the opportunity to review the methodology and data, it shall also notify the provider or supplier in writing of their opportunity to provide an Internet Web site link pursuant to subdivision (f).

(d) If the information proposed to be furnished to enrollees and subscribers on the quality of services performed by a provider or supplier is data that the plan has developed and compiled, the plan shall utilize appropriate risk adjustment factors to account for different characteristics of the population, such as case mix, severity of patient's condition, comorbidities, outlier epi-

sodes, and other factors to account for differences in the use of health care resources among providers and suppliers.

(e) Any Internet Web site owned or controlled by a health care service plan, or operated by another person or entity under contract with or on behalf of a health care service plan, that displays the information developed and compiled by the health care service plan as referenced by this section shall prominently post the following statement:

"Individual facilities or health care providers may disagree with the methodology used to define the cost ranges, the cost data, or quality measures. Many factors may influence cost or quality, including, but not limited to, the cost of uninsured and charity care, the type and severity of procedures, the case mix of a facility, special services such as trauma centers, burn units, medical and other educational programs, research, transplant services, technology, payer mix, and other factors affecting individual facilities and health care providers."

A health care service plan and a provider or supplier shall not be precluded from mutually agreeing in writing to an alternative method of conveying this statement.

(f) If a provider or supplier chooses to provide an Internet Web site link where a response to the health care service plan's posting may be found, it shall do so in a timely manner in order to satisfy the requirements of this section. If a provider or supplier chooses to provide a response, a plan shall post, in an easily identified manner, a prominent link to the provider's or supplier's Internet Web site where a response to the plan's posting may be found. A health care service plan and a provider or supplier shall not be precluded from mutually agreeing in writing to an alternative method to convey a provider's or supplier's response.

(g) For the purposes of this section, the following definitions shall apply:

(1) "Consumers" means enrollees or subscribers of the health care service plan or beneficiaries of a self-funded health coverage arrangement administered by the health care service plan or other persons entitled to access services through a network established by the health care service plan.

(2) "Provider" has the same meaning as that term is defined in Section 1367.50.

(3) "Purchasers" means the sponsors of a self-funded health coverage arrangement administered by the health care service plan.

(4) "Supplier" has the same meaning as that term is defined in Section 1367.50.

(h) Section 1390 shall not apply for purposes of this section.

HISTORY:
Added Stats 2011 ch 244 § 2 (SB 751), effective January 1, 2012. Amended Stats 2014 ch 83 § 1 (SB 1340), effective January 1, 2015.

§ 1367.5. Health service plan contract restrictions

No health care service plan contract that is issued, amended, renewed, or delivered on and after January 1, 2002, shall contain a provision that prohibits or restricts any health facilities' compliance with the requirements of Section 1262.5.

HISTORY:
Added Stats 2001 ch 691 § 5 (SB 587).

§ 1367.50. Disclosure of claims data to qualified entity

(a) No contract in existence or issued, amended, or renewed on or after January 1, 2013, between a health care service plan and a provider or a supplier shall prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to an enrollee or subscriber of the health care service plan or beneficiaries of any self-funded health coverage arrangement administered by the health care service plan, to a qualified entity, as defined in Section 1395kk(e)(2) of Title 42 of the United States Code. All disclosures of data made under this section shall comply with all applicable state and federal laws for the protection of the privacy and security of the data, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the federal Health Information Technology for Economic and Clinical Health Act, Title XIII of the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and implementing regulations.

(b) For purposes of this section, the following definitions apply:

(1) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(2) "Provider" means a hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, a hospice, a clinic, or a rehabilitation agency.

(3) "Supplier" means a physician and surgeon or other health care practitioner, or an entity that furnishes health care services other than a provider.

HISTORY:
Added Stats 2012 ch 869 § 2 (SB 1196), effective January 1, 2013.

§ 1367.51. Coverage of equipment and supplies for treatment of diabetes; Prescription items; Outpatient self-management and training

(a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, and that covers hospital, medical, or surgical expenses shall include coverage for the following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription:

(1) Blood glucose monitors and blood glucose testing strips.
(2) Blood glucose monitors designed to assist the visually impaired.
(3) Insulin pumps and all related necessary supplies.
(4) Ketone urine testing strips.
(5) Lancets and lancet puncture devices.
(6) Pen delivery systems for the administration of insulin.
(7) Podiatric devices to prevent or treat diabetes-related complications.
(8) Insulin syringes.

(9) Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

(b) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits shall include coverage for the following prescription items if the items are determined to be medically necessary:

(1) Insulin.

(2) Prescriptive medications for the treatment of diabetes.

(3) Glucagon.

(c) The copayments and deductibles for the benefits specified in subdivisions (a) and (b) shall not exceed those established for similar benefits within the given plan.

(d) Every plan shall provide coverage for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable an enrollee to properly use the equipment, supplies, and medications set forth in subdivisions (a) and (b), and additional diabetes outpatient self-management training, education, and medical nutrition therapy upon the direction or prescription of those services by the enrollee's participating physician. If a plan delegates outpatient self-management training to contracting providers, the plan shall require contracting providers to ensure that diabetes outpatient self-management training, education, and medical nutrition therapy are provided by appropriately licensed or registered health care professionals.

(e) The diabetes outpatient self-management training, education, and medical nutrition therapy services identified in subdivision (d) shall be provided by appropriately licensed or registered health care professionals as prescribed by a participating health care professional legally authorized to prescribe the service. These benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications.

(f) The copayments for the benefits specified in subdivision (d) shall not exceed those established for physician office visits by the plan.

(g) Every health care service plan governed by this section shall disclose the benefits covered pursuant to this section in the plan's evidence of coverage and disclosure forms.

(h) A health care service plan may not reduce or eliminate coverage as a result of the requirements of this section.

(i) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.

HISTORY:
Added Stats 1999 ch 540 § 1 (SB 64). Amended Stats 2000 ch 1067 § 10 (SB 2094); Stats 2002 ch 791 § 6 (SB 842).

§ 1367.54. California Prenatal Screening Program

(a) Every group health care service plan contract that provides maternity benefits, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 1999, and every

individual health care service plan contract of a type and form first offered for sale on or after January 1, 1999, that provides maternity benefits, except a specialized health care service plan contract, shall provide coverage for participation in the California Prenatal Screening Program, which is a statewide prenatal testing program administered by the State Department of Public Health, pursuant to Section 124977. Notwithstanding any other provision of law, a health care service plan that provides maternity benefits shall not require participation in the statewide prenatal testing program administered by the State Department of Public Health as a prerequisite to eligibility for, or receipt of, any other service.

(b) Coverage required by this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing.

(c) Reimbursement for services covered pursuant to this section shall be paid at the amount set pursuant to Section 124977 and regulations adopted thereunder.

HISTORY:
Added Stats 1998 ch 1064 § 1 (AB 2438).
Amended Stats 2015 ch 18 § 7 (SB 75), effective June 24, 2015.

§ 1367.6. Coverage for breast cancer screening, diagnosis, and treatment; Denial of enrollment or coverage on grounds related to breast cancer; Prosthetic devices or reconstructive surgery

(a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, shall provide coverage for screening for, diagnosis of, and treatment for, breast cancer.

(b) No health care service plan contract shall deny enrollment or coverage to an individual solely due to a family history of breast cancer, or who has had one or more diagnostic procedures for breast disease but has not developed or been diagnosed with breast cancer.

(c) Every health care service plan contract shall cover screening and diagnosis of breast cancer, consistent with generally accepted medical practice and scientific evidence, upon the referral of the enrollee's participating physician.

(d) Treatment for breast cancer under this section shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the copayment, or deductible and coinsurance conditions, that are applicable to the mastectomy and all other terms and conditions applicable to other benefits.

(e) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon. Partial removal of a breast includes, but is not limited to, lumpectomy, which includes surgical removal of the tumor with clear margins.

(f) As used in this section, "prosthetic devices" means the provision of initial and subsequent devices pursuant to an order of the patient's physician and surgeon.

HISTORY:
Added Stats 1999 ch 537 § 2 (SB 5). Amended Stats 2012 ch 449 § 2 (SB 255), effective January 1, 2013.

§ 1367.61. Coverage for prosthetic devices to restore method of speaking incident to laryngectomy

Every health care service plan contract which provides for the surgical procedure known as a laryngectomy and which is issued, amended, delivered, or renewed in this state on or after January 1, 1993, shall include coverage for prosthetic devices to restore a method of speaking for the patient incident to the laryngectomy.

Coverage for prosthetic devices shall be subject to the deductible and coinsurance conditions applied to the laryngectomy and all other terms and conditions applicable to other benefits. As used in this section, "laryngectomy" means the removal of all or part of the larynx for medically necessary reasons, as determined by a licensed physician and surgeon.

Any provision in any contract issued, amended, delivered, or renewed in this state on or after January 1, 1993, which is in conflict with this section shall be of no force or effect.

As used in this section, "prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices, including installation accessories, pursuant to an order of the patient's physician and surgeon. "Prosthetic devices" does not include electronic voice producing machines.

HISTORY:
Added Stats 1992 ch 808 § 1 (SB 1597).

§ 1367.62. Restrictions on limiting inpatient hospital care following childbirth; Proscription on specified treatment and coverage practices; Notice of required coverage

(a) No health care service plan contract that is issued, amended, renewed, or delivered on or after the effective date of the act adding this section, that provides maternity coverage, shall do any of the following:

(1) Restrict benefits for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following a delivery by caesarean section. However, coverage for inpatient hospital care may be for a time period less than 48 or 96 hours if both of the following conditions are met:

(A) The decision to discharge the mother and newborn before the 48- or 96-hour time period is made by the treating physicians in consultation with the mother.

(B) The contract covers a postdischarge followup visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician. The visit shall be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit shall include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician shall disclose to the mother the availability of a postdischarge visit, including an in-home visit, physician office visit, or plan facility visit. The treating physician, in consultation with the mother, shall determine

whether the postdischarge visit shall occur at home, the plan's facility, or the treating physician's office after assessment of certain factors. These factors shall include, but not be limited to, the transportation needs of the family, and environmental and social risks.

(2) Reduce or limit the reimbursement of the attending provider for providing care to an individual enrollee in accordance with the coverage requirements.

(3) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual enrollee in a manner inconsistent with the coverage requirements.

(4) Deny a mother or her newborn eligibility, or continued eligibility, to enroll or to renew coverage solely to avoid the coverage requirements.

(5) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum coverage requirements.

(6) Restrict inpatient benefits for the second day of hospital care in a manner that is less than favorable to the mother or her newborn than those provided during the preceding portion of the hospital stay.

(7) Require the treating physician to obtain authorization from the health care service plan prior to prescribing any services covered by this section.

(b)(1) Every health care service plan shall include notice of the coverage specified in subdivision (a) in the plan's evidence of coverage for evidences of coverage issued on or after January 1, 1998, and except as specified in paragraph (2), shall provide additional written notice of this coverage during the course of the enrollee's prenatal care. The contract may require the treating physician or the enrollee's medical group to provide this additional written notice of coverage during the course of the enrollee's prenatal care.

(2) Health care service plans that issue contracts that provide for coverage of the type commonly referred to as "preferred provider organizations" shall provide additional written notice to all females between the ages of 10 and 50 who are covered by those contracts of the coverage under subdivision (a) within 60 days of the effective date of this act. The plan shall provide additional written notice of the coverage specified in subdivision (a) during the course of prenatal care if both of the following conditions are met:

(A) The plan previously notified subscribers that hospital stays for delivery would be inconsistent with the requirement in subparagraph (A) of paragraph (1) of subdivision (a).

(B) The plan received notice, whether by receipt of a claim, a request for preauthorization for pregnancy-related services, or other actual notice that the enrollee is pregnant.

(c) Nothing in this section shall be construed to prohibit a plan from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

HISTORY:
Added Stats 1997 ch 389 § 3 (AB 38), effective August 26, 1997. Amended Stats 1997 ch 798 § 1 (AB 1553), effective October 9, 1997.

§ 1367.625. Maternal mental health program

(a) By July 1, 2019, a health care service plan shall develop a maternal mental health program designed to promote quality and cost-effective out-

comes. The program shall be developed consistent with sound clinical principles and processes. The program guidelines and criteria shall be made available upon request to medical providers, including a contracting obstetric provider.

(b) For the purposes of this section, the following terms have the following meanings:

(1) "Contracting obstetric provider" means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or an initiative act referred to in that division, and who is contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.

(2) "Maternal mental health" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

(c) This section shall not apply to specialized health care service plans, except specialized behavioral health-only plans offering professional mental health services.

HISTORY:
Added Stats 2018 ch 755 § 1 (AB 2193), effective January 1, 2019.

§ 1367.63. Reconstructive surgery

(a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, renewed, or delivered in this state on or after July 1, 1999, shall cover reconstructive surgery, as defined in subdivision (c), that is necessary to achieve the purposes specified in subparagraph (A) or (B) of paragraph (1) of subdivision (c). Nothing in this section shall be construed to require a plan to provide coverage for cosmetic surgery, as defined in subdivision (d).

(b) No individual, other than a licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment pursuant to this section. For a treatment authorization request submitted by a podiatrist or an oral and maxillofacial surgeon, the request may be reviewed by a similarly licensed individual, competent to evaluate the specific clinical issues involved in the care requested.

(c)(1) "Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

(A) To improve function.

(B) To create a normal appearance, to the extent possible.

(2) As of July 1, 2010, "reconstructive surgery" shall include medically necessary dental or orthodontic services that are an integral part of reconstructive surgery, as defined in paragraph (1), for cleft palate procedures.

(3) For purposes of this section, "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

(d) "Cosmetic surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

(e) In interpreting the definition of reconstructive surgery, a health care service plan may utilize prior authorization and utilization review that may include, but need not be limited to, any of the following:

(1) Denial of the proposed surgery if there is another more appropriate surgical procedure that will be approved for the enrollee.

(2) Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, offer only a minimal improvement in the appearance of the enrollee.

(3) Denial of payment for procedures performed without prior authorization.

(4) For services provided under the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), denial of the proposed surgery if the procedure offers only a minimal improvement in the appearance of the enrollee, as may be defined in any regulations that may be promulgated by the State Department of Health Care Services.

(f) As applied to services described in paragraph (2) of subdivision (c) only, this section shall not apply to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code, where such contracts do not provide coverage for California Children's Services (CCS) or dental services.

HISTORY:
Added Stats 1998 ch 788 § 2 (AB 1621). Amended Stats 2009 ch 604 § 1 (SB 630), effective January 1, 2010; Stats 2011 ch 367 § 3 (AB 574), effective January 1, 2012.

§ 1367.635. Mastectomies and lymph node dissections

(a) Every health care service plan contract that is issued, amended, renewed, or delivered on or after January 1, 1999, that provides coverage for surgical procedures known as mastectomies and lymph node dissections, shall do all of the following:

(1) Allow the length of a hospital stay associated with those procedures to be determined by the attending physician and surgeon in consultation with the patient, postsurgery, consistent with sound clinical principles and processes. No health care service plan shall require a treating physician and surgeon to receive prior approval from the plan in determining the length of hospital stay following those procedures.

(2) Cover prosthetic devices or reconstructive surgery, including devices or surgery to restore and achieve symmetry for the patient incident to the mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applicable to other benefits.

(3) Cover all complications from a mastectomy, including lymphedema.

(b) As used in this section, all of the following definitions apply:

(1) "Coverage for prosthetic devices or reconstructive surgery" means any

initial and subsequent reconstructive surgeries or prosthetic devices, and followup care deemed necessary by the attending physician and surgeon.

(2) "Prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the patient's physician and surgeon.

(3) "Mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon. Partial removal of a breast includes, but is not limited to, lumpectomy, which includes surgical removal of the tumor with clear margins.

(4) "To restore and achieve symmetry" means that, in addition to coverage of prosthetic devices and reconstructive surgery for the diseased breast on which the mastectomy was performed, prosthetic devices and reconstructive surgery for a healthy breast is also covered if, in the opinion of the attending physician and surgeon, this surgery is necessary to achieve normal symmetrical appearance.

(c) No individual, other than a licensed physician and surgeon competent to evaluate the specific clinical issues involved in the care requested, may deny requests for authorization of health care services pursuant to this section.

(d) No health care service plan shall do any of the following in providing the coverage described in subdivision (a):

(1) Reduce or limit the reimbursement of the attending provider for providing care to an individual enrollee or subscriber in accordance with the coverage requirements.

(2) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual enrollee or subscriber in a manner inconsistent with the coverage requirements.

(3) Provide monetary payments or rebates to an individual enrollee or subscriber to encourage acceptance of less than the coverage requirements.

(e) On or after July 1, 1999, every health care service plan shall include notice of the coverage required by this section in the plan's evidence of coverage.

(f) Nothing in this section shall be construed to limit retrospective utilization review and quality assurance activities by the plan.

HISTORY:
Added Stats 1998 ch 787 § 2 (AB 7). Amended Stats 2012 ch 449 § 3 (SB 255), effective January 1, 2013.

§ 1367.64. Coverage for screening and diagnosis of prostate cancer

(a) Every individual or group health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 1999, shall be deemed to provide coverage for the screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when medically necessary and consistent with good professional practice.

(b) Nothing in this section shall be construed to establish a new mandated benefit or to prevent application of deductible or copayment provisions in a policy or plan, nor shall this section be construed to require that a policy or plan be extended to cover any other procedures under an individual or a group health care service plan contract. Nothing in this section shall be construed to

authorize an enrollee to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, unless the enrollee is referred to that provider by a participating physician or nurse practitioner providing care.

HISTORY:
Added Stats 1998 ch 839 § 1 (SB 2020).

§ 1367.65. Coverage for mammography for screening and diagnostic purposes

(a) On or after January 1, 2000, each health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed shall be deemed to provide coverage for mammography for screening or diagnostic purposes upon referral by a participating nurse practitioner, participating certified nurse-midwife, participating physician assistant, or participating physician, providing care to the patient and operating within the scope of practice provided under existing law.

(b) This section does not prevent application of copayment or deductible provisions in a plan, nor shall this section be construed to require that a plan be extended to cover any other procedures under an individual or a group health care service plan contract. This section does not authorize a plan enrollee to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, unless the plan enrollee is referred to that provider by a participating physician, nurse practitioner, or certified nurse-midwife providing care.

HISTORY:
Added Stats 1987 ch 550 § 1. Amended Stats 1988 ch 1598 § 1; Stats 1990 ch 733 § 1 (AB 3117); Stats 1991 ch 239 § 1 (AB 137); Stats 1999 ch 537 § 3 (SB 5); Stats 2012 ch 436 § 1 (AB 137), effective January 1, 2013; Stats 2013 ch 76 § 108 (AB 383), effective January 1, 2014.

§ 1367.656. Healthcare coverage for orally administered anticancer medication [Effective until January 1, 2024; Repealed effective January 1, 2024]

(a) Notwithstanding any other law, an individual or group health care service plan contract issued, amended, or renewed on or after January 1, 2015, that provides coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells shall comply with all of the following:

(1) Notwithstanding any deductible, the total amount of copayments and coinsurance an enrollee is required to pay shall not exceed two hundred fifty dollars ($250) for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the contract.

(2) For a health care service plan contract that meets the definition of a "high deductible health plan" set forth in Section 223(c)(2) of Title 26 of the United States Code, paragraph (1) shall only apply once an enrollee's deductible has been satisfied for the year.

(3) Paragraph (1) shall not apply to any coverage under a health care

service plan contract for the Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(4) A prescription for an orally administered anticancer medication shall be provided consistent with the appropriate standard of care for that medication.

(b) This section shall remain in effect only until January 1, 2024, and as of that date is repealed.

HISTORY:
Added Stats 2013 ch 661 § 2 (AB 219), effective January 1, 2014. Amended Stats 2018 ch 427 § 1 (AB 1860), effective January 1, 2019, repealed January 1, 2024.

§ 1367.66. Coverage for annual cervical cancer screening test

Every individual or group health care service plan contract, except for a specialized health care service plan, that is issued, amended, or renewedon or after January 1, 2002, and that includes coverage for treatment or surgery of cervical cancer shall also be deemed to provide coverage for an annual cervical cancer screening test upon the referral of the patient's physician and surgeon, a nurse practitioner, or a certified nurse midwife, providing care to the patient and operating within the scope of practice otherwise permitted for the licensee.

The coverage for an annual cervical cancer screening test provided pursuant to this section shall include the conventional Pap test, a human papillomavirus screening test that is approved by the federal Food and Drug Administration, and the option of any cervical cancer screening test approved by the federal Food and Drug Administration, upon the referral of the patient's health care provider.

Nothing in this section shall be construed to establish a new mandated benefit or to prevent application of deductible or copayment provisions in an existing plan contract. The Legislature intends in this section to provide that cervical cancer screening services are deemed to be covered if the plan contract includes coverage for cervical cancer treatment or surgery.

HISTORY:
Added Stats 1990 ch 1279 § 1 (AB 2542). Amended Stats 2001 ch 380 § 1 (SB 1219); Stats 2006 ch 482 § 1 (SB 1245), effective January 1, 2007; Stats 2010 ch 328 § 119 (SB 1330), effective January 1, 2011.

§ 1367.665. Coverage for cancer screening tests

Every individual or group health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after July 1, 2000, shall be deemed to provide coverage for all generally medically accepted cancer screening tests, subject to all terms and conditions that would otherwise apply.

HISTORY:
Added Stats 1999 ch 543 § 1 (SB 205).

§ 1367.67. Coverage for osteoporosis

Every health care service plan contract that provides hospital, medical, or surgical coverage, that is issued, amended, delivered, or renewed in this state on or after January 1, 1994, shall be deemed to include coverage for services

related to diagnosis, treatment, and appropriate management of osteoporosis. The services may include, but need not be limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.

HISTORY:
Added Stats 1993 ch 1208 § 2 (AB 547).

§ 1367.68. Coverage for surgical procedure for conditions affecting upper or lower jawbone

(a) Any provision in a health care service plan contract entered into, amended, or renewed in this state on or after July 1, 1995, that excludes coverage for any surgical procedure for any condition directly affecting the upper or lower jawbone, or associated bone joints, shall have no force or effect as to any enrollee if that provision results in any failure to provide medically-necessary basic health care services to the enrollee pursuant to the plan's definition of medical necessity.

(b) For purposes of this section, "plan contract" means every plan contract, except a specialized health care service plan contract, that covers hospital, medical, or surgical expenses.

(c) Nothing in this section shall be construed to prohibit a plan from excluding coverage for dental services provided that any exclusion does not result in any failure to provide medically-necessary basic health care services.

HISTORY:
Added Stats 1994 ch 1282 § 1 (AB 2994).

§ 1367.69. Obstetrician-gynecologists as eligible primary care physicians

(a) On or after January 1, 1995, every health care service plan contract that provides hospital, medical, or surgical coverage, that is issued, amended, delivered, or renewed in this state, shall include obstetrician-gynecologists as eligible primary care physicians, provided they meet the plan's eligibility criteria for all specialists seeking primary care physician status.

(b) For purposes of this section, the term "primary care physician" means a physician, as defined in Section 14254 of the Welfare and Institutions Code, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.

HISTORY:
Added Stats 1994 ch 759 § 2 (AB 2493).

§ 1367.695. Requirement for enrollee's choice of obstetrical or gynecological services provider [Effective until January 1, 2020]

(a) The Legislature finds and declares that the unique, private, and personal relationship between women patients and their obstetricians and gyne-

cologists warrants direct access to obstetrical and gynecological physician services.

(b) Commencing January 1, 1999, every health care service plan contract issued, amended, renewed, or delivered in this state, except a specialized health care service plan, shall allow an enrollee the option to seek obstetrical and gynecological physician services directly from a participating obstetrician and gynecologist or directly from a participating family practice physician and surgeon designated by the plan as providing obstetrical and gynecological services.

(c) In implementing this section, a health care service plan may establish reasonable provisions governing utilization protocols and the use of obstetricians and gynecologists, or family practice physicians and surgeons, as provided for in subdivision (b), participating in the plan network, medical group, or independent practice association, provided that these provisions shall be consistent with the intent of this section and shall be those customarily applied to other physicians and surgeons, such as primary care physicians and surgeons, to whom the enrollee has direct access, and shall not be more restrictive for the provision of obstetrical and gynecological physician services. An enrollee shall not be required to obtain prior approval from another physician, another provider, or the health care service plan prior to obtaining direct access to obstetrical and gynecological physician services, but the plan may establish reasonable requirements for the participating obstetrician and gynecologist or family practice physician and surgeon, as provided for in subdivision (b), to communicate with the enrollee's primary care physician and surgeon regarding the enrollee's condition, treatment, and any need for followup care.

(d) This section shall not be construed to diminish the provisions of Section 1367.69.

(e) The Department of Managed Health Care shall report to the Legislature, on or before January 1, 2000, on the implementation of this section.

HISTORY:
Added Stats 1998 ch 22 § 1 (AB 12). Amended Stats 1999 ch 525 § 98 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 33 (AB 2903).

§ 1367.695. Requirement for enrollee's choice of obstetrical or gynecological services provider [Effective January 1, 2020]

(a) The Legislature finds and declares that the unique, private, and personal relationship between women patients and their obstetricians and gynecologists warrants direct access to obstetrical and gynecological physician services.

(b) Each health care service plan contract issued, amended, renewed, or delivered in this state, except a specialized health care service plan, shall allow an enrollee the option to seek obstetrical and gynecological physician services directly from a participating obstetrician and gynecologist or directly from a participating family physician and surgeon designated by the plan as providing obstetrical and gynecological services.

(c) In implementing this section, a health care service plan may establish reasonable requirements governing utilization protocols and the use of obstetricians and gynecologists, or family physicians and surgeons, as provided for in subdivision (b), participating in the plan network, medical group, or

independent practice association, if those requirements are consistent with the intent of this section, are customarily applied to other physicians and surgeons, such as primary care physicians and surgeons, to whom the enrollee has direct access, and are no more restrictive for the provision of obstetrical and gynecological physician services. An enrollee shall not be required to obtain prior approval from another physician, another provider, or the health care service plan prior to obtaining direct access to obstetrical and gynecological physician services, but the plan may establish reasonable requirements for the participating obstetrician and gynecologist or family physician and surgeon, as provided for in subdivision (b), to communicate with the enrollee's primary care physician and surgeon regarding the enrollee's condition, treatment, and any need for followup care.

(d) This section does not diminish the requirements of Section 1367.69.

HISTORY:
Added Stats 1998 ch 22 § 1 (AB 12). Amended Stats 1999 ch 525 § 98 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 33 (AB 2903); Stats 2019 ch 632 § 7 (AB 1622), effective January 1, 2020.

§ 1367.7. Coverage for prenatal diagnosis of genetic disorders of fetus

On and after January 1, 1980, every health care service plan contract that covers hospital, medical, or surgical expenses on a group basis, and which offers maternity coverage in such groups, shall also offer coverage for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy. Every health care service plan shall communicate the availability of such coverage to all group contract holders and to all groups with whom they are negotiating.

HISTORY:
Added Stats 1979 ch 629 § 1.

§ 1367.71. General anesthesia and associated facility charges for dental procedures

(a) Every health care service plan contract, other than a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2000, shall be deemed to cover general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting. The health care service plan may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.

(b) This section shall apply only to general anesthesia and associated facility charges for only the following enrollees, and only if the enrollees meet the criteria in subdivision (a):

(1) Enrollees who are under seven years of age.

(2) Enrollees who are developmentally disabled, regardless of age.

(3) Enrollees whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

(c) Nothing in this section shall require the health care service plan to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section shall be subject to all other terms and conditions of the plan that apply generally to other benefits.

(d) Nothing in this section shall be construed to allow a health care service plan to deny coverage for basic health care services, as defined in Section 1345.

(e) A health care service plan may include coverage specified in subdivision (a) at any time prior to January 1, 2000.

HISTORY:
Added Stats 1998 ch 790 § 1 (AB 2003).

§ 1367.8. Coverage for handicapped persons

No plan issuing, providing, or administering any individual or group health care service plan entered into, amended, or issued on or after January 1, 1981, shall refuse to cover, or refuse to continue to cover, or limit the amount, extent or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation or rate differential is based on sound actuarial principles applied to actual experience, or, if insufficient actual experience is available, then to sound underwriting practices.

This section shall not apply to a health maintenance organization qualified pursuant to Title XIII of the federal Public Health Service Act if such organization gives public notice 30 days in advance, in a newspaper of general circulation published in the area served by the health maintenance organization, of its open enrollment period required by such act.

HISTORY:
Added Stats 1980 ch 352 § 1.

§ 1367.9. Coverage for conditions attributable to diethylstilbestrol

No health care service plan contract which covers hospital, medical, or surgical expenses shall be issued, amended, delivered, or renewed in this state on or after January 1, 1981, if it contains any exclusion, reduction, or other limitations, as to coverage, deductibles, or coinsurance or copayment provisions applicable solely to conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol.

Any provision in any contract issued, amended, delivered, or renewed in this state on or after January 1, 1981, which is in conflict with this section shall be of no force or effect.

HISTORY:
Added Stats 1980 ch 776 § 2, as H & S C § 1367.8. Renumbered Stats 1981 ch 714 § 217.

§ 1367.10. Disclosure of effect of participation in plan on choice of provider

(a) Every health care service plan shall include within its disclosure form and within its evidence of coverage a statement clearly describing how

participation in the plan may affect the choice of physician, hospital, or other health care providers, the basic method of reimbursement, including the scope and general methods of payment made to its contracting providers of health care services, and whether financial bonuses or any other incentives are used. The disclosure form and evidence of coverage shall indicate that if an enrollee wishes to know more about these issues, the enrollee may request additional information from the health care service plan, the enrollee's provider, or the provider's medical group or independent practice association regarding the information required pursuant to subdivision (b).

(b) If a plan, medical group, independent practice association, or participating health care provider uses or receives financial bonuses or any other incentives, the plan, medical group, independent practice association, or health care provider shall provide a written summary to any person who requests it that includes all of the following:

(1) A general description of the bonus and any other incentive arrangements used in its compensation agreements. Nothing in this section shall be construed to require disclosure of trade secrets or commercial or financial information that is privileged or confidential, such as payment rates, as determined by the director, pursuant to state law.

(2) A description regarding whether, and in what manner, the bonuses and any other incentives are related to a provider's use of referral services.

(c) The statements and written information provided pursuant to subdivisions (a) and (b) shall be communicated in clear and simple language that enables consumers to evaluate and compare health care service plans.

(d) The plan shall clearly inform prospective enrollees that participation in that plan will affect the person's choice of provider by placing the following statement in a conspicuous place on all material required to be given to prospective enrollees including promotional and descriptive material, disclosure forms, and certificates and evidences of coverage:

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. —

It is not the intent of this section to require that the names of individual health care providers be enumerated to prospective enrollees.

If the health care service plan provides a list of providers to patients or contracting providers, the plan shall include within the provider listing a notification that enrollees may contact the plan in order to obtain a list of the facilities with which the health care service plan is contracting for subacute care and/or transitional inpatient care.

HISTORY:
Added Stats 1986 ch 568 § 1. Amended Stats 1996 ch 1014 § 3 (AB 2649), ch 1024 § 4.5 (SB 1547); Stats 1998 ch 835 § 1; Stats 1999 ch 525 § 99 (AB 78), operative July 1, 2000.

§ 1367.11. Direct reimbursement to providers of covered medical transportation services

(a) Every health care service plan issued, amended, or renewed on or after January 1, 1987, that offers coverage for medical transportation services, shall contain a provision providing for direct reimbursement to any provider of

covered medical transportation services if the provider has not received payment for those services from any other source.

(b) Subdivision (a) shall not apply to any transaction between a provider of medical transportation services and a health care service plan if the parties have entered into a contract providing for direct payment.

(c) For purposes of this subdivision, "direct reimbursement" means the following:

The enrollee shall file a claim for the medical transportation service with the plan; the plan shall pay the medical transportation provider directly; and the medical transportation provider shall not demand payment from the enrollee until having received payment from the plan, at which time the medical transportation provider may demand payment from the enrollee for any unpaid portion of the provider's fee.

HISTORY:
Added Stats 1986 ch 930 § 1.

§ 1367.12. Number of forms to be submitted per claim for payment or reimbursement

No health care service plan that administers Medicare coverage and federal employee programs may require that more than one form be submitted per claim in order to receive payment or reimbursement under any or all of those policies or programs.

HISTORY:
Added Stats 1987 ch 1191 § 1.

§ 1367.15. Closure of "block of business"

(a) This section shall apply to individual health care service plan contracts and plan contracts sold to employer groups with fewer than two eligible employees as defined in subdivision (b) of Section 1357 covering hospital, medical, or surgical expenses, which is issued, amended, delivered, or renewed on or after January 1, 1994.

(b) As used in this section, "block of business" means individual plan contracts or plan contracts sold to employer groups with fewer than two eligible employees as defined in subdivision (b) of Section 1357, with distinct benefits, services, and terms. A "closed block of business" means a block of business for which a health care service plan ceases to actively offer or sell new plan contracts.

(c) No block of business shall be closed by a health care service plan unless (1) the plan permits an enrollee to receive health care services from any block of business that is not closed and that provides comparable benefits, services, and terms, with no additional underwriting requirement, or (2) the plan pools the experience of the closed block of business with all appropriate blocks of business that are not closed for the purpose of determining the premium rate of any plan contract within the closed block, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool.

(d) A block of business shall be presumed closed if either of the following is applicable:

(1) There has been an overall reduction in that block of 12 percent in the number of in force plan contracts for a period of 12 months.

(2) That block has less than 1,000 enrollees in this state. This presumption shall not apply to a block of business initiated within the previous 24 months, but notification of that block shall be provided to the director pursuant to subdivision (e).

The fact that a block of business does not meet one of the presumptions set forth in this subdivision shall not preclude a determination that it is closed as defined in subdivision (b).

(e) A health care service plan shall notify the director in writing within 30 days of its decision to close a block of business or, in the absence of an actual decision to close a block of business, within 30 days of its determination that a block of business is within the presumption set forth in subdivision (d). When the plan decides to close a block, the written notice shall fully disclose all information necessary to demonstrate compliance with the requirements of subdivision (c). When the plan determines that a block is within the presumption, the written notice shall fully disclose all information necessary to demonstrate that the presumption is applicable. In the case of either notice, the plan shall provide additional information within 15 days after any request of the director.

(f) A health care service plan shall preserve for a period of not less than five years in an identified location and readily accessible for review by the director all books and records relating to any action taken by a plan pursuant to subdivision (c).

(g) No health care service plan shall offer or sell any contract, or provide misleading information about the active or closed status of a block of business, for the purpose of evading this section.

(h) A health care service plan shall bring any blocks of business closed prior to the effective date of this section into compliance with the terms of this section no later than December 31, 1994.

(i) This section shall not apply to health care service plan contracts providing small employer health coverage to individuals or employer groups with fewer than two eligible employees if that coverage is provided pursuant to Article 3.1 (commencing with Section 1357) and, with specific reference to coverage for individuals or employer groups with fewer than two eligible employees, is approved by the director pursuant to Section 1357.15, provided a plan electing to sell coverage pursuant to this subdivision shall do so until such time as the plan ceases to market coverage to small employers and complies with paragraph (5) of subdivision (a) of Section 1365.

(j) This section shall not apply to coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, dental, vision, or conversion coverage.

HISTORY:
Added Stats 1993 ch 729 § 1 (AB 1743). Amended Stats 1997 ch 336 § 13 (SB 578), effective August 21, 1997; Stats 1999 ch 525 § 100 (AB 78), operative July 1, 2000; Stats 2010 ch 658 § 6 (AB 2470), effective January 1, 2011.

§ 1367.18. Coverage for orthotic and prosthetic devices and services; Benefit amount

(a) Every health care service plan, except a specialized health care service

plan, that covers hospital, medical, or surgical expenses on a group basis shall offer coverage for orthotic and prosthetic devices and services under the terms and conditions that may be agreed upon between the group subscriber and the plan. Every plan shall communicate the availability of that coverage to all group contractholders and to all prospective group contractholders with whom they are negotiating. Any coverage for prosthetic devices shall include original and replacement devices, as prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license. Any coverage for orthotic devices shall provide for coverage when the device, including original and replacement devices, is prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license, or is ordered by a licensed health care provider acting within the scope of his or her license. Every plan shall have the right to conduct a utilization review to determine medical necessity prior to authorizing these services.

(b) Notwithstanding subdivision (a), on and after July 1, 2007, the amount of the benefit for orthotic and prosthetic devices and services shall be no less than the annual and lifetime benefit maximums applicable to the basic health care services required to be provided under Section 1367. If the contract does not include any annual or lifetime benefit maximums applicable to basic health care services, the amount of the benefit for orthotic and prosthetic devices and services shall not be subject to an annual or lifetime maximum benefit level. Any copayment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for orthotic and prosthetic devices and services shall be no more than the most common amounts applied to the basic health care services required to be provided under Section 1367.

HISTORY:
Added Stats 1985 ch 73 § 1, as H & S C § 1367.4. Renumbered Stats 1988 ch 160 § 87. Amended Stats 1991 ch 330 § 1 (AB 2234); Stats 2006 ch 756 § 1 (AB 2012), effective January 1, 2007.

§ 1367.19. Coverage for special footwear for those suffering from foot disfigurement

On and after January 1, 1991, every health care service plan, except a specialized health care service plan, that covers hospital, medical, or surgical expenses on a group basis shall offer coverage as an option for special footwear needed by persons who suffer from foot disfigurement under such terms and conditions as may be agreed upon between the group contract holder and the plan.

As used in this section, foot disfigurement shall include, but not be limited to, disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes, and foot disfigurement caused by accident or developmental disability.

HISTORY:
Added Stats 1990 ch 1680 § 1 (AB 1311).

§ 1367.20. Provision of list of prescription drugs on plan's formulary

Every health care service plan that provides prescription drug benefits and maintains one or more drug formularies shall provide to members of the public, upon request, a copy of the most current list of prescription drugs on the formulary of the plan by major therapeutic category, with an indication of

whether any drugs on the list are preferred over other listed drugs. If the health care service plan maintains more than one formulary, the plan shall notify the requester that a choice of formulary lists is available.

HISTORY:
Added Stats 1998 ch 69 § 1 (SB 625), effective January 1, 1999.

§ 1367.205. Formularies to be posted on Internet Web site; Required updates; Template

(a) In addition to the list required to be provided under Section 1367.20, a health care service plan that provides prescription drug benefits and maintains one or more drug formularies shall do all of the following:

(1) Post the formulary or formularies for each product offered by the plan on the plan's Internet Web site in a manner that is accessible and searchable by potential enrollees, enrollees, providers, the general public, the department, and federal agencies as required by federal law or regulations.

(2) Update the formularies posted pursuant to paragraph (1) with any change to those formularies on a monthly basis.

(3) No later than six months after the date that a standard formulary template is developed under subdivision (b), use that template to display the formulary or formularies for each product offered by the plan.

(b)(1) By January 1, 2017, the department and the Department of Insurance shall jointly, and with input from interested parties from at least one public meeting, develop a standard formulary template for purposes of paragraph (3) of subdivision (a). In developing the template, the department and Department of Insurance shall take into consideration existing requirements for reporting of formulary information established by the federal Centers for Medicare and Medicaid Services. To the extent feasible, in developing the template, the department and the Department of Insurance shall evaluate a way to include on the template, in addition to the information required to be included under paragraph (2), cost-sharing information for drugs subject to coinsurance.

(2) The standard formulary template shall include the notification described in subdivision (c) of Section 1363.01, and as applied to a particular formulary for a product offered by a plan, shall do all of the following:

(A) Include information on cost-sharing tiers and utilization controls, including prior authorization or step therapy requirements, for each drug covered by the product.

(B) Indicate any drugs on the formulary that are preferred over other drugs on the formulary.

(C) Include information to educate enrollees about the differences between drugs administered or provided under a health care service plan's medical benefit and drugs prescribed under a health care service plan's prescription drug benefit and about how to obtain coverage information regarding drugs that are not covered under the plan's prescription drug benefit.

(D) Include information to educate enrollees that health care service plans that provide prescription drug benefits are required to have a

method for enrollees to obtain prescription drugs not listed in the health plan drug formulary if the drugs are deemed medically necessary by a clinician pursuant to Section 1367.24.

(E) Include information on which medications are covered, including both generic and brand name.

(F) Include information on what tier of the plan's drug formulary each medication is in.

(c) For purposes of this section, "formulary" means the complete list of drugs preferred for use and eligible for coverage under a health care service plan product and includes the drugs covered under the pharmacy benefit of the product.

HISTORY:
Added Stats 2014 ch 575 § 3 (SB 1052), effective January 1, 2015. Amended Stats 2015 ch 619 § 5 (AB 339), effective January 1, 2016.

§ 1367.21. Limitation or exclusion of coverage for drug prescribed for use different from which drug was approved

(a) No health care service plan contract which covers prescription drug benefits shall be issued, amended, delivered, or renewed in this state if the plan limits or excludes coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:

(1) The drug is approved by the FDA.

(2)(A) The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; or

(B) The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the plan formulary. If the drug is not on the plan formulary, the participating subscriber's request shall be considered pursuant to the process required by Section 1367.24.

(3) The drug has been recognized for treatment of that condition by any of the following:

(A) The American Hospital Formulary Service's Drug Information.

(B) One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:

(i) The Elsevier Gold Standard's Clinical Pharmacology.

(ii) The National Comprehensive Cancer Network Drug and Biologics Compendium.

(iii) The Thomson Micromedex DrugDex.

(C) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

(b) It shall be the responsibility of the participating prescriber to submit to the plan documentation supporting compliance with the requirements of subdivision (a), if requested by the plan.

(c) Any coverage required by this section shall also include medically necessary services associated with the administration of a drug, subject to the conditions of the contract.

(d) For purposes of this section, "life-threatening" means either or both of the following:

(1) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(2) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

(e) For purposes of this section, "chronic and seriously debilitating" means diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

(f) The provision of drugs and services when required by this section shall not, in itself, give rise to liability on the part of the plan.

(g) Nothing in this section shall be construed to prohibit the use of a formulary, copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA.

(h) If a plan denies coverage pursuant to this section on the basis that its use is experimental or investigational, that decision is subject to review under Section 1370.4.

(i) Health care service plan contracts for the delivery of Medi-Cal services under the Waxman-Duffy Prepaid Health Plan Act (Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code) are exempt from the requirements of this section.

HISTORY:
Added Stats 1992 ch 1268 § 2 (AB 1985). Amended Stats 2000 ch 852 § 1 (SB 2046); Stats 2009 ch 479 § 1 (AB 830), effective January 1, 2010.

§ 1367.215. Coverage of pain management medications for terminally ill patients

(a) Every health care service plan contract that covers prescription drug benefits shall provide coverage for appropriately prescribed pain management medications for terminally ill patients when medically necessary. The plan shall approve or deny the request by the provider for authorization of coverage for an enrollee who has been determined to be terminally ill in a timely fashion, appropriate for the nature of the enrollee's condition, not to exceed 72 hours of the plan's receipt of the information requested by the plan to make the decision. If the request is denied or if additional information is required, the plan shall contact the provider within one working day of the determination, with an explanation of the reason for the denial or the need for additional information. The requested treatment shall be deemed authorized as of the expiration of the applicable timeframe. The provider shall contact the plan within one business day of proceeding with the deemed authorized treatment, to do all of the following:

(1) Confirm that the timeframe has expired.

(2) Provide enrollee identification.

(3) Notify the plan of the provider or providers performing the treatment.

(4) Notify the plan of the facility or location where the treatment was rendered.

(b) This section does not apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration. Coverage for different-use drugs is subject to Section 1367.21.

(c) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.

HISTORY:
Added Stats 1998 ch 984 § 3 (AB 2305).
Amended Stats 2002 ch 791 § 2 (SB 842).

§ 1367.22. Plan's obligations relating to drug previously approved for enrollee's medical condition

(a) A health care service plan contract, issued, amended, or renewed on or after July 1, 1999, that covers prescription drug benefits shall not limit or exclude coverage for a drug for an enrollee if the drug previously had been approved for coverage by the plan for a medical condition of the enrollee and the plan's prescribing provider continues to prescribe the drug for the medical condition, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition. Nothing in this section shall preclude the prescribing provider from prescribing another drug covered by the plan that is medically appropriate for the enrollee, nor shall anything in this section be construed to prohibit generic drug substitutions as authorized by Section 4073 of the Business and Professions Code. For purposes of this section, a prescribing provider shall include a provider authorized to write a prescription, pursuant to subdivision (a) of Section 4059 of the Business and Professions Code, to treat a medical condition of an enrollee.

(b) This section does not apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration. Coverage for different-use drugs is subject to Section 1367.21.

(c) This section shall not be construed to restrict or impair the application of any other provision of this chapter, including, but not limited to, Section 1367, which includes among its requirements that plans furnish services in a manner providing continuity of care and demonstrate that medical decisions are rendered by qualified medical providers unhindered by fiscal and administrative management.

(d) This section does not prohibit a health care service plan from charging a subscriber or enrollee a copayment or a deductible for prescription drug benefits or from setting forth, by contract, limitations on maximum coverage of prescription drug benefits, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

HISTORY:
Added Stats 1998 ch 68 § 3 (AB 974).
Amended Stats 2002 ch 760 § 2 (AB 3048).

§ 1367.23. Plan provision requiring notification of group contractholders and subscribers of cancellation

(a) On and after January 1, 1994, every group health care service plan contract, which is issued, amended, or renewed, shall include a provision requiring the health care service plan to notify the group contractholders in writing of the cancellation of the plan contract and shall include in their contract with group contractholders a provision requiring the group contractholder to mail promptly to each subscriber a legible, true copy of any notice of cancellation of the plan contract which may be received from the plan and to provide promptly to the plan proof of that mailing and the date thereof.

(b) The notice of cancellation from the group contractholder to the subscriber required by subdivision (a) shall include information regarding the conversion rights of persons covered under the plan contract upon termination of the plan contract. This information shall be in clear and easily understandable language.

HISTORY:
Added Stats 1993 ch 1154 § 1 (AB 1834).

§ 1367.24. Process for authorization of medically necessary nonformulary prescription drug; Required recordkeeping by plan; Review of plan's provision of prescription drug benefits

(a) Every health care service plan that provides prescription drug benefits shall maintain an expeditious process by which prescribing providers may obtain authorization for a medically necessary nonformulary prescription drug. On or before July 1, 1999, every health care service plan that provides prescription drug benefits shall file with the department a description of its process, including timelines, for responding to authorization requests for nonformulary drugs. Any changes to this process shall be filed with the department pursuant to Section 1352. Each plan shall provide a written description of its most current process, including timelines, to its prescribing providers. For purposes of this section, a prescribing provider shall include a provider authorized to write a prescription, pursuant to subdivision (a) of Section 4040 of the Business and Professions Code, to treat a medical condition of an enrollee.

(b) Any plan that disapproves a request made pursuant to subdivision (a) by a prescribing provider to obtain authorization for a nonformulary drug shall provide the reasons for the disapproval in a notice provided to the enrollee. The notice shall indicate that the enrollee may file a grievance with the plan if the enrollee objects to the disapproval, including any alternative drug or treatment offered by the plan. The notice shall comply with subdivision (b) of Section 1368.02. Any health plan that is required to maintain an external exception request review process pursuant to subdivision (k) shall indicate in the notice required under this subdivision that the enrollee may file a grievance seeking an external exception request review.

(c) The process described in subdivision (a) by which prescribing providers

may obtain authorization for medically necessary nonformulary drugs shall not apply to a nonformulary drug that has been prescribed for an enrollee in conformance with the provisions of Section 1367.22.

(d) The process described in subdivision (a) by which enrollees may obtain medically necessary nonformulary drugs, including specified timelines for responding to prescribing provider authorization requests, shall be described in evidence of coverage and disclosure forms, as required by subdivision (a) of Section 1363, issued on or after July 1, 1999.

(e) Every health care service plan that provides prescription drug benefits shall maintain, as part of its books and records under Section 1381, all of the following information, which shall be made available to the director upon request:

(1) The complete drug formulary or formularies of the plan, if the plan maintains a formulary, including a list of the prescription drugs on the formulary of the plan by major therapeutic category with an indication of whether any drugs are preferred over other drugs.

(2) Records developed by the pharmacy and therapeutic committee of the plan, or by others responsible for developing, modifying, and overseeing formularies, including medical groups, individual practice associations, and contracting pharmaceutical benefit management companies, used to guide the drugs prescribed for the enrollees of the plan, that fully describe the reasoning behind formulary decisions.

(3) Any plan arrangements with prescribing providers, medical groups, individual practice associations, pharmacists, contracting pharmaceutical benefit management companies, or other entities that are associated with activities of the plan to encourage formulary compliance or otherwise manage prescription drug benefits.

(f) If a plan provides prescription drug benefits, the department shall, as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, review the performance of the plan in providing those benefits, including, but not limited to, a review of the procedures and information maintained pursuant to this section, and describe the performance of the plan as part of its report issued pursuant to Section 1380.

(g) The director shall not publicly disclose any information reviewed pursuant to this section that is determined by the director to be confidential pursuant to state law.

(h) For purposes of this section, "authorization" means approval by the health care service plan to provide payment for the prescription drug.

(i) Nonformulary prescription drugs shall include any drug for which an enrollee's copayment or out-of-pocket costs are different than the copayment for a formulary prescription drug, except as otherwise provided by law or regulation or in cases in which the drug has been excluded in the plan contract pursuant to Section 1342.7.

(j) Nothing in this section shall be construed to restrict or impair the application of any other provision of this chapter, including, but not limited to, Section 1367, which includes among its requirements that a health care service plan furnish services in a manner providing continuity of care and demonstrate that medical decisions are rendered by qualified medical providers unhindered by fiscal and administrative management.

(k) For any individual, small group, or large health plan contracts, a health care service plan's process described in subdivision (a) shall comply with the request for exception and external exception request review processes described in subdivision (c) of Section 156.122 of Title 45 of the Code of Federal Regulations. This subdivision shall not apply to Medi-Cal managed care health care service plan contracts as described in subdivision (l).

(*l*) "Medi-Cal managed care health care service plan contract" means any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(m) Nothing in this section shall be construed to affect an enrollee's or subscriber's eligibility to submit a grievance to the department for review under Section 1368 or to apply to the department for an independent medical review under Section 1370.4, or Article 5.55 (commencing with Section 1374.30) of this chapter.

HISTORY:
Added Stats 1998 ch 69 § 2 (SB 625). Amended Stats 1999 ch 83 § 100 (SB 966), ch 525 § 101 (AB 78), operative July 1, 2000; Stats 2002 ch 791 § 3 (SB 842); Stats 2015 ch 654 § 1 (SB 282), effective January 1, 2016.

§ 1367.241. Prior authorization for prescription drugs

(a) Notwithstanding any other law, on and after January 1, 2013, a health care service plan that provides coverage for prescription drugs shall accept only the prior authorization form developed pursuant to subdivision (c), or an electronic prior authorization process described in subdivision (e), when requiring prior authorization for prescription drugs. This section does not apply in the event that a physician or physician group has been delegated the financial risk for prescription drugs by a health care service plan and does not use a prior authorization process. This section does not apply to a health care service plan, or to its affiliated providers, if the health care service plan owns and operates its pharmacies and does not use a prior authorization process for prescription drugs.

(b) If a health care service plan or a contracted physician group fails to respond within 72 hours for nonurgent requests, and within 24 hours if exigent circumstances exist, upon receipt of a completed prior authorization request from a prescribing provider, the prior authorization request shall be deemed to have been granted. The requirements of this subdivision shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code. Medi-Cal managed care health care service plans that contract under those chapters shall not be required to maintain an external exception request review as provided in Section 156.122 of Title 45 of the Code of Federal Regulations.

(c) On or before January 1, 2017, the department and the Department of Insurance shall jointly develop a uniform prior authorization form. Notwithstanding any other law, on and after July 1, 2017, or six months after the form is completed pursuant to this section, whichever is later, every prescribing provider shall use that uniform prior authorization form, or an electronic prior

authorization process described in subdivision (e), to request prior authorization for coverage of prescription drugs and every health care service plan shall accept that form or electronic process as sufficient to request prior authorization for prescription drugs.

(d) The prior authorization form developed pursuant to subdivision (c) shall meet the following criteria:

(1) The form shall not exceed two pages.

(2) The form shall be made electronically available by the department and the health care service plan.

(3) The completed form may also be electronically submitted from the prescribing provider to the health care service plan.

(4) The department and the Department of Insurance shall develop the form with input from interested parties from at least one public meeting.

(5) The department and the Department of Insurance, in development of the standardized form, shall take into consideration the following:

(A) Existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

(B) National standards pertaining to electronic prior authorization.

(e) A prescribing provider may use an electronic prior authorization system utilizing the standardized form described in subdivision (c) or an electronic process developed specifically for transmitting prior authorization information that meets the National Council for Prescription Drug Programs' SCRIPT standard for electronic prior authorization transactions.

(f) Subdivision (a) does not apply if any of the following occurs:

(1) A contracted physician group is delegated the financial risk for prescription drugs by a health care service plan.

(2) A contracted physician group uses its own internal prior authorization process rather than the health care service plan's prior authorization process for plan enrollees.

(3) A contracted physician group is delegated a utilization management function by the health care service plan concerning any prescription drug, regardless of the delegation of financial risk.

(g) For prescription drugs, prior authorization requirements described in subdivisions (c) and (e) apply regardless of how that benefit is classified under the terms of the health plan's group or individual contract.

(h) For purposes of this section:

(1) "Prescribing provider" shall include a provider authorized to write a prescription, pursuant to subdivision (a) of Section 4040 of the Business and Professions Code, to treat a medical condition of an enrollee.

(2) "Exigent circumstances" exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

(3) "Completed prior authorization request" means a completed uniform prior authorization form developed pursuant to subdivision (c), or a completed request submitted using an electronic prior authorization system described in subdivision (e), or, for contracted physician groups described in subdivision (f), the process used by the contracted physician group.

HISTORY:
Added Stats 2011 ch 648 § 1 (SB 866), effective January 1, 2012. Amended Stats 2012 ch 162 § 81 (SB 1171), effective January 1, 2013; Stats 2015 ch 654 § 2 (SB 282), effective January 1, 2016.

§ 1367.243. Prescription drug reporting requirements for health service plans reporting rate information; Legislative report on drug cost impact on health care premiums

(a)(1) A health care service plan that reports rate information pursuant to Section 1385.03 or 1385.045 shall report the information described in paragraph (2) to the department no later than October 1 of each year, beginning October 1, 2018.

(2) For all covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be reported:

(A) The 25 most frequently prescribed drugs.

(B) The 25 most costly drugs by total annual plan spending.

(C) The 25 drugs with the highest year-over-year increase in total annual plan spending.

(b) The department shall compile the information reported pursuant to subdivision (a) into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums. The data in the report shall be aggregated and shall not reveal information specific to individual health care service plans.

(c) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

(d) By January 1 of each year, beginning January 1, 2019, the department shall publish on its Internet Web site the report required pursuant to subdivision (b).

(e) After the report required in subdivision (b) is released, the department shall include the report as part of the public meeting required pursuant to subdivision (b) of Section 1385.045.

(f) Except for the report required pursuant to subdivision (b), the department shall keep confidential all of the information provided to the department pursuant to this section, and the information shall be protected from public disclosure.

HISTORY:
Added Stats 2017 ch 603 § 1 (SB 17), effective January 1, 2018.

§ 1367.244. Request for exception to plan's step therapy process for prescription drugs

(a) A request for an exception to a health care service plan's step therapy process for prescription drugs may be submitted in the same manner as a request for prior authorization for prescription drugs pursuant to Section 1367.241, and shall be treated in the same manner, and shall be responded to

by the health care service plan in the same manner, as a request for prior authorization for prescription drugs.

(b) The department and the Department of Insurance shall include a provision for step therapy exception requests in the uniform prior authorization form developed pursuant to subdivision (c) of Section 1367.241.

HISTORY:
Added Stats 2015 ch 621 § 1 (AB 374), effective January 1, 2016.

§ 1367.25. Contraceptive coverage

(a) A group health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2000, to December 31, 2015, inclusive, and an individual health care service plan contract that is amended, renewed, or delivered on or after January 1, 2000, to December 31, 2015, inclusive, except for a specialized health care service plan contract, shall provide coverage for the following, under general terms and conditions applicable to all benefits:

(1) A health care service plan contract that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal Food and Drug Administration (FDA)-approved prescription contraceptive methods designated by the plan. In the event the patient's participating provider, acting within his or her scope of practice, determines that none of the methods designated by the plan is medically appropriate for the patient's medical or personal history, the plan shall also provide coverage for another FDA-approved, medically appropriate prescription contraceptive method prescribed by the patient's provider.

(2) Benefits for an enrollee under this subdivision shall be the same for an enrollee's covered spouse and covered nonspouse dependents.

(b)(1) A health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2016, shall provide coverage for all of the following services and contraceptive methods for women:

(A) Except as provided in subparagraphs (B) and (C) of paragraph (2), all FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the enrollee's provider.

(B) Voluntary sterilization procedures.

(C) Patient education and counseling on contraception.

(D) Followup services related to the drugs, devices, products, and procedures covered under this subdivision, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(2)(A) Except for a grandfathered health plan, a health care service plan subject to this subdivision shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this subdivision. Cost sharing shall not be imposed on any Medi-Cal beneficiary.

(B) If the FDA has approved one or more therapeutic equivalents of a

contraceptive drug, device, or product, a health care service plan is not required to cover all of those therapeutically equivalent versions in accordance with this subdivision, as long as at least one is covered without cost sharing in accordance with this subdivision.

(C) If a covered therapeutic equivalent of a drug, device, or product is not available, or is deemed medically inadvisable by the enrollee's provider, a health care service plan shall provide coverage, subject to a plan's utilization management procedures, for the prescribed contraceptive drug, device, or product without cost sharing. Any request by a contracting provider shall be responded to by the health care service plan in compliance with the Knox-Keene Health Care Service Plan Act of 1975, as set forth in this chapter and, as applicable, with the plan's Medi-Cal managed care contract.

(3) Except as otherwise authorized under this section, a health care service plan shall not impose any restrictions or delays on the coverage required under this subdivision.

(4) Benefits for an enrollee under this subdivision shall be the same for an enrollee's covered spouse and covered nonspouse dependents.

(5) For purposes of paragraphs (2) and (3) of this subdivision, and subdivision (d), "health care service plan" shall include Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(c) Notwithstanding any other provision of this section, a religious employer may request a health care service plan contract without coverage for FDA-approved contraceptive methods that are contrary to the religious employer's religious tenets. If so requested, a health care service plan contract shall be provided without coverage for contraceptive methods.

(1) For purposes of this section, a "religious employer" is an entity for which each of the following is true:

(A) The inculcation of religious values is the purpose of the entity.

(B) The entity primarily employs persons who share the religious tenets of the entity.

(C) The entity serves primarily persons who share the religious tenets of the entity.

(D) The entity is a nonprofit organization as described in Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(2) Every religious employer that invokes the exemption provided under this section shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the contraceptive health care services the employer refuses to cover for religious reasons.

(d)(1) Every health care service plan contract that is issued, amended, renewed, or delivered on or after January 1, 2017, shall cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time for an enrollee by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

(2) Nothing in this subdivision shall be construed to require a health care service plan contract to cover contraceptives provided by an out-of-network

provider, pharmacy, or location licensed or otherwise authorized to dispense drugs or supplies, except as may be otherwise authorized by state or federal law or by the plan's policies governing out-of-network coverage.

(3) Nothing in this subdivision shall be construed to require a provider to prescribe, furnish, or dispense 12 months of self-administered hormonal contraceptives at one time.

(4) A health care service plan subject to this subdivision, in the absence of clinical contraindications, shall not impose utilization controls or other forms of medical management limiting the supply of FDA-approved, self-administered hormonal contraceptives that may be dispensed or furnished by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies to an amount that is less than a 12-month supply.

(e) This section shall not be construed to exclude coverage for contraceptive supplies as prescribed by a provider, acting within his or her scope of practice, for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for contraception that is necessary to preserve the life or health of an enrollee.

(f) This section shall not be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for contraceptive drugs, devices, and products.

(g) This section shall not be construed to require an individual or group health care service plan contract to cover experimental or investigational treatments.

(h) For purposes of this section, the following definitions apply:

(1) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.

(2) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(3) With respect to health care service plan contracts issued, amended, or renewed on or after January 1, 2016, "provider" means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or an initiative act referred to in that division, or Division 2.5 (commencing with Section 1797) of this code.

HISTORY:

Added Stats 1999 ch 532 § 2 (AB 39). Amended Stats 2000 ch 857 § 32 (AB 2903); Stats 2002 ch 791 § 4 (SB 842); Stats 2014 ch 576 § 2 (SB 1053), effective January 1, 2015; Stats 2015 ch 303 § 255 (AB 731), effective January 1, 2016; Stats 2016 ch 499 § 3 (SB 999).

§ 1367.26. [Section repealed 2016.]

HISTORY:

Added Stats 2001 ch 817 § 3 (AB 938), operative July 1, 2002. Amended Stats 2011 ch 381 § 29 (SB 146), effective January 1, 2012. Repealed Stats 2015 ch 649 § 1 (SB 137), effective January 1, 2016. The repealed section related to contracting providers available on request.

§ 1367.27. Provider directory

(a) Commencing July 1, 2016, a health care service plan shall publish and

maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrollees, including those that accept new patients. A provider directory shall not list or include information on a provider that is not currently under contract with the plan.

(b) A health care service plan shall provide the directory or directories for the specific network offered for each product using a consistent method of network and product naming, numbering, or other classification method that ensures the public, enrollees, potential enrollees, the department, and other state or federal agencies can easily identify the networks and plan products in which a provider participates. By July 31, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, a health care service plan shall use the naming, numbering, or classification method developed by the department pursuant to subdivision (k).

(c)(1) An online provider directory or directories shall be available on the plan's Internet Web site to the public, potential enrollees, enrollees, and providers without any restrictions or limitations. The directory or directories shall be accessible without any requirement that an individual seeking the directory information demonstrate coverage with the plan, indicate interest in obtaining coverage with the plan, provide a member identification or policy number, provide any other identifying information, or create or access an account.

(2) The online provider directory or directories shall be accessible on the plan's public Internet Web site through an identifiable link or tab and in a manner that is accessible and searchable by enrollees, potential enrollees, the public, and providers. By July 31, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, the plan's public Internet Web site shall allow provider searches by, at a minimum, name, practice address, city, ZIP Code, California license number, National Provider Identifier number, admitting privileges to an identified hospital, product, tier, provider language or languages, provider group, hospital name, facility name, or clinic name, as appropriate.

(d)(1) A health care service plan shall allow enrollees, potential enrollees, providers, and members of the public to request a printed copy of the provider directory or directories by contacting the plan through the plan's toll-free telephone number, electronically, or in writing. A printed copy of the provider directory or directories shall include the information required in subdivisions (h) and (i). The printed copy of the provider directory or directories shall be provided to the requester by mail postmarked no later than five business days following the date of the request and may be limited to the geographic region in which the requester resides or works or intends to reside or work.

(2) A health care service plan shall update its printed provider directory or directories at least quarterly, or more frequently, if required by federal law.

(e)(1) The plan shall update the online provider directory or directories, at least weekly, or more frequently, if required by federal law, when informed of and upon confirmation by the plan of any of the following:

(A) A contracting provider is no longer accepting new patients for that product, or an individual provider within a provider group is no longer accepting new patients.

(B) A provider is no longer under contract for a particular plan product.

(C) A provider's practice location or other information required under subdivision (h) or (i) has changed.

(D) Upon completion of the investigation described in subdivision (o), a change is necessary based on an enrollee complaint that a provider was not accepting new patients, was otherwise not available, or whose contact information was listed incorrectly.

(E) Any other information that affects the content or accuracy of the provider directory or directories.

(2) Upon confirmation of any of the following, the plan shall delete a provider from the directory or directories when:

(A) A provider has retired or otherwise has ceased to practice.

(B) A provider or provider group is no longer under contract with the plan for any reason.

(C) The contracting provider group has informed the plan that the provider is no longer associated with the provider group and is no longer under contract with the plan.

(f) The provider directory or directories shall include both an email address and a telephone number for members of the public and providers to notify the plan if the provider directory information appears to be inaccurate. This information shall be disclosed prominently in the directory or directories and on the plan's Internet Web site.

(g) The provider directory or directories shall include the following disclosures informing enrollees that they are entitled to both of the following:

(1) Language interpreter services, at no cost to the enrollee, including how to obtain interpretation services in accordance with Section 1367.04.

(2) Full and equal access to covered services, including enrollees with disabilities as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

(h) A full service health care service plan and a specialized mental health plan shall include all of the following information in the provider directory or directories:

(1) The provider's name, practice location or locations, and contact information.

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license.

(5) The area of specialty, including board certification, if any.

(6) The provider's office email address, if available.

(7) The name of each affiliated provider group currently under contract with the plan through which the provider sees enrollees.

(8) A listing for each of the following providers that are under contract with the plan:

(A) For physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with the plan.

(B) Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, as defined in Section 1374.73, nurse midwives, and dentists.

(C) For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.

(D) For any provider described in subparagraph (A) or (B) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with the plan, the name of the provider, and the name of the federally qualified health center or clinic.

(E) Facilities, including, but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, and inpatient rehabilitation facilities.

(F) Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.

(9) The provider directory or directories may note that authorization or referral may be required to access some providers.

(10) Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 1367.04, if any, on the provider's staff.

(11) Identification of providers who no longer accept new patients for some or all of the plan's products.

(12) The network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable. Nothing in this section shall be construed to require the use of network tiers other than contract and noncontracting tiers.

(13) All other information necessary to conduct a search pursuant to paragraph (2) of subdivision (c).

(i) A vision, dental, or other specialized health care service plan, except for a specialized mental health plan, shall include all of the following information for each provider directory or directories used by the plan for its networks:

(1) The provider's name, practice location or locations, and contact information.

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license, if applicable.

(5) The area of specialty, including board certification, or other accreditation, if any.

(6) The provider's office email address, if available.

(7) The name of each affiliated provider group or specialty plan practice group currently under contract with the plan through which the provider sees enrollees.

(8) The names of each allied health care professional to the extent there is a direct contract for those services covered through a contract with the plan.

(9) The non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 1367.04, if any, on the provider's staff.

(10) Identification of providers who no longer accept new patients for some or all of the plan's products.

(11) All other applicable information necessary to conduct a provider search pursuant to paragraph (2) of subdivision (c).

(j)(1) The contract between the plan and a provider shall include a requirement that the provider inform the plan within five business days when either of the following occurs:

(A) The provider is not accepting new patients.

(B) If the provider had previously not accepted new patients, the provider is currently accepting new patients.

(2) If a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider shall direct the enrollee or potential enrollee to both the plan for additional assistance in finding a provider and to the department to report any inaccuracy with the plan's directory or directories.

(3) If an enrollee or potential enrollee informs a plan of a possible inaccuracy in the provider directory or directories, the plan shall promptly investigate, and, if necessary, undertake corrective action within 30 business days to ensure the accuracy of the directory or directories.

(k)(1) On or before December 31, 2016, the department shall develop uniform provider directory standards to permit consistency in accordance with subdivision (b) and paragraph (2) of subdivision (c) and development of a multiplan directory by another entity. Those standards shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2021. No more than two revisions of those standards shall be exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) pursuant to this subdivision.

(2) In developing the standards under this subdivision, the department shall seek input from interested parties throughout the process of developing the standards and shall hold at least one public meeting. The department shall take into consideration any requirements for provider directories established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

(3) By July 31, 2017, or 12 months after the date provider directory standards are developed under this subdivision, whichever occurs later, a plan shall use the standards developed by the department for each product offered by the plan.

(*l*)(1) A plan shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the plan's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire provider directory or directories for each product offered. Each calendar year the plan shall notify all contracted providers described in subdivisions (h) and (i) as follows:

(A) For individual providers who are not affiliated with a provider group described in subparagraph (A) or (B) of paragraph (8) of subdivision (h) and providers described in subdivision (i), the plan shall notify each provider at least once every six months.

(B) For all other providers described in subdivision (h) who are not subject to the requirements of subparagraph (A), the plan shall notify its

contracted providers to ensure that all of the providers are contacted by the plan at least once annually.

(2) The notification shall include all of the following:

(A) The information the plan has in its directory or directories regarding the provider or provider group, including a list of networks and plan products that include the contracted provider or provider group.

(B) A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subdivision (p).

(C) Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface developed pursuant to subdivision (m).

(3) The plan shall require an affirmative response from the provider or provider group acknowledging that the notification was received. The provider or provider group shall confirm that the information in the provider directory or directories is current and accurate or update the information required to be in the directory or directories pursuant to this section, including whether or not the provider or provider group is accepting new patients for each plan product.

(4) If the plan does not receive an affirmative response and confirmation from the provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory or directories pursuant to this section, within 30 business days, the plan shall take no more than 15 business days to verify whether the provider's information is correct or requires updates. The plan shall document the receipt and outcome of each attempt to verify the information. If the plan is unable to verify whether the provider's information is correct or requires updates, the plan shall notify the provider 10 business days in advance of removal that the provider will be removed from the provider directory or directories. The provider shall be removed from the provider directory or directories at the next required update of the provider directory or directories after the 10-business-day notice period. A provider shall not be removed from the provider directory or directories if he or she responds before the end of the 10-business-day notice period.

(5) General acute care hospitals shall be exempt from the requirements in paragraphs (3) and (4).

(m) A plan shall establish policies and procedures with regard to the regular updating of its provider directory or directories, including the weekly, quarterly, and annual updates required pursuant to this section, or more frequently, if required by federal law or guidance.

(1) The policies and procedures described under this subdivision shall be submitted by a plan annually to the department for approval and in a format described by the department pursuant to Section 1367.035.

(2) Every health care service plan shall ensure processes are in place to allow providers to promptly verify or submit changes to the information required to be in the directory or directories pursuant to this section. Those processes shall, at a minimum, include an online interface for providers to submit verification or changes electronically and shall generate an acknowledgment of receipt from the health care service plan. Providers shall verify

or submit changes to information required to be in the directory or directories pursuant to this section using the process required by the health care service plan.

(3) The plan shall establish and maintain a process for enrollees, potential enrollees, other providers, and the public to identify and report possible inaccurate, incomplete, or misleading information currently listed in the plan's provider directory or directories. This process shall, at a minimum, include a telephone number and a dedicated email address at which the plan will accept these reports, as well as a hyperlink on the plan's provider directory Internet Web site linking to a form where the information can be reported directly to the plan through its Internet Web site.

(n)(1) This section does not prohibit a plan from requiring its provider groups or contracting specialized health care service plans to provide information to the plan that is required by the plan to satisfy the requirements of this section for each of the providers that contract with the provider group or contracting specialized health care service plan. This responsibility shall be specifically documented in a written contract between the plan and the provider group or contracting specialized health care service plan.

(2) If a plan requires its contracting provider groups or contracting specialized health care service plans to provide the plan with information described in paragraph (1), the plan shall continue to retain responsibility for ensuring that the requirements of this section are satisfied.

(3) A provider group may terminate a contract with a provider for a pattern or repeated failure of the provider to update the information required to be in the directory or directories pursuant to this section.

(4) A provider group is not subject to the payment delay described in subdivision (p) if all of the following occurs:

(A) A provider does not respond to the provider group's attempt to verify the provider's information. As used in this paragraph, "verify" means to contact the provider in writing, electronically, and by telephone to confirm whether the provider's information is correct or requires updates.

(B) The provider group documents its efforts to verify the provider's information.

(C) The provider group reports to the plan that the provider should be deleted from the provider group in the plan directory or directories.

(5) Section 1375.7, known as the Health Care Providers' Bill of Rights, applies to any material change to a provider contract pursuant to this section.

(o)(1) Whenever a health care service plan receives a report indicating that information listed in its provider directory or directories is inaccurate, the plan shall promptly investigate the reported inaccuracy and, no later than 30 business days following receipt of the report, either verify the accuracy of the information or update the information in its provider directory or directories, as applicable.

(2) When investigating a report regarding its provider directory or directories, the plan shall, at a minimum, do the following:

(A) Contact the affected provider no later than five business days following receipt of the report.

(B) Document the receipt and outcome of each report. The documentation shall include the provider's name, location, and a description of the

plan's investigation, the outcome of the investigation, and any changes or updates made to its provider directory or directories.

(C) If changes to a plan's provider directory or directories are required as a result of the plan's investigation, the changes to the online provider directory or directories shall be made no later than the next scheduled weekly update, or the update immediately following that update, or sooner if required by federal law or regulations. For printed provider directories, the change shall be made no later than the next required update, or sooner if required by federal law or regulations.

(p)(1) Notwithstanding Sections 1371 and 1371.35, a plan may delay payment or reimbursement owed to a provider or provider group as specified in subparagraph (A) or (B), if the provider or provider group fails to respond to the plan's attempts to verify the provider's or provider group's information as required under subdivision (*l*). The plan shall not delay payment unless it has attempted to verify the provider's or provider group's information. As used in this subdivision, "verify" means to contact the provider or provider group in writing, electronically, and by telephone to confirm whether the provider's or provider group's information is correct or requires updates. A plan may seek to delay payment or reimbursement owed to a provider or provider group only after the 10-business day notice period described in paragraph (4) of subdivision (*l*) has lapsed.

(A) For a provider or provider group that receives compensation on a capitated or prepaid basis, the plan may delay no more than 50 percent of the next scheduled capitation payment for up to one calendar month.

(B) For any claims payment made to a provider or provider group, the plan may delay the claims payment for up to one calendar month beginning on the first day of the following month.

(2) A plan shall notify the provider or provider group 10 business days before it seeks to delay payment or reimbursement to a provider or provider group pursuant to this subdivision. If the plan delays a payment or reimbursement pursuant to this subdivision, the plan shall reimburse the full amount of any payment or reimbursement subject to delay to the provider or provider group according to either of the following timelines, as applicable:

(A) No later than three business days following the date on which the plan receives the information required to be submitted by the provider or provider group pursuant to subdivision (*l*).

(B) At the end of the one-calendar month delay described in subparagraph (A) or (B) of paragraph (1), as applicable, if the provider or provider group fails to provide the information required to be submitted to the plan pursuant to subdivision (*l*).

(3) A plan may terminate a contract for a pattern or repeated failure of the provider or provider group to alert the plan to a change in the information required to be in the directory or directories pursuant to this section.

(4) A plan that delays payment or reimbursement under this subdivision shall document each instance a payment or reimbursement was delayed and report this information to the department in a format described by the department pursuant to Section 1367.035. This information shall be submitted along with the policies and procedures required to be submitted annually to the department pursuant to paragraph (1) of subdivision (m).

(5) With respect to plans with Medi-Cal managed care contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of the Welfare and Institutions Code, this subdivision shall be implemented only to the extent consistent with federal law and guidance.

(q) In circumstances where the department finds that an enrollee reasonably relied upon materially inaccurate, incomplete, or misleading information contained in a health plan's provider directory or directories, the department may require the health plan to provide coverage for all covered health care services provided to the enrollee and to reimburse the enrollee for any amount beyond what the enrollee would have paid, had the services been delivered by an in-network provider under the enrollee's plan contract. Prior to requiring reimbursement in these circumstances, the department shall conclude that the services received by the enrollee were covered services under the enrollee's plan contract. In those circumstances, the fact that the services were rendered or delivered by a noncontracting or out-of-plan provider shall not be used as a basis to deny reimbursement to the enrollee.

(r) Whenever a plan determines as a result of this section that there has been a 10 percent change in the network for a product in a region, the plan shall file an amendment to the plan application with the department consistent with subdivision (f) of Section 1300.52 of Title 28 of the California Code of Regulations.

(s) This section applies to plans with Medi-Cal managed care contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of the Welfare and Institutions Code to the extent consistent with federal law and guidance and state law guidance issued after January 1, 2016. Notwithstanding any other provision to the contrary in a plan contract with the State Department of Health Care Services, and to the extent consistent with federal law and guidance and state guidance issued after January 1, 2016, a Medi-Cal managed care plan that complies with the requirements of this section shall not be required to distribute a printed provider directory or directories, except as required by paragraph (1) of subdivision (d).

(t) A health plan that contracts with multiple employer welfare agreements regulated pursuant to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 of the Insurance Code shall meet the requirements of this section.

(u) This section shall not be construed to alter a provider's obligation to provide health care services to an enrollee pursuant to the provider's contract with the plan.

(v) As part of the department's routine examination of the fiscal and administrative affairs of a health care service plan pursuant to Section 1382, the department shall include a review of the health care service plan's compliance with subdivision (p).

(w) For purposes of this section, "provider group" means a medical group, independent practice association, or other similar group of providers.

HISTORY:
Added Stats 2015 ch 649 § 2 (SB 137), effective January 1, 2016. Amended Stats 2016 ch 86 § 178 (SB 1171), effective January 1, 2017.

§ 1367.29. Issuance of identification card to assist enrollee with accessing health benefits coverage information; Contents of identification card

(a) On and after July 1, 2011, in accordance with subdivision (b), a health care service plan that provides coverage for professional mental health services, including a specialized health care service plan that provides coverage for professional mental health services, shall issue an identification card to an enrollee in order to assist the enrollee with accessing health benefits coverage information, including, but not limited to, in-network provider access information, and claims processing purposes. The identification card, at a minimum, shall include all of the following information:

(1) The name of the health care service plan issuing the identification card.

(2) The enrollee's identification number.

(3) A telephone number that enrollees or providers may call for assistance with health benefits coverage information, in-network provider access information, and claims processing information, and if assessment services are provided by the health care service plan, access to assessment services for the purpose of referral to an appropriate level of care or an appropriate health care provider.

(4) The health care service plan's Internet Web site address.

(b) The identification card required by this section shall be issued by a health care service plan or a specialized health care service plan to an enrollee upon enrollment or upon a change in the enrollee's coverage that impacts the data content or format of the card.

(c) This section does not require a health care service plan to issue a separate identification card for professional mental health services coverage if the plan issues a card for health care coverage in general and the card provides the information required by this section.

(d) If a health care service plan or a specialized health care service plan, as described in subdivision (a), delegates responsibility for issuing the identification card to a contractor or an agent, the contractor or agent shall be required to comply with this section.

(e) This section does not prohibit a health care service plan or a specialized health care service plan from meeting the standards of the Workgroup for Electronic Data Interchange (WEDI) or other national uniform standards with respect to identification cards, and a health care service plan shall be deemed compliant with this section if the plan conforms with these standards, as long as the minimum requirements described in subdivision (a) have been met.

(f) For the purposes of this section, "identification card" includes other technology that performs substantially the same function as an identification card.

(g)(1) This section shall not apply to Medicare supplement insurance, employee assistance programs, CHAMPUS supplement insurance, or TRICARE supplement insurance, or to hospital indemnity, accident-only, and specified disease insurance. This section shall also not apply to specialized health care service plans, except behavioral health-only plans.

(2) Notwithstanding paragraph (1), this section shall not apply to a behavioral health-only plan that provides coverage for professional mental health services pursuant to a contract with a health care service plan or insurer if that plan or insurer issues an identification card to its subscribers or insureds pursuant to this section or Section 10123.198 of the Insurance Code.

HISTORY:
Added Stats 2009 ch 575 § 1 (SB 296), effective January 1, 2010. Amended Stats 2018 ch 687 § 1 (SB 910), effective January 1, 2019.

§ 1367.30. Group health care service plan contracts; Applicable law

Notwithstanding any other provision of law, every group health care service plan contract marketed, issued, or delivered to a resident of this state, regardless of the situs of the contract or the subscriber, shall be subject to Section 1374.58.

HISTORY:
Added Stats 2011 ch 722 § 1 (SB 757), effective January 1, 2012.

§ 1367.31. Referral requirement prohibited for receiving reproductive and sexual health care coverage or services

(a) Every health care service plan contract issued, amended, renewed, or delivered on or after January 1, 2017, shall be prohibited from requiring an enrollee to receive a referral prior to receiving coverage or services for reproductive and sexual health care.

(b)(1) For the purposes of this section, "reproductive and sexual health care services" are all reproductive and sexual health services described in Sections 6925, 6926, 6927, and 6928 of the Family Code, or Section 121020 of the Health and Safety Code, obtained by a patient.

(2) For the purposes of this section, "reproductive and sexual health care services" do not include the services subject to a health care service plan's referral procedures as required by subdivisions (a) and (b) of Section 1374.16.

(3) This section applies whether or not the patient is a minor.

(c) In implementing this section, a health care service plan may establish reasonable provisions governing utilization protocols for obtaining reproductive and sexual health care services, as provided for in subdivision (a), from health care providers participating in, or contracting with, the plan network, medical group, or independent practice association, provided that these provisions shall be consistent with the intent of this section and shall be those customarily applied to other health care providers, such as primary care physicians and surgeons, to whom the enrollee has direct access, and shall not be more restrictive for the provision of reproductive and sexual health care services. An enrollee shall not be required to obtain prior approval from another physician, another provider, or the health care service plan prior to obtaining direct access to reproductive and sexual health care services. A health care service plan may establish reasonable provisions governing communication with the enrollee's primary care physician and surgeon regarding the enrollee's condition, treatment, and any need for followup care.

(d) This section shall not apply to a health care service plan contract that does not require enrollees to obtain a referral from their primary care physician prior to seeking covered health care services from a specialist.

(e) A health care service plan shall not impose utilization protocols related to contraceptive drugs, supplies, and devices beyond the provisions outlined in Section 1367.25 of this code or Section 14132 of the Welfare and Institutions Code.

(f) This section shall not apply to specialized health care service plan contracts or any health care service plan that is governed by Section 14131 of the Welfare and Institutions Code.

HISTORY:
Added Stats 2016 ch 495 § 3 (AB 1954), effective January 1, 2017.

§ 1368. Grievance systems

(a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

(2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.

(3) Provide forms for grievances to be given to subscribers and enrollees who wish to register written grievances. The forms used by plans licensed pursuant to Section 1353 shall be approved by the director in advance as to format.

(4)(A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:

(i) That the grievance has been received.

(ii) The date of receipt.

(iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.

(B)(i) Grievances received by telephone, by facsimile, by email, or online through the plan's Internet Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:

(I) The date of the call.

(II) The name of the complainant.

(III) The complainant's member identification number.

(IV) The nature of the grievance.

(V) The nature of the resolution.

(VI) The name of the plan representative who took the call and resolved the grievance.

(ii) For health plan contracts in the individual, small group, or large group markets, a health care service plan's response to grievances subject to Section 1367.24 shall also comply with subdivision (c) of Section 156.122 of Title 45 of the Code of Federal Regulations. This paragraph shall not apply to Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

(6) For grievances involving the cancellation, rescission, or nonrenewal of a health care service plan contract, the health care service plan shall continue to provide coverage to the enrollee or subscriber under the terms of the health care service plan contract until a final determination of the enrollee's or subscriber's request for review has been made by the health care service plan or the director pursuant to Section 1365 and this section. This paragraph shall not apply if the health care service plan cancels or fails to renew the enrollee's or subscriber's health care service plan contract for nonpayment of premiums pursuant to paragraph (1) of subdivision (a) of Section 1365.

(7) Keep in its files all copies of grievances, and the responses thereto, for a period of five years.

(b)(1)(A) After either completing the grievance process described in subdivision (a), or participating in the process for at least 30 days, a subscriber or enrollee may submit the grievance to the department for review. In any case determined by the department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, cancellations, rescissions, or the nonrenewal of a health care service plan contract, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the grievance process or to participate in the process for at least 30 days before submitting a grievance to the department for review.

(B) A grievance may be submitted to the department for review and resolution prior to any arbitration.

(C) Notwithstanding subparagraphs (A) and (B), the department may refer any grievance that does not pertain to compliance with this chapter to the State Department of Public Health, the California Department of Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity for investigation and resolution.

(2) If the subscriber or enrollee is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the subscriber or enrollee, as appropriate, may submit the grievance to the department as the agent of the subscriber or enrollee. Further, a provider may join with, or otherwise assist, a subscriber or enrollee, or the agent, to submit the grievance to the department. In addition, following submission of the grievance to the department, the subscriber or enrollee, or the agent, may authorize the provider to assist, including advocating on behalf of the subscriber or enrollee. For purposes of this section, a "relative" includes the parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the subscriber or enrollee.

(3) The department shall review the written documents submitted with the subscriber's or the enrollee's request for review, or submitted by the agent on behalf of the subscriber or enrollee. The department may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or who are otherwise assisting or advocating on behalf of the subscriber or enrollee. If after reviewing the record, the department concludes that the grievance, in whole or in part, is eligible for review under the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department shall immediately notify the subscriber or enrollee, or agent, of that option and shall, if requested orally or in writing, assist the subscriber or enrollee in participating in the independent medical review system.

(4) If after reviewing the record of a grievance, the department concludes that a health care service eligible for coverage and payment under a health care service plan contract has been delayed, denied, or modified by a plan, or by one of its contracting providers, in whole or in part due to a determination that the service is not medically necessary, and that determination was not communicated to the enrollee in writing along with a notice of the enrollee's potential right to participate in the independent medical review system, as required by this chapter, the director shall, by order, assess administrative penalties. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(5) The department shall send a written notice of the final disposition of the grievance, and the reasons therefor, to the subscriber or enrollee, the agent, to any provider that has joined with or is otherwise assisting the subscriber or enrollee, and to the plan, within 30 calendar days of receipt of the request for review unless the director, in his or her discretion, deter-

mines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. In any case not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department's written notice shall include, at a minimum, the following:

(A) A summary of its findings and the reasons why the department found the plan to be, or not to be, in compliance with any applicable laws, regulations, or orders of the director.

(B) A discussion of the department's contact with any medical provider, or any other independent expert relied on by the department, along with a summary of the views and qualifications of that provider or expert.

(C) If the enrollee's grievance is sustained in whole or in part, information about any corrective action taken.

(6) In any department review of a grievance involving a disputed health care service, as defined in subdivision (b) of Section 1374.30, that is not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), in which the department finds that the plan has delayed, denied, or modified health care services that are medically necessary, based on the specific medical circumstances of the enrollee, and those services are a covered benefit under the terms and conditions of the health care service plan contract, the department's written notice shall do either of the following:

(A) Order the plan to promptly offer and provide those health care services to the enrollee.

(B) Order the plan to promptly reimburse the enrollee for any reasonable costs associated with urgent care or emergency services, or other extraordinary and compelling health care services, when the department finds that the enrollee's decision to secure those services outside of the plan network was reasonable under the circumstances.

The department's order shall be binding on the plan.

(7) Distribution of the written notice shall not be deemed a waiver of any exemption or privilege under existing law, including, but not limited to, Section 6254.5 of the Government Code, for any information in connection with and including the written notice, nor shall any person employed or in any way retained by the department be required to testify as to that information or notice.

(8) The director shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

(9) A subscriber or enrollee, or the agent acting on behalf of a subscriber or enrollee, may also request voluntary mediation with the plan prior to exercising the right to submit a grievance to the department. The use of mediation services shall not preclude the right to submit a grievance to the department upon completion of mediation. In order to initiate mediation, the subscriber or enrollee, or the agent acting on behalf of the subscriber or enrollee, and the plan shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The department shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

(c) The plan's grievance system shall include a system of aging of grievances that are pending and unresolved for 30 days or more. The plan shall provide a quarterly report to the director of grievances pending and unresolved for 30 or more days with separate categories of grievances for Medicare enrollees and Medi-Cal enrollees. The plan shall include with the report a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more. The plan may include the following statement in the quarterly report that is made available to the public by the director:

"Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues of appeal that are not available to other enrollees. Therefore, grievances pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights."

If requested by a plan, the director shall include this statement in a written report made available to the public and prepared by the director that describes or compares grievances that are pending and unresolved with the plan for 30 days or more. Additionally, the director shall, if requested by a plan, append to that written report a brief explanation, provided in writing by the plan, of the reasons why grievances described in that written report are pending and unresolved for 30 days or more. The director shall not be required to include a statement or append a brief explanation to a written report that the director is required to prepare under this chapter, including Sections 1380 and 1397.5.

(d) Subject to subparagraph (C) of paragraph (1) of subdivision (b), the grievance or resolution procedures authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law.

(e) Nothing in this section shall be construed to allow the submission to the department of any provider grievance under this section. However, as part of a provider's duty to advocate for medically appropriate health care for his or her patients pursuant to Sections 510 and 2056 of the Business and Professions Code, nothing in this subdivision shall be construed to prohibit a provider from contacting and informing the department about any concerns he or she has regarding compliance with or enforcement of this chapter.

(f) To the extent required by Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations, there shall be an independent external review pursuant to the standards required by the United States Secretary of Health and Human Services of a health care service plan's cancellation, rescission, or nonrenewal of an enrollee's or subscriber's coverage.

HISTORY:

Added Stats 1999 ch 542 § 2 (SB 189), operative January 1, 2001. Amended Stats 2000 ch 135 § 87 (AB 2539), ch 1067 § 11 (SB 2094) (ch 1067 prevails); Stats 2002 ch 796 § 1 (AB 2085); Stats 2008 ch 607 § 5 (SB 1379), effective September 30, 2008; Stats 2010 ch 658 § 7 (AB 2470), effective January 1, 2011; Stats 2015 ch 654 § 3 (SB 282), effective January 1, 2016.

§ 1368.01. Time period in which to resolve grievances; Expedited review for cases involving serious threat to patient's health

(a) The grievance system shall require the plan to resolve grievances within 30 days, except as provided in subdivision (c).

(b) The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the department of the grievance. The grievance system shall also require the plan to provide enrollees, subscribers, and the department with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance, except as provided in subdivision (c). Paragraph (4) of subdivision (a) of Section 1368 shall not apply to grievances handled pursuant to this section.

(c) A health care service plan contract in the individual, small group, or large group markets that provides coverage for outpatient prescription drugs shall comply with subdivision (c) of Section 156.122 of Title 45 of the Code of Federal Regulations. This subdivision shall not apply to Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

HISTORY:
Added Stats 1995 ch 789 § 2.5 (SB 689). Amended Stats 1999 ch 542 § 3 (SB 189); Stats 2002 ch 796 § 2 (AB 2085); Stats 2015 ch 654 § 4 (SB 282), effective January 1, 2016.

§ 1368.015. Online grievance procedure [Effective until January 1, 2020]

(a) Effective July 1, 2003, every plan with an Internet Web site shall provide an online form through its Internet Web site that subscribers or enrollees can use to file with the plan a grievance, as described in Section 1368, online.

(b) The Internet Web site shall have an easily accessible online grievance submission procedure that shall be accessible through a hyperlink on the Internet Web site's home page or member services portal clearly identified as "GRIEVANCE FORM." All information submitted through this process shall be processed through a secure server.

(c) The online grievance submission process shall be approved by the Department of Managed Health Care and shall meet the following requirements:

(1) It shall utilize an online grievance form in HTML format that allows the user to enter required information directly into the form.

(2) It shall allow the subscriber or enrollee to preview the grievance that will be submitted, including the opportunity to edit the form prior to submittal.

(3) It shall include a current hyperlink to the California Department of Managed Health Care Internet Web site, and shall include a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the following language:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your

health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

The plan shall update the URL, hyperlink, and telephone numbers in this statement as necessary.

(d) A plan that utilizes a hardware system that does not have the minimum system requirements to support the software necessary to meet the requirements of this section is exempt from these requirements until January 1, 2006.

(e) For purposes of this section, the following terms shall have the following meanings:

(1) "Homepage" means the first page or welcome page of an Internet Web site that serves as a starting point for navigation of the Internet Web site.

(2) "HTML" means Hypertext Markup Language, the authoring language used to create documents on the World Wide Web, which defines the structure and layout of a Web document.

(3) "Hyperlink" means a special HTML code that allows text or graphics to serve as a link that, when clicked on, takes a user to another place in the same document, to another document, or to another Internet Web site or Web page.

(4) "Member services portal" means the first page or welcome page of an Internet Web site that can be reached directly by the Internet Web site's homepage and that serves as a starting point for a navigation of member services available on the Internet Web site.

(5) "Secure server" means an Internet connection to an Internet Web site that encrypts and decrypts transmissions, protecting them against third-party tampering and allowing for the secure transfer of data.

(6) "URL" or "Uniform Resource Locator" means the address of an Internet Web site or the location of a resource on the World Wide Web that allows a browser to locate and retrieve the Internet Web site or the resource.

(7) "Internet Web site" means a site or location on the World Wide Web.

(f)(1) Every health care service plan, except a plan that primarily serves Medi-Cal or Healthy Families Program enrollees, shall maintain an Internet Web site. For a health care service plan that provides coverage for professional mental health services, the Internet Web site shall include, but not be limited to, providing information to subscribers, enrollees, and providers

that will assist subscribers and enrollees in accessing mental health services as well as the information described in Section 1368.016.

(2) The provision in paragraph (1) that requires compliance with Section 1368.016 shall not apply to a health care service plan that contracts with a specialized health care service plan, insurer, or other entity to cover professional mental health services for its enrollees, provided that the health care service plan provides a link on its Internet Web site to an Internet Web site operated by the specialized health care service plan, insurer, or other entity with which it contracts, and that plan, insurer, or other entity complies with Section 1368.016.

HISTORY:
Added Stats 2002 ch 796 § 3 (AB 2085). Amended Stats 2003 ch 62 § 178 (SB 600); Stats 2008 ch 722 § 2 (SB 1553), effective January 1, 2009; Stats 2009 ch 575 § 2 (SB 296), effective January 1, 2010.

§ 1368.015. Online grievance procedure [Effective January 1, 2020]

(a) Effective July 1, 2003, every plan with an internet website shall provide an online form through its internet website that subscribers or enrollees can use to file with the plan a grievance, as described in Section 1368, online.

(b) The internet website shall have an easily accessible online grievance submission procedure that shall be accessible through a hyperlink on the internet website's home page or member services portal clearly identified as "GRIEVANCE FORM." All information submitted through this process shall be processed through a secure server.

(c) The online grievance submission process shall be approved by the Department of Managed Health Care and shall meet the following requirements:

(1) It shall utilize an online grievance form in HTML format that allows the user to enter required information directly into the form.

(2) It shall allow the subscriber or enrollee to preview the grievance that will be submitted, including the opportunity to edit the form prior to submittal.

(3) It shall include a current hyperlink to the Department of Managed Health Care internet website, and shall include a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the following language:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature

and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online."

The plan shall update the URL, hyperlink, and telephone numbers in this statement as necessary.

(d) A plan that utilizes a hardware system that does not have the minimum system requirements to support the software necessary to meet the requirements of this section is exempt from these requirements until January 1, 2006.

(e) For purposes of this section, the following terms shall have the following meanings:

(1) "Homepage" means the first page or welcome page of an internet website that serves as a starting point for navigation of the internet website.

(2) "HTML" means Hypertext Markup Language, the authoring language used to create documents on the World Wide Web, which defines the structure and layout of a web document.

(3) "Hyperlink" means a special HTML code that allows text or graphics to serve as a link that, when clicked on, takes a user to another place in the same document, to another document, or to another internet website or page.

(4) "Member services portal" means the first page or welcome page of an internet website that can be reached directly by the internet website's homepage and that serves as a starting point for a navigation of member services available on the internet website.

(5) "Secure server" means an Internet connection to an internet website that encrypts and decrypts transmissions, protecting them against third-party tampering and allowing for the secure transfer of data.

(6) "URL" or "Uniform Resource Locator" means the address of an internet website or the location of a resource on the World Wide Web that allows a browser to locate and retrieve the internet website or the resource.

(7) "Internet website" means a site or location on the World Wide Web.

(f)(1) Every health care service plan, except a plan that primarily serves Medi-Cal or Healthy Families Program enrollees, shall maintain an internet website. For a health care service plan that provides coverage for professional mental health services, the internet website shall include, but not be limited to, providing information to subscribers, enrollees, and providers that will assist subscribers and enrollees in accessing mental health services as well as the information described in Section 1368.016.

(2) The provision in paragraph (1) that requires compliance with Section 1368.016 shall not apply to a health care service plan that contracts with a specialized health care service plan, insurer, or other entity to cover professional mental health services for its enrollees, provided that the health care service plan provides a link on its internet website to an internet website operated by the specialized health care service plan, insurer, or other entity with which it contracts, and that plan, insurer, or other entity complies with Section 1368.016.

HISTORY:
Added Stats 2002 ch 796 § 3 (AB 2085). Amended Stats 2003 ch 62 § 178 (SB 600); Stats 2008 ch 722 § 2 (SB 1553), effective January 1, 2009; Stats 2009 ch 575 § 2 (SB 296), effective January 1, 2010; Stats 2019 ch 113 § 2 (AB 1802), effective January 1, 2020.

§ 1368.016. Establishment of Internet Web site; Link to specified information required; Updates; Applicability of section

(a) A health care service plan that provides coverage for professional mental health services, including a specialized health care service plan that provides coverage for professional mental health services, shall, pursuant to subdivision (f) of Section 1368.015, include on its Internet Web site, or provide a link to, the following information:

(1) A telephone number that the enrollee or provider can call, during normal business hours, for assistance obtaining mental health benefits coverage information, including the extent to which benefits have been exhausted, in-network provider access information, and claims processing information.

(2) A link to prescription drug formularies posted pursuant to Section 1367.205, or instructions on how to obtain the formulary, as described in Section 1367.20.

(3) A detailed summary that describes the process by which the plan reviews and authorizes or approves, modifies, or denies requests for health care services as described in Sections 1363.5 and 1367.01.

(4) Lists of providers or instructions on how to obtain the provider list, as required by Section 1367.27.

(5) A detailed summary of the enrollee grievance process as described in Sections 1368 and 1368.015.

(6) A detailed description of how an enrollee may request continuity of care pursuant to subdivisions (a) and (b) of Section 1373.95.

(7) Information concerning the right, and applicable procedure, of an enrollee to request an independent medical review pursuant to Section 1374.30.

(b) Any modified material described in subdivision (a) shall be updated at least quarterly.

(c) The information described in subdivision (a) may be made available through a secured Internet Web site that is only accessible to enrollees.

(d) The material described in subdivision (a) shall also be made available to enrollees in hard copy upon request.

(e) This article does not preclude a health care service plan from including additional information on its Internet Web site for applicants, enrollees or subscribers, or providers, including, but not limited to, the cost of procedures or services by health care providers in a plan's network.

(f) The department shall include on the department's Internet Web site a link to the Internet Web site of each health care service plan and specialized health care service plan described in subdivision (a).

(g) This section shall not apply to Medicare supplement insurance, employee assistance programs, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, and specified disease insurance. This section shall also not apply to specialized health care service plans, except behavioral health-only plans.

(h) This section shall not apply to a health care service plan that contracts with a specialized health care service plan, insurer, or other entity to cover professional mental health services for its enrollees, provided that the health care service plan provides a link on its Internet Web site to an Internet Web site operated by the specialized health care service plan, insurer, or other entity with which it contracts, and that plan, insurer, or other entity complies with this section or Section 10123.199 of the Insurance Code.

HISTORY:
Added Stats 2009 ch 575 § 3 (SB 296), effective January 1, 2010. Amended Stats 2014 ch 575 § 4 (SB 1052), effective January 1, 2015; Stats 2018 ch 687 § 2 (SB 910), effective January 1, 2019.

§ 1368.02. Toll-free telephone number for complaints [Effective until January 1, 2020]

(a) The director shall establish and maintain a toll-free telephone number for the purpose of receiving complaints regarding health care service plans regulated by the director.

(b) Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet Web site address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet Web site address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

HISTORY:
Added Stats 1998 ch 377 § 3 (SB 1443), operative July 1, 1999. Amended Stats 1999 ch 525 § 103 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 34 (AB 2903); Stats 2002 ch 796 § 4 (AB 2085); Stats 2003 ch 62 § 179 (SB 600); Stats 2011 ch 552 § 3 (AB 922), effective January 1, 2012.

§ 1368.02. Toll-free telephone number for complaints [Effective January 1, 2020]

(a) The director shall establish and maintain a toll-free telephone number for the purpose of receiving complaints regarding health care service plans regulated by the director.

(b) Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's internet website address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's internet website address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online."

HISTORY:
Added Stats 1998 ch 377 § 3 (SB 1443), operative July 1, 1999. Amended Stats 1999 ch 525 § 103 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 34 (AB 2903); Stats 2002 ch 796 § 4 (AB 2085); Stats 2003 ch 62 § 179 (SB 600); Stats 2011 ch 552 § 3 (AB 922), effective January 1, 2012; Stats 2019 ch 113 § 3 (AB 1802), effective January 1, 2020.

§ 1368.03. Participation in plan's grievance process before complaint with department

(a) The department may require enrollees and subscribers to participate in a plan's grievance process for up to 30 days before pursuing a grievance

through the department or the independent medical review system. However, the department may not impose this waiting period for expedited review cases covered by subdivision (b) of Section 1368.01 or in any other case where the department determines that an earlier review is warranted.

(b) Notwithstanding subdivision (a), the department may refer any grievance issue that does not pertain to compliance with this chapter to the State Department of Health Services, the California Department of Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity for investigation and resolution.

(c) This section shall become operative on January 1, 2001, and then only if Assembly Bill 55 of the 1999-2000 Regular Session is enacted.

HISTORY:
Added Stats 1999 ch 542 § 5 (SB 189), operative January 1, 2001.

§ 1368.04. Enforcement by director; Violations; Administrative penalty

(a) The director shall investigate and take enforcement action against plans regarding grievances reviewed and found by the department to involve noncompliance with the requirements of this chapter, including grievances that have been reviewed pursuant to the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30). Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director shall, by order, assess administrative penalties subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(b) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:

(1) Repeated failure to act promptly and reasonably to investigate and resolve grievances in accordance with Section 1368.01.

(2) Repeated failure to act promptly and reasonably to resolve grievances when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(c) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

(d) The administrative penalties authorized pursuant to this section shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

HISTORY:
Added Stats 1999 ch 542 § 7 (SB 189), operative January 1, 2001. Amended Stats 2000 ch 135 § 88 (AB 2539), ch 1067 § 12 (SB 2094) (ch 1067 prevails); Stats 2008 ch 607 § 6 (SB 1379), effective September 30, 2008.

§ 1368.05. Direct consumer assistance activities by Department of Managed Health Care; Contracts with community-based consumer assistance organizations

(a)(1) By enacting this section, which was originally enacted by Assembly Bill 922 (Chapter 552 of the Statutes of 2011), the Legislature recognizes that, because of the enactment of federal health care reform on March 23, 2010, and the implementation of various provisions by January 1, 2014, and the ongoing complexities of health care reform, it is appropriate to transfer the direct consumer assistance activities that were newly conferred on the Office of Patient Advocate to the Department of Managed Health Care, and the Legislature recognizes that these new duties are necessary to be carried out by the department in partnership with community-based consumer assistance organizations for the purposes of serving California's health care consumers.

(2) In addition to maintaining the toll-free telephone number for the purpose of receiving complaints regarding health care service plans as required in Section 1368.02, the department and its contractors shall carry out these new responsibilities, which include assisting consumers in navigating private and public health care coverage and assisting consumers in determining the regulator that regulates the health care coverage of a particular consumer. In order to further assist in implementing health care reform, the department and its contractors shall also receive and respond to inquiries, complaints, and requests for assistance and education concerning health care coverage available in California.

(b)(1) The department shall annually contract with community-based organizations in furtherance of providing assistance to consumers as described in subdivision (a), as authorized by and in accordance with Section 19130 of the Government Code.

(2) These organizations shall be community-based nonprofit consumer assistance programs that shall include in their mission the assistance of, and duty to, health care consumers.

(3) Contracting consumer assistance organizations shall have experience in assisting consumers in navigating the local health care system, advising consumers regarding their health care coverage options, assisting consumers with problems in accessing health care services, and serving consumers with special needs, including, but not limited to, consumers with limited-English language proficiency, consumers requiring culturally competent services, low-income consumers, consumers with disabilities, consumers with low literacy rates, and consumers with multiple health conditions, including behavioral health. The organizations shall also have experience with, and the capacity for, collecting and reporting data regarding the consumers they assist, including demographic data, source of coverage, regulator, type of problem or issue, and resolution of complaints.

HISTORY:
Added Stats 2014 ch 31 § 7 (SB 857), effective June 20, 2014. Amended Stats 2015 ch 303 § 256 (AB 731), effective January 1, 2016.

§ 1368.1. Information provided by plan denying coverage to enrollee with terminal illness; Conference to review information

(a) A plan that denies coverage to an enrollee with a terminal illness, which for the purposes of this section refers to an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider, shall provide to the enrollee within five business days all of the following information:

(1) A statement setting forth the specific medical and scientific reasons for denying coverage.

(2) A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.

(3) Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of the plan's grievance system provided under Section 1368.

(b) Upon receiving a complaint form requesting a conference pursuant to paragraph (3) of subdivision (a), the plan shall provide the enrollee, within 30 calendar days, an opportunity to attend a conference, to review the information provided to the enrollee pursuant to paragraphs (1) and (2) of subdivision (a), conducted by a plan representative having authority to determine the disposition of the complaint. The plan shall allow attendance, in person, at the conference, by an enrollee, a designee of the enrollee, or both, or, if the enrollee is a minor or incompetent, the parent, guardian, or conservator of the enrollee, as appropriate. However, the conference required by this subdivision shall be held within five business days if the treating participating physician determines, after consultation with the health plan medical director or his or her designee, based on standard medical practice, that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by the plan, would be materially reduced if not provided at the earliest possible date.

(c) Nothing in this section shall limit the responsibilities, rights, or authority provided in Sections 1370 and 1370.1.

HISTORY:
Added Stats 1994 ch 582 § 1 (AB 3244).

§ 1368.2. Hospice care

(a) On and after January 1, 2002, every group health care service plan contract, except a specialized health care service plan contract, which is issued, amended, or renewed, shall include a provision for hospice care.

(b) The hospice care shall at a minimum be equivalent to hospice care provided by the federal Medicare program pursuant to Title XVIII of the Social Security Act.

(c) The hospice care provided under this section is not required to include preliminary services set forth in subdivision (d) of Section 1749. However, an enrollee who receives those preliminary services shall remain eligible for

coverage of curative treatment by a health care service plan during the course of preliminary services and prior to the election of hospice services.

(d) The following are applicable to this section and to paragraph (7) of subdivision (b) of Section 1345:

(1) The definitions in Section 1746, except for subdivisions (o) and (p) of that section.

(2) The "federal regulations" which means the regulations adopted for hospice care under Title XVIII of the Social Security Act in Title 42 of the Code of Federal Regulations, Chapter IV, Part 418, except Subparts A, B, G, and H, and any amendments or successor provisions thereto.

(e) The director no later than January 1, 2001, shall adopt regulations to implement this section. The regulations shall meet all of the following requirements:

(1) Be consistent with all material elements of the federal regulations that are not by their terms applicable only to eligible Medicare beneficiaries. If there is a conflict between a federal regulation and any state regulation, other than those adopted pursuant to this section, the director shall adopt the regulation that is most favorable for plan subscribers, members or enrollees to receive hospice care.

(2) Be consistent with any other applicable federal or state laws.

(3) Be consistent with the definitions of Section 1746, except for subdivisions (o) and (p) of that section.

(f) This section is not applicable to the subscribers, members, or enrollees of a health care service plan who elect to receive hospice care under the Medicare program.

HISTORY:
Added Stats 1999 ch 528 § 2 (AB 892). Amended Stats 2000 ch 857 § 35 (AB 2903); Stats 2004 ch 825 § 1 (AB 1299); Stats 2005 ch 77 § 30 (SB 64), effective January 1, 2006.

§ 1368.5. Pharmacist coverage

(a) Every health care service plan that offers coverage for a service that is within the scope of practice of a duly licensed pharmacist may pay or reimburse the cost of the service performed by a pharmacist for the plan if the pharmacist otherwise provides services for the plan.

(b) Payment or reimbursement may be made pursuant to this section for a service performed by a duly licensed pharmacist only when all of the following conditions are met:

(1) The service performed is within the lawful scope of practice of the pharmacist.

(2) The coverage otherwise provides reimbursement for identical services performed by other licensed health care providers.

(c) Nothing in this section shall require the plan to pay a claim to more than one provider for duplicate service or be interpreted to limit physician reimbursement.

HISTORY:
Added Stats 1996 ch 527 § 1 (SB 1596).

§ 1368.6. Pilot project to assess the impact of heath care service plan and prohibitions of dispensing prescription drugs; Required reporting [Effective until January 1, 2023; Repealed effective January 1, 2023]

(a) Effective January 1, 2020, there is established a pilot project to assess the impact of health care service plan and pharmacy benefit manager prohibitions on the dispensing of certain amounts of prescription drugs by network retail pharmacies. The provisions of subdivision (b) shall apply to pharmacy providers located in the Counties of Riverside and Sonoma.

(b) Pursuant to the pilot project, a health care service plan shall not prohibit, or permit any delegated pharmacy benefit manager to prohibit, a pharmacy provider from dispensing a particular amount of a prescribed medication if the plan or pharmacy benefit manager allows that amount to be dispensed through a pharmacy owned or controlled by the plan or pharmacy benefit manager, unless the prescription drug is subject to restricted distribution by the federal Food and Drug Administration or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

(c) This section shall not be construed to prohibit a health care service plan or pharmacy benefit manager from requiring the same reimbursement and terms and conditions for a pharmacy network provider as for a pharmacy owned or controlled by the health care service plan or pharmacy benefit manager.

(d) This section shall not be construed to prohibit differential cost sharing designed to encourage or discourage the use of mail-order pharmacy services or preferred pharmacies.

(e) On or before July 1, 2020, health care service plans subject to this section shall report annually to the Department of Managed Health Care information and data relating to changes, if any, to costs and utilization of prescription drugs attributable to the prohibition of contract terms in subdivision (b). The department shall solicit and receive any additional information relevant to changes in costs or utilization attributable to the pilot project from other interested stakeholders. The department shall summarize data received pursuant to this subdivision and provide the summary to the Governor and health policy committees of the Legislature on or before December 31, 2022.

(f) This section shall remain in effect only until January 1, 2023, and as of that date is repealed.

HISTORY:
Added Stats 2018 ch 905 § 3 (AB 315), effective January 1, 2019, repealed January 1, 2023.

§ 1368.7. State of emergency; Access to medically necessary health care services; Disruption to operation of health care service plan

(a) A health care service plan shall provide an enrollee who has been displaced by a state of emergency, as declared by the Governor pursuant to Section 8625 of the Government Code, access to medically necessary health care services.

(b) Within 48 hours of a declaration by the Governor of a state of emergency

that displaces or has the immediate potential to displace enrollees, a health care service plan operating in the county or counties included in the declaration shall file with the department a notification describing whether the plan has experienced or expects to experience any disruption to the operation of the plan, explaining how the plan is communicating with potentially impacted enrollees, and summarizing the actions the plan has taken or is in the process of taking to ensure that the health care needs of enrollees are met. This may require the plan to take actions, including, but not limited to, the following:

(1) Relax time limits for prior authorization, precertification, or referrals.

(2) Extend filing deadlines for claims.

(3) Suspend prescription refill limitations and allow an impacted enrollee to refill his or her prescriptions at an out-of-network pharmacy.

(4) Authorize an enrollee to replace medical equipment or supplies.

(5) Allow an enrollee to access an appropriate out-of-network provider if an in-network provider is unavailable due to the state of emergency or if the enrollee is out of the area due to displacement.

(6) Have a toll-free telephone number that an affected enrollee may call for answers to questions, including questions about the loss of health insurance identification cards, access to prescription refills, or how to access health care.

(c) This section shall not be construed to limit the Governor's authority under the California Emergency Services Act (Chapter 7 (commencing with Section 8550) of Division 1 of Title 2 of the Government Code), or the director's authority under any provision of this chapter.

HISTORY:
Added Stats 2018 ch 196 § 1 (AB 2941), effective January 1, 2019.

§ 1369. Participation by subscribers and enrollees

Every plan shall establish procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan. For purposes of this section, public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1977 ch 818 § 10, effective September 16, 1977; Stats 1983 ch 611 § 3; Stats 2005 ch 45 § 1 (SB 108), effective January 1, 2006.

§ 1370. Review procedures

Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who participates in plan or provider quality of care or utilization reviews by peer review committees which are composed chiefly of physicians and surgeons or dentists, psychologists, or optometrists, or any of the above, for any act

performed during the reviews if the person acts without malice, has made a reasonable effort to obtain the facts of the matter, and believes that the action taken is warranted by the facts, and neither the proceedings nor the records of the reviews shall be subject to discovery, nor shall any person in attendance at the reviews be required to testify as to what transpired thereat. Disclosure of the proceedings or records to the governing body of a plan or to any person or entity designated by the plan to review activities of the plan or provider committees shall not alter the status of the records or of the proceedings as privileged communications.

The above prohibition relating to discovery or testimony shall not apply to the statements made by any person in attendance at a review who is a party to an action or proceeding the subject matter of which was reviewed, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits, or to the director in conducting surveys pursuant to Section 1380.

This section shall not be construed to confer immunity from liability on any health care service plan. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against a health care service plan, the cause of action shall exist notwithstanding the provisions of this section.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1978 ch 285 § 5, effective June 23, 1978; Stats 1979 ch 303 § 1; Stats 1980 ch 95 § 1; Stats 1988 ch 828 § 1; Stats 1990 ch 138 § 1 (AB 1841); Stats 1993 ch 987 § 1 (SB 1221); Stats 1999 ch 525 § 105 (AB 78), operative July 1, 2000.

§ 1370.1. Review subcommittees

Nothing in this article shall be construed to prevent a plan from utilizing subcommittees to participate in peer review activities, nor to prevent a plan from delegating the responsibilities required by Section 1370, as it determines to be appropriate, to subcommittees including subcommittees composed of a majority of nonphysician health care providers licensed pursuant to the Business and Professions Code, so long as the plan controls the scope of authority delegated and may revoke all or part of this authority at any time. Persons who participate in the subcommittees shall be entitled to the same immunity from monetary liability and actions for civil damages as persons who participate in plan or provider peer review committees pursuant to Section 1370.

HISTORY:
Added Stats 1980 ch 454 § 2. Amended Stats 1988 ch 828 § 2.

§ 1370.2. Review of appeal of contested claim

Upon an appeal to the plan of a contested claim, the plan shall refer the claim to the medical director or other appropriately licensed health care provider. This health care provider or the medical director shall review the appeal and, if he or she determines that he or she is competent to evaluate the specific clinical issues presented in the claim, shall make a determination on

the appealed claim. If the health care provider or medical director determines that he or she is not competent to evaluate the specific clinical issues of the appealed claim, prior to making a determination, he or she shall consult with an appropriately licensed health care provider who is competent to evaluate the specific clinical issues presented in the claim. For the purposes of this section, "competent to evaluate the specific clinical issues" means that the reviewer has education, training, and relevant expertise that is pertinent for evaluating the specific clinical issues that serve as the basis of the contested claim. The requirements of this section shall apply to claims that are contested on the basis of a clinical issue, the necessity for treatment, or the type of treatment proposed or utilized. The plan shall determine whether or not to use an appropriate specialist provider in the review of contested claims.

HISTORY:
Added Stats 1994 ch 614 § 2 (SB 1832).

§ 1370.4. Independent external review process for coverage decisions on experimental or investigational therapies

(a) Every health care service plan shall provide an external, independent review process to examine the plan's coverage decisions regarding experimental or investigational therapies for individual enrollees who meet all of the following criteria:

(1)(A) The enrollee has a life-threatening or seriously debilitating condition.

(B) For purposes of this section, "life-threatening" means either or both of the following:

(i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

(C) For purposes of this section, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

(2) The enrollee's physician certifies that the enrollee has a condition, as defined in paragraph (1), for which standard therapies have not been effective in improving the condition of the enrollee, for which standard therapies would not be medically appropriate for the enrollee, or for which there is no more beneficial standard therapy covered by the plan than the therapy proposed pursuant to paragraph (3).

(3) Either (A) the enrollee's physician, who is under contract with or employed by the plan, has recommended a drug, device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to the enrollee than any available standard therapies, or (B) the enrollee, or the enrollee's physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the enrollee's condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined in subdivision (d), is likely to be more beneficial for the enrollee than any available standard therapy. The physician certification pursuant to this subdivision shall include a statement of the evidence relied upon by the physician in certifying

his or her recommendation. Nothing in this subdivision shall be construed to require the plan to pay for the services of a nonparticipating physician provided pursuant to this subdivision, that are not otherwise covered pursuant to the plan contact.

(4) The enrollee has been denied coverage by the plan for a drug, device, procedure, or other therapy recommended or requested pursuant to paragraph (3).

(5) The specific drug, device, procedure, or other therapy recommended pursuant to paragraph (3) would be a covered service, except for the plan's determination that the therapy is experimental or investigational.

(b) The plan's decision to delay, deny, or modify experimental or investigational therapies shall be subject to the independent medical review process under Article 5.55 (commencing with Section 1374.30) except that, in lieu of the information specified in subdivision (b) of Section 1374.33, an independent medical reviewer shall base his or her determination on relevant medical and scientific evidence, including, but not limited to, the medical and scientific evidence defined in subdivision (d).

(c) The independent medical review process shall also meet the following criteria:

(1) The plan shall notify eligible enrollees in writing of the opportunity to request the external independent review within five business days of the decision to deny coverage.

(2) If the enrollee's physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the experts on the panel shall be rendered within seven days of the request for expedited review. At the request of the expert, the deadline shall be extended by up to three days for a delay in providing the documents required. The timeframes specified in this paragraph shall be in addition to any otherwise applicable timeframes contained in subdivision (c) of Section 1374.33.

(3) Each expert's analysis and recommendation shall be in written form and state the reasons the requested therapy is or is not likely to be more beneficial for the enrollee than any available standard therapy, and the reasons that the expert recommends that the therapy should or should not be provided by the plan, citing the enrollee's specific medical condition, the relevant documents provided, and the relevant medical and scientific evidence, including, but not limited to, the medical and scientific evidence as defined in subdivision (d), to support the expert's recommendation.

(4) Coverage for the services required under this section shall be provided subject to the terms and conditions generally applicable to other benefits under the plan contract.

(d) For the purposes of subdivision (b), "medical and scientific evidence" means the following sources:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(2) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's

National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR).

(3) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.

(4) Either of the following reference compendia:

(A) The American Hospital Formulary Service's Drug Information.

(B) The American Dental Association Accepted Dental Therapeutics.

(5) Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:

(A) The Elsevier Gold Standard's Clinical Pharmacology.

(B) The National Comprehensive Cancer Network Drug and Biologics Compendium.

(C) The Thomson Micromedex DrugDex.

(6) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(7) Peer-reviewed abstracts accepted for presentation at major medical association meetings.

(e) The independent review process established by this section shall be required on and after January 1, 2001.

HISTORY:

Added Stats 1999 ch 542 § 9 (SB 189), operative January 1, 2001. Amended Stats 2000 ch 135 § 89 (AB 2539), ch 1067 § 13 (SB 2094) (ch 1067 prevails); Stats 2009 ch 479 § 2 (AB 830), effective January 1, 2010.

§ 1370.6. Coverage relating to cancer clinical trials [Repealed effective January 1, 2020]

(a) For an enrollee diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer, every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed in this state, shall provide coverage for all routine patient care costs related to the clinical trial if the enrollee's treating physician, who is providing covered health care services to the enrollee under the enrollee's health benefit plan contract, recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the enrollee. For purposes of this section, a clinical trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.

(b)(1) "Routine patient care costs" means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including:

(A) Health care services typically provided absent a clinical trial.

(B) Health care services required solely for the provision of the investigational drug, item, device, or service.

(C) Health care services required for the clinically appropriate monitoring of the investigational item or service.

(D) Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.

(E) Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

(2) For purposes of this section, "routine patient care costs" does not include the costs associated with the provision of any of the following:

(A) Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.

(B) Services other than health care services, such as travel, housing, companion expenses, and other nonclinical expenses, that an enrollee may require as a result of the treatment being provided for purposes of the clinical trial.

(C) Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.

(D) Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the enrollee's health plan.

(E) Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

(3) Nothing in this section shall require a health care service plan contracting with the State Department of Health Services for the purpose of providing Medi-Cal benefits to enrolled beneficiaries or contracting with the Managed Risk Medical Insurance Board for the purposes of providing benefits under the Healthy Families Program, the Access for Infants and Mothers Program, or the California Major Risk Medical Insurance Program, to be responsible for reimbursement of services excluded from their contract because another entity is responsible by statute or otherwise for reimbursement of the service provider.

(c) The treatment shall be provided in a clinical trial that either:

(1) Involves a drug that is exempt under federal regulations from a new drug application.

(2) Is approved by one of the following:

(A) One of the National Institutes of Health.

(B) The federal Food and Drug Administration, in the form of an investigational new drug application.

(C) The United States Department of Defense.

(D) The United States Veterans' Administration.

(d) In the case of health care services provided by a participating provider, the payment rate shall be at the agreed-upon rate. In the case of a nonparticipating provider, the payment shall be at the negotiated rate the plan would otherwise pay to a participating provider for the same services, less any applicable copayments and deductibles.

(e) Nothing in this section shall be construed to prohibit a health care service plan from restricting coverage for clinical trials to participating hospitals and physicians in California unless the protocol for the clinical trial is not provided for at a California hospital or by a California physician.

(f) The provision of services when required by this section shall not, in itself, give rise to liability on the part of the health care service plan.

(g) Nothing in this section shall be construed to limit, prohibit, or modify an enrollee's rights to the independent review process available under Section 1370.4 or to the Independent Medical Review System available under Article 5.55 (commencing with Section 1374.30).

(h) Nothing in this section shall be construed to otherwise limit or modify any existing requirements under the provisions of this chapter or to prevent application of copayment or deductible provisions in a plan.

(i) Copayments and deductibles applied to services delivered in a clinical trial shall be the same as those applied to the same services if not delivered in a clinical trial.

HISTORY:
Added Stats 2001 ch 172 § 1 (SB 37). Repealed Stats 2019 ch 482 § 1 (SB 583), effective January 1, 2020.

§ 1370.6. Coverage for approved clinical trials [Effective January 1, 2020]

(a) An individual or group health care service plan contract that is issued, amended, or renewed on or after January 1, 2020, shall not:

(1) Deny a qualified enrollee's participation in an approved clinical trial.

(2) Deny, limit, or impose additional conditions on the coverage of routine patient care costs for items and services furnished in connection with a qualified enrollee's participation in an approved clinical trial.

(3) Discriminate against an enrollee based on the qualified enrollee's participation in an approved clinical trial.

(b)(1) Subdivision (a) applies to:

(A) A qualified enrollee participating in an approved clinical trial conducted by a participating provider.

(B) A qualified enrollee participating in an approved clinical trial conducted by a nonparticipating provider, including a nonparticipating provider located outside this state, if the clinical trial is not offered or available through a participating provider.

(2) If one or more participating providers is conducting an approved clinical trial, a health care service plan may require a qualified enrollee to participate in the clinical trial through a participating provider if the participating provider accepts the enrollee as a clinical trial participant.

(3) A health care service plan may restrict coverage to an approved clinical trial in this state, unless the clinical trial is not offered or available through a participating provider in this state.

(c)(1) The payment rate for routine patient care costs provided by a nonparticipating provider under a contract that is issued, amended, or renewed on or after January 1, 2020, shall be the negotiated rate the health care service plan would otherwise pay a participating provider for the same services, less applicable cost sharing.

(2) Cost sharing for routine patient care costs shall be the same as that applied to the same services not delivered in a clinical trial, except that the in-network cost sharing and out-of-pocket maximum shall apply if the clinical trial is not offered or available through a participating provider.

(3) This section does not limit or modify any existing requirements under this chapter or prevent application of cost-sharing provisions in a contract, except as provided in paragraph (2).

(d) For purposes of this section:

(1) "Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease or condition that meets at least one of the following:

(A) The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:

(i) The National Institutes of Health.

(ii) The federal Centers for Disease Control and Prevention.

(iii) The Agency for Healthcare Research and Quality.

(iv) The federal Centers for Medicare and Medicaid Services.

(v) A cooperative group or center of any of the entities described in clauses (i) to (iv), inclusive, the Department of Defense, or the United States Department of Veterans Affairs.

(vi) A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(vii) One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

(I) The United States Department of Veterans Affairs.

(II) The United States Department of Defense.

(III) The United States Department of Energy.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.

(C) The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

(2) "Life-threatening disease or condition" means a disease or condition from which the likelihood of death is probable, unless the course of the disease or condition is interrupted.

(3) "Qualified enrollee" means an enrollee who meets both of the following conditions:

(A) The enrollee is eligible to participate in an approved clinical trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition.

(B) Either of the following applies:

(i) The referring health care professional is a participating provider and has concluded that the enrollee's participation in the clinical trial would be appropriate because the enrollee meets the conditions of subparagraph (A).

(ii) The enrollee provides medical and scientific information establishing that the enrollee's participation in the clinical trial would be appropriate because the enrollee meets the conditions of subparagraph (A).

(4) "Routine patient care costs" include drugs, items, devices, and services provided consistent with coverage under the contract for an enrollee who is not enrolled in an approved clinical trial, including the following:

(A) Drugs, items, devices, and services typically covered absent a clinical trial.

(B) Drugs, items, devices, and services required solely for the provision of an investigational drug, item, device, or service.

(C) Drugs, items, devices, and services required for the clinically appropriate monitoring of the investigational drug, item, device, or service.

(D) Drugs, items, devices, and services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.

(E) Drugs, items, devices, and services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis and treatment of complications.

(5) "Routine patient care costs" does not include the following:

(A) The investigational drug, item, device, or service itself.

(B) Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the enrollee.

(C) Drugs, items, devices, and services specifically excluded from coverage in the contract, except for drugs, items, devices, and services required to be covered pursuant to this section or other applicable law.

(D) Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

(e) This section shall not be construed to limit coverage provided by a health care service plan contract with respect to clinical trials.

(f) The provision of services required by this section shall not, in itself, give rise to liability on the part of the health care service plan.

(g) This section does not apply to a specialized health care service plan contract.

(h) This section does not limit, prohibit, or modify an enrollee's rights to the independent review process available under Section 1370.4 or to the Independent Medical Review System available under Article 5.55 (commencing with Section 1374.30).

HISTORY:

Added Stats 2019 ch 482 § 2 (SB 583), effective January 1, 2020.

§ 1371. Reimbursement of claims; Contested claims [Effective until January 1, 2020]

(a)(1) A health care service plan, including a specialized health care service plan, shall reimburse claims or a portion of a claim, whether in state or out of state, as soon as practicable, but no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by the plan, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

(2) If an uncontested claim is not reimbursed by delivery to the claimants' address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. A plan failing to comply with this requirement shall pay the claimant a ten dollar ($10) fee.

(3) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the plan to determine the medical necessity for the health care services provided.

(4) If a claim or portion thereof is contested on the basis that the plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided pursuant to this section, the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a plan has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim it has determined to be payable within 30 working days of the receipt of that information, or if the plan is a health maintenance organization, within 45 working days of receipt of that information, interest shall accrue and be payable at a rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period.

(b) Notwithstanding any other law, a specialized health care service plan that undertakes solely to arrange for the provision of vision care services may use a statistically reliable method to investigate suspected fraud and to recover

overpayments made as a result of fraud only if the specialized health care service plan complies with this subdivision.

(1) A specialized health care service plan's statistically reliable method, and how the specialized health care service plan intends to utilize that method to determine recovery of overpayments made as a result of fraud, shall be submitted to, and approved by, the department as elements of the specialized health care service plan's antifraud plan established and approved pursuant to Section 1348. The specialized health care service plan's utilization of a statistically reliable method shall help protect and promote the interests of enrollees and shall help ensure a stable health care delivery system. The statistically reliable method shall be consistent with direction provided by the International Standards for the Professional Practice of Internal Auditing and the guidance provided by the International Professional Practices Framework guide, which are both produced by the Institute of Internal Auditors.

(2) Pursuant to its antifraud plan established and approved pursuant to Section 1348, a specialized health care service plan shall provide a written notice of suspected fraud to a provider that includes, at a minimum, all of the following:

(A) A clear description of the specialized health care service plan's statistically reliable methodology. The description shall include information that ensures that the sample size used to calculate the repayment amount is consistent with the professional guidance provided in the 2009 edition of the American Institute of Certified Public Accountants' Audit Sampling Considerations of Circular A-133 Compliance Audits.

(B) A clear description of the universe of claims from which the statistical random sample was drawn and, if different, the universe of claims upon which the statistical analysis was applied to generate the recovery amount.

(C) A clear explanation of how the specialized health care service plan's statistically reliable methodology was utilized in the specialized health care service plan's findings of suspected fraud.

(D) Notice that a provider may dispute the specialized health care service plan's findings within 45 working days from the date of receipt of the notice of suspected fraud.

(E) The following information for each of the claims in the statistical sample that was utilized in the specialized health care service plan's findings:

(i) The claim number.

(ii) The name of the patient.

(iii) The date of service.

(iv) The date of payment.

(v) A clear explanation of the basis upon which the specialized health care service plan suspects the claim is fraudulent.

(3) A specialized health care service plan that undertakes solely to arrange for the provision of vision care services may use a statistically reliable method to recover overpayments made as a result of suspected fraud only if the universe of claims upon which the statistical analysis is performed consists only of those claims made between 365 days from the date of

payment of the earliest in time claim and the date of payment of the latest in time claim. Notice shall be mailed to the provider no later than 60 days following the date of payment of the latest in time claim.

(4) If the provider contests the specialized health care service plan's notice of suspected fraud, the provider, within 45 working days of the date of receipt of the notice of suspected fraud, shall send written notice to the specialized health care service plan stating the basis upon which the provider believes that the claims are not fraudulent. The specialized health care service plan shall receive and process this contested notice of suspected fraud as a provider dispute pursuant to subdivision (a) of this section, paragraph (1) of subdivision (h) of Section 1367, and the regulations promulgated thereunder.

(5) A specialized health care service plan may offset the amount the specialized health care service plan disclosed as overpaid to the provider in an uncontested notice of suspected fraud against the provider's current claim submissions only if all of the following requirements are met:

(A) The provider fails to reimburse the specialized health care service plan within 45 working days from the date of receipt by the provider of the notice of suspected fraud.

(B) The specialized health care service plan sends written notice to the provider no less than 10 working days prior to withholding current claim payments in which the specialized health care service plan, at a minimum, states its intent to withhold current claim payments and identifies the claim payments that the specialized health care service plan intends to withhold.

(C) The withheld claim payments do not exceed the amount asserted by the specialized health care service plan to be owed to the specialized health care service plan in its notice of suspected fraud.

(6) This section does not limit or remove a specialized health care service plan's obligation to comply with its antifraud plan established pursuant to Section 1348, or to limit or remove the specialized health care service plan's obligation to comply with the requirements for claims subject to subdivision (a).

(7) This subdivision does not limit or remove a specialized health care service plan's ability to recover overpayments as long as recovery is consistent with applicable law, including subdivision (a) and the regulations promulgated thereunder.

(8) This subdivision does not apply to claims submitted by a physician and surgeon for medical or surgical services that are outside the scope of practice of an optometrist pursuant to the Optometry Practice Act (Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code).

(c) The obligation of a specialized health care service plan to comply with this section is not waived when the specialized health care service plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services.

HISTORY:

Added Stats 1986 ch 957 § 1. Amended Stats 1989 ch 968 § 1; Stats 1992 ch 747 § 1 (AB 2656), ch 1357 § 1 (SB 382); Stats 1994 ch 614 § 3 (SB 1832); Stats 1996 ch 711 § 1 (SB 1478); Stats 2000 ch 825 § 3 (SB 1177), ch 827 § 3 (AB

1455); Stats 2009 ch 140 § 98 (AB 1164), effective January 1, 2010; Stats 2018 ch 525 § 1 (AB 1092), effective January 1, 2019.

§ 1371. Reimbursement of claims; Contested claims [Effective January 1, 2020]

(a)(1) A health care service plan, including a specialized health care service plan, shall reimburse claims or a portion of a claim, whether in state or out of state, as soon as practicable, but no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by the plan, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

(2) If an uncontested claim is not reimbursed by delivery to the claimants' address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. A plan failing to comply with this requirement shall pay the claimant a ten dollar ($10) fee.

(3) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the plan to determine the medical necessity for the health care services provided.

(4) If a claim or portion thereof is contested on the basis that the plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided pursuant to this section, the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a plan has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim it has determined to be payable within 30 working days of the receipt of that information, or if the plan is a health maintenance organization, within 45 working days of receipt of that information, interest shall accrue and be payable at a rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period.

(b) Notwithstanding any other law, a specialized health care service plan that undertakes solely to arrange for the provision of vision care services may use a statistically reliable method to investigate suspected fraud and to recover overpayments made as a result of fraud only if the specialized health care service plan complies with this subdivision.

(1) A specialized health care service plan's statistically reliable method, and how the specialized health care service plan intends to utilize that method to determine recovery of overpayments made as a result of fraud, shall be submitted to, and approved by, the department as elements of the specialized health care service plan's antifraud plan established and approved pursuant to Section 1348. The specialized health care service plan's utilization of a statistically reliable method shall help protect and promote the interests of enrollees and shall help ensure a stable health care delivery system. The statistically reliable method shall be consistent with direction provided by the International Standards for the Professional Practice of Internal Auditing and the guidance provided by the International Professional Practices Framework guide, which are both produced by the Institute of Internal Auditors.

(2) Pursuant to its antifraud plan established and approved pursuant to Section 1348, a specialized health care service plan shall provide a written notice of suspected fraud to a provider that includes, at a minimum, all of the following:

(A) A clear description of the specialized health care service plan's statistically reliable methodology. The description shall include information that ensures that the sample size used to calculate the repayment amount is consistent with the professional guidance provided in the 2009 edition of the American Institute of Certified Public Accountants' Audit Sampling Considerations of Circular A-133 Compliance Audits.

(B) A clear description of the universe of claims from which the statistical random sample was drawn and, if different, the universe of claims upon which the statistical analysis was applied to generate the recovery amount.

(C) A clear explanation of how the specialized health care service plan's statistically reliable methodology was utilized in the specialized health care service plan's findings of suspected fraud.

(D) Notice that a provider may dispute the specialized health care service plan's findings within 45 working days from the date of receipt of the notice of suspected fraud.

(E) The following information for each of the claims in the statistical sample that was utilized in the specialized health care service plan's findings:

(i) The claim number.

(ii) The name of the patient.

(iii) The date of service.

(iv) The date of payment.

(v) A clear explanation of the basis upon which the specialized health care service plan suspects the claim is fraudulent.

(3) A specialized health care service plan that undertakes solely to arrange for the provision of vision care services may use a statistically

reliable method to recover overpayments made as a result of suspected fraud only if the universe of claims upon which the statistical analysis is performed consists only of those claims made between 365 days from the date of payment of the earliest in time claim and the date of payment of the latest in time claim. Notice shall be mailed to the provider no later than 60 days following the date of payment of the latest in time claim.

(4) If the provider contests the specialized health care service plan's notice of suspected fraud, the provider, within 45 working days of the date of receipt of the notice of suspected fraud, shall send written notice to the specialized health care service plan stating the basis upon which the provider believes that the claims are not fraudulent. The specialized health care service plan shall receive and process this contested notice of suspected fraud as a provider dispute pursuant to subdivision (a) of this section, paragraph (1) of subdivision (h) of Section 1367, and the regulations promulgated thereunder.

(5) A specialized health care service plan may offset the amount the specialized health care service plan disclosed as overpaid to the provider in an uncontested notice of suspected fraud against the provider's current claim submissions only if all of the following requirements are met:

(A) The provider fails to reimburse the specialized health care service plan within 45 working days from the date of receipt by the provider of the notice of suspected fraud.

(B) The specialized health care service plan sends written notice to the provider no less than 10 working days prior to withholding current claim payments in which the specialized health care service plan, at a minimum, states its intent to withhold current claim payments and identifies the claim payments that the specialized health care service plan intends to withhold.

(C) The withheld claim payments do not exceed the amount asserted by the specialized health care service plan to be owed to the specialized health care service plan in its notice of suspected fraud.

(6) This section does not limit or remove a specialized health care service plan's obligation to comply with its antifraud plan established pursuant to Section 1348, or to limit or remove the specialized health care service plan's obligation to comply with the requirements for claims subject to subdivision (a).

(7) This subdivision does not limit or remove a specialized health care service plan's ability to recover overpayments as long as recovery is consistent with applicable law, including subdivision (a) and the regulations promulgated thereunder.

(8) This subdivision does not apply to claims submitted by a physician and surgeon for medical or surgical services that are outside the scope of practice of an optometrist pursuant to the Optometry Practice Act (Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code).

(c) The obligation of a plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services.

HISTORY:
Added Stats 1986 ch 957 § 1. Amended Stats 1989 ch 968 § 1; Stats 1992 ch 747 § 1 (AB 2656), ch 1357 § 1 (SB 382); Stats 1994 ch 614 § 3 (SB 1832); Stats 1996 ch 711 § 1 (SB 1478); Stats 2000 ch 825 § 3 (SB 1177), ch 827 § 3 (AB 1455); Stats 2009 ch 140 § 98 (AB 1164), effective January 1, 2010; Stats 2018 ch 525 § 1 (AB 1092), effective January 1, 2019; Stats 2019 ch 113 § 4 (AB 1802), effective January 1, 2020.

§ 1371.1. Notification to provider of overpayment; Reimbursement; Contested claims; Accrual of interest

(a)(1) Whenever a health care service plan, including a specialized health care service plan, determines that in reimbursing a claim for provider services an institutional or professional provider has been overpaid, and then notifies the provider in writing through a separate notice identifying the overpayment and the amount of the overpayment, the provider shall reimburse the health care service plan within 30 working days of receipt by the provider of the notice of overpayment unless the overpayment or portion thereof is contested by the provider in which case the health care service plan shall be notified, in writing, within 30 working days. The notice that an overpayment is being contested shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

(2) If the provider does not make reimbursement for an uncontested overpayment within 30 working days after receipt, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period.

(3) A prorated cost-sharing payment, or any portion thereof, made to a pharmacist for the dispensing of a partial fill pursuant to Section 4052.10 of the Business and Professions Code shall not be considered to be an overpayment pursuant to this section.

(b)(1) This subdivision shall only apply to a health care service plan contract covering dental services or a specialized health care service plan contract covering dental services pursuant to this chapter.

(2) The health care service plan's notice of overpayment shall inform the provider how to access the plan's dispute resolution mechanism offered pursuant to subdivision (h) of Section 1367. The notice shall include the name and address to which the dispute should be submitted and a statement that Section 1371.1 of the Health and Safety Code requires a provider to reimburse the plan for an overpayment within 30 working days of receipt by the provider of the notice of overpayment unless the provider contests the overpayment within 30 working days. The notice shall also include information clearly identifying the claim, the name of the patient, the date of service, and a clear explanation of the basis upon which the plan or the plan's capitated provider believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim. The notice shall also include a statement that if the provider does not make reimbursement of an uncontested overpayment within 30 working days after receipt of the notice, interest shall accrue at a rate of 10 percent per annum.

HISTORY:
Added Stats 1989 ch 968 § 1.5. Amended Stats 1992 ch 747 § 2 (AB 2656), ch 1357 § 2 (SB 382); Stats 2008 ch 403 § 1 (SB 1387), effective January 1, 2009; Stats 2009 ch 140 § 99 (AB 1164), effective January 1, 2010; Stats 2017 ch 615 § 4 (AB 1048), effective January 1, 2018.

§ 1371.2. Prohibited request for reimbursement or reduction of level of payment

No health care service plan, including a specialized health care service plan, shall request reimbursement for overpayment or reduce the level of payment to a provider based solely on the allegation that the provider has entered into a contract with any other licensed health care service plan for participation in a benefit plan that has been approved by the director.

HISTORY:
Added Stats 1992 ch 1357 § 3 (SB 382).
Amended Stats 2002 ch 760 § 3 (AB 3048).

§ 1371.22. Acceptance of lowest payment rate charged by provider to patient or third-party; Inapplicability of policy provision to cash payments made to provider by patient without private or public health care

If a contract between a health care service plan and a provider requires that the provider accept, as payment from the plan, the lowest payment rate charged by the provider to any patient or third party, this contract provision shall not be deemed to apply to, or take into consideration, any cash payments made to the provider by individual patients who do not have any private or public form of health care coverage for the service rendered by the provider, as described in subdivision (c) of Section 657 of the Business and Professions Code. This section shall apply to a provider contract that is issued, amended, or renewed on or after the effective date of this section.

HISTORY:
Added Stats 1998 ch 20 § 2 (SB 1255), effective April 14, 1998.

§ 1371.25. Liability

A plan, any entity contracting with a plan, and providers are each responsible for their own acts or omissions, and are not liable for the acts or omissions of, or the costs of defending, others. Any provision to the contrary in a contract with providers is void and unenforceable. Nothing in this section shall preclude a finding of liability on the part of a plan, any entity contracting with a plan, or a provider, based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability.

HISTORY:
Added Stats 1995 ch 774 § 2 (AB 1840).

§ 1371.3. Assignment of right to reimbursement

On and after January 1, 1994, every group health care service plan that provides hospital, medical, or surgical expense benefits for plan members and their dependents shall authorize and permit assignment of the enrollee's or subscriber's right to any reimbursement for health care services covered under the plan contract to the State Department of Health Services when health care services are provided to a Medi-Cal beneficiary. This section, however, shall not apply to a Medi-Cal beneficiary for health care services provided pursuant to

a contract with the State Department of Health Services under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

HISTORY:
Added Stats 1993 ch 744 § 1 (AB 2309).

§ 1371.30. Independent dispute resolution process for noncontracting individual health professional

(a)(1) By September 1, 2017, the department shall establish an independent dispute resolution process for the purpose of processing and resolving a claim dispute between a health care service plan and a noncontracting individual health professional for services subject to subdivision (a) of Section 1371.9.

(2) Prior to initiating the independent dispute resolution process, the parties shall complete the plan's internal process.

(3) If either the noncontracting individual health professional or the plan appeals a claim to the department's independent dispute resolution process, the other party shall participate in the appeal process as described in this section.

(b)(1) The department shall establish uniform written procedures for the submission, receipt, processing, and resolution of claim payment disputes pursuant to this section and any other guidelines for implementing this section.

(2) The department shall establish reasonable and necessary fees for the purpose of administering this section, to be paid by both parties.

(3) In establishing the independent dispute resolution process, the department shall permit the bundling of claims submitted to the same plan or the same delegated entity for the same or similar services by the same noncontracting individual health professional.

(4) The department shall permit a physician group, independent practice association, or other entity authorized to act on behalf of a noncontracting individual health professional to initiate and participate in the independent dispute resolution process.

(5) In deciding the dispute, the independent organization shall base its decision regarding the appropriate reimbursement on all relevant information.

(c)(1) The department may contract with one or more independent organizations to conduct the proceedings. The independent organization handling a dispute shall be independent of either party to the dispute.

(2) The department shall establish conflict-of-interest standards, consistent with the purposes of this section, that an organization shall meet in order to qualify to administer the independent dispute resolution program. The conflict-of-interest standards shall be consistent with the standards pursuant to subdivisions (c) and (d) of Section 1374.32.

(3) The department may contract with the same independent organization or organizations as the Department of Insurance.

(4) The department shall provide, upon the request of an interested person, a copy of all nonproprietary information, as determined by the

director, filed with the department by an independent organization seeking to contract with the department to administer the independent dispute resolution process pursuant to this section. The department may charge a nominal fee to cover the costs of providing a copy of the information pursuant to this paragraph.

(5) The independent organization retained to conduct proceedings shall be deemed to be consultants for purposes of Section 43.98 of the Civil Code.

(6) Contracts entered into pursuant to the authority in this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code and shall be exempt from the review or approval of any division of the Department of General Services.

(d) The decision obtained through the department's independent dispute resolution process shall be binding on both parties. The plan shall implement the decision obtained through the independent dispute resolution process. If dissatisfied, either party may pursue any right, remedy, or penalty established under any other applicable law.

(e) This section shall not apply to a Medi-Cal managed health care service plan or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(f) If a health care service plan delegates payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, then the delegated entity shall comply with this section.

(g) This section shall not apply to emergency services and care, as defined in Section 1317.1.

(h) The definitions in subdivision (f) of Section 1371.9 shall apply for purposes of this section.

(i) This section shall not be construed to alter a health care service plan's obligations pursuant to Sections 1371 and 1371.4.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-plan letters or similar instructions, without taking regulatory action, until the time regulations are adopted.

(k) By January 1, 2019, the department shall provide a report to the Governor, the President pro Tempore of the Senate, the Speaker of the Assembly, and the Senate and Assembly Committees on Health of the data and information provided in the independent dispute resolution process in a manner and format specified by the Legislature.

HISTORY:

Added Stats 2016 ch 492 § 1 (AB 72), effective January 1, 2017.

§ 1371.31. Reimbursement rate for noncontracting individual health professional; Reporting requirements; Exemptions

(a)(1) For services rendered subject to Section 1371.9, effective July 1, 2017, unless otherwise agreed to by the noncontracting individual health professional and the plan, the plan shall reimburse the greater of the average contracted rate or 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered. For the purposes of this section, "average contracted rate" means the average of the contracted commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region. This subdivision does not apply to subdivision (c) of Section 1371.9 or subdivision (b) of this section.

(2)(A) By July 1, 2017, each health care service plan and its delegated entities shall provide to the department all of the following:

(i) Data listing its average contracted rates for the plan for services most frequently subject to Section 1371.9 in each geographic region in which the services are rendered for the calendar year 2015.

(ii) Its methodology for determining the average contracted rate for the plan for services subject to Section 1371.9. The methodology to determine an average contracted rate shall ensure that the plan includes the highest and lowest contracted rates for the calendar year 2015.

(iii) The policies and procedures used to determine the average contracted rates under this subdivision.

(B) For each calendar year after the plan's initial submission of the average contracted rate as specified in subparagraph (A) and until the standardized methodology under paragraph (3) is specified, a health care service plan and the plan's delegated entities shall adjust the rate initially established pursuant to this subdivision by the Consumer Price Index for Medical Care Services, as published by the United States Bureau of Labor Statistics.

(3)(A) By January 1, 2019, the department shall specify a methodology that plans and delegated entities shall use to determine the average contracted rates for services most frequently subject to Section 1371.9. This methodology shall take into account, at a minimum, information from the independent dispute resolution process, the specialty of the individual health professional, and the geographic region in which the services are rendered. The methodology to determine an average contracted rate shall ensure that the plan includes the highest and lowest contracted rates.

(B) Health care service plans and delegated entities shall provide to the department the policies and procedures used to determine the average contracted rates in compliance with subparagraph (A).

(C) If, based on the health care service plan's model, a health care service plan does not pay a statistically significant number or dollar amount of claims for services covered under Section 1371.9, the health care service plan shall demonstrate to the department that it has access to a statistically credible database reflecting rates paid to noncontracting individual health professionals for services provided in a geographic

region and shall use that database to determine an average contracted rate required pursuant to paragraph (1).

(D) The department shall review the information filed pursuant to this subdivision as part of its examination of fiscal and administrative affairs pursuant to Section 1382.

(E) The average contracted rate data submitted pursuant to this section shall be confidential and not subject to disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(F) In developing the standardized methodology under this subdivision, the department shall consult with interested parties throughout the process of developing the standards, including the Department of Insurance, representatives of health plans, insurers, health care providers, hospitals, consumer advocates, and other stakeholders it deems appropriate. The department shall hold the first stakeholder meeting no later than July 1, 2017.

(4) A health care service plan shall include in its reports submitted to the department pursuant to Section 1367.035 and regulations adopted pursuant to that section, in a manner specified by the department, the number of payments made to noncontracting individual health professionals for services at a contracting health facility and subject to Section 1371.9, as well as other data sufficient to determine the proportion of noncontracting individual health professionals to contracting individual health professionals at contracting health facilities, as defined in subdivision (f) of Section 1371.9. The department shall include a summary of this information in its January 1, 2019, report required pursuant to subdivision (k) of Section 1371.30 and its findings regarding the impact of the act that added this section on health care service plan contracting and network adequacy.

(5) A health care service plan that provides services subject to Section 1371.9 shall meet the network adequacy requirements set forth in this chapter, including, but not limited to, subdivisions (d) and (e) of Section 1367 of this code and in Exhibits (H) and (I) of subdivision (d) of Section 1300.51 of, and Sections 1300.67.2 and 1300.67.2.1 of, Title 28 of the California Code of Regulations, including, but not limited to, inpatient hospital services and specialist physician services, and if necessary, the department may adopt additional regulations related to those services. This section shall not be construed to limit the director's authority under this chapter.

(6) For purposes of this section for Medicare fee-for-service reimbursement, geographic regions shall be the geographic regions specified for physician reimbursement for Medicare fee-for-service by the United States Department of Health and Human Services.

(7) A health care service plan shall authorize and permit assignment of the enrollee's right, if any, to any reimbursement for health care services covered under the plan contract to a noncontracting individual health professional who furnishes the health care services rendered subject to Section 1371.9. Lack of assignment pursuant to this paragraph shall not be construed to limit the applicability of this section, Section 1371.30, or Section 1371.9.

(8) A noncontracting individual health professional, health care service plan, or health care service plan's delegated entity who disputes the claim

reimbursement under this section shall utilize the independent dispute resolution process described in Section 1371.30.

(b) If nonemergency services are provided by a noncontracting individual health professional consistent with subdivision (c) of Section 1371.9 to an enrollee who has voluntarily chosen to use his or her out-of-network benefit for services covered by a plan that includes coverage for out-of-network benefits, unless otherwise agreed to by the plan and the noncontracting individual health professional, the amount paid by the health care service plan shall be the amount set forth in the enrollee's evidence of coverage. This payment is not subject to the independent dispute resolution process described in Section 1371.30.

(c) If a health care service plan delegates the responsibility for payment of claims to a contracted entity, including, but not limited to, a medical group or independent practice association, then the entity to which that responsibility is delegated shall comply with the requirements of this section.

(d)(1) A payment made by the health care service plan to the noncontracting health care professional for nonemergency services as required by Section 1371.9 and this section, in addition to the applicable cost sharing owed by the enrollee, shall constitute payment in full for nonemergency services rendered unless either party uses the independent dispute resolution process or other lawful means pursuant to Section 1371.30.

(2) Notwithstanding any other law, the amounts paid by a plan for services under this section shall not constitute the prevailing or customary charges, the usual fees to the general public, or other charges for other payers for an individual health professional.

(3) This subdivision shall not preclude the use of the independent dispute resolution process pursuant to Section 1371.30.

(e) This section shall not apply to a Medi-Cal managed health care service plan or any other entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(f) This section shall not apply to emergency services and care, as defined in Section 1317.1.

(g) The definitions in subdivision (f) of Section 1371.9 shall apply for purposes of this section.

(h) This section shall not be construed to alter a health care service plan's obligations pursuant to Sections 1371 and 1371.4.

HISTORY:
Added Stats 2016 ch 492 § 2 (AB 72), effective January 1, 2017.

§ 1371.35. Time limits for reimbursement, contest, or denial of certain claims; What constitutes complete claim; Claims excepted from time limits

(a) A health care service plan, including a specialized health care service plan, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after

receipt of the complete claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the complete claim by the health care service plan. However, a plan may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial. A plan may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the plan pays those charges specified in subdivision (b).

(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt, the plan shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. However, if the plan requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the plan may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. The provider shall provide the plan reasonable relevant information within 10 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the plan requires further information, the plan shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. A plan shall specify, in a written notice sent to the provider within the respective 30- or 45-working days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the plan has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt of the additional information, the plan shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(f) The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services. This section shall not be construed to prevent a plan from assigning, by a written contract, the responsibility to pay interest and late charges pursuant to this section to medical groups, independent practice associations, or other entities.

(g) A plan shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the plan's actions to resolve the claim, to the provider that submitted the claim.

(h) A health care service plan shall not request or require that a provider waive its rights pursuant to this section.

(i) This section shall not apply to capitated payments.

(j) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 in the United States on or after September 1, 1999.

(k) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 1371.

(*l*) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

HISTORY:
Added Stats 1998 ch 994 § 4 (AB 1560). Amended Stats 2000 ch 825 § 4 (SB 1177), ch 827 § 4 (AB 1455).

§ 1371.36. Denial of payment based on authorization

(a) A health care service plan shall not deny payment of a claim on the basis that the plan, medical group, independent practice association, or other contracting entity did not provide authorization for health care services that

were provided in a licensed acute care hospital and that were related to services that were previously authorized, if all of the following conditions are met:

(1) It was medically necessary to provide the services at the time.

(2) The services were provided after the plan's normal business hours.

(3) The plan does not maintain a system that provides for the availability of a plan representative or an alternative means of contact through an electronic system, including voicemail or electronic mail, whereby the plan can respond to a request for authorization within 30 minutes of the time that a request was made.

(b) This section shall not apply to investigational or experimental therapies, or other noncovered services.

HISTORY:
Added Stats 2000 ch 827 § 5 (AB 1455), effective January 1, 2001.

§ 1371.37. Prohibition against unfair patterns

(a) A health care service plan is prohibited from engaging in an unfair payment pattern, as defined in this section.

(b) Consistent with subdivision (a) of Section 1371.39, the director may investigate a health care service plan to determine whether it has engaged in an unfair payment pattern.

(c) An "unfair payment pattern," as used in this section, means any of the following:

(1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that results in payment delays.

(2) Engaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims.

(3) Failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Section 1371, 1371.1, or 1371.35.

(4) Failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.

(d)(1) Upon a final determination by the director that a health care service plan has engaged in an unfair payment pattern, the director may:

(A) Impose monetary penalties as permitted under this chapter.

(B) Require the health care service plan for a period of three years from the date of the director's determination, or for a shorter period prescribed by the director, to pay complete and accurate claims from the provider within a shorter period of time than that required by Section 1371. The provisions of this subparagraph shall not become operative until January 1, 2002.

(C) Include a claim for costs incurred by the department in any administrative or judicial action, including investigative expenses and the cost to monitor compliance by the plan.

(2) For any overpayment made by a health care service plan while subject to the provisions of paragraph (1), the provider shall remain liable to the plan for repayment pursuant to Section 1371.1.

(e) The enforcement remedies provided in this section are not exclusive and shall not limit or preclude the use of any otherwise available criminal, civil, or administrative remedy.

(f) The penalties set forth in this section shall not preclude, suspend, affect, or impact any other duty, right, responsibility, or obligation under a statute or under a contract between a health care service plan and a provider.

(g) A health care service plan may not delegate any statutory liability under this section.

(h) For the purposes of this section, "complete and accurate claim" has the same meaning as that provided in the regulations adopted by the department pursuant to subdivision (a) of Section 1371.38.

(i) On or before December 31, 2001, the department shall report to the Legislature and the Governor information regarding the development of the definition of "unjust pattern" as used in this section. This report shall include, but not be limited to, a description of the process used and a list of the parties involved in the department's development of this definition as well as recommendations for statutory adoption.

(j) The department shall make available upon request and on its website, information regarding actions taken pursuant to this section, including a description of the activities that were the basis for the action.

HISTORY:
Added Stats 2000 ch 827 § 6 (AB 1455), effective January 1, 2001.

§ 1371.38. Regulations and reports

(a) The department shall, on or before July 1, 2001, adopt regulations that ensure that plans have adopted a dispute resolution mechanism pursuant to subdivision (h) of Section 1367. The regulations shall require that any dispute resolution mechanism of a plan is fair, fast, and cost-effective for contracting and non-contracting providers and define the term "complete and accurate claim, including attachments and supplemental information or documentation."

(b) On or before December 31, 2001, the department shall report to the Governor and the Legislature its recommendations for any additional statutory requirements relating to plan and provider dispute resolution mechanisms.

HISTORY:
Added Stats 2000 ch 827 § 7 (AB 1455), effective January 1, 2001.

§ 1371.39. Instances of unfair payment patterns

(a) Providers may report to the department through the toll-free provider line, email address, or another method designated by the department, instances in which the provider believes a plan is engaging in an unfair payment pattern.

(b) Plans may report to the department through the toll-free provider line, email address, or another method designated by the department, instances in which the plan believes a provider is engaging in an unfair billing pattern.

(c) "Unfair billing pattern" means engaging in a demonstrable and unjust pattern of unbundling of claims, upcoding of claims, or other demonstrable and unjustified billing patterns, as defined by the department.

(d) On or before July 1, 2019, and at least annually thereafter, the department shall review complaints filed pursuant to subdivision (a). If the review of complaint data indicates a possible unfair payment pattern, the department may conduct an audit or an enforcement action pursuant to subdivision (s) of Section 1300.71 of Title 28 of the California Code of Regulations.

HISTORY:
Added Stats 2000 ch 827 § 8 (AB 1455), effective January 1, 2001. Amended Stats 2018 ch 303 § 1 (AB 2674), effective January 1, 2019.

§ 1371.4. Authorization for emergency services

(a) A health care service plan that covers hospital, medical, or surgical expenses, or its contracting medical providers, shall provide 24-hour access for enrollees and providers, including, but not limited to, noncontracting hospitals, to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.

(b) A health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan, or its contracting medical providers, reasonably determines that the emergency services and care were never performed; provided that a health care service plan, or its contracting medical providers, may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section

1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

(e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.

(f) Subdivisions (b), (c), (d), (g), and (h) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician.

(g) The Department of Managed Health Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when an enrollee requires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization.

(h) The Department of Managed Health Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider requires necessary medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan.

(i) The definitions set forth in Section 1317.1 shall control the construction of this section.

(j)(1) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall, within 30 minutes of the time the hospital makes the initial telephone call requesting information, either authorize poststabilization care or inform the hospital that it will arrange for the prompt transfer of the enrollee to another hospital.

(2) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall reimburse the hospital for poststabilization care rendered to the enrollee if any of the following occur:

(A) The health care service plan authorizes the hospital to provide poststabilization care.

(B) The health care service plan does not respond to the hospital's initial contact or does not make a decision regarding whether to authorize poststabilization care or to promptly transfer the enrollee within the timeframe set forth in paragraph (1).

(C) There is an unreasonable delay in the transfer of the enrollee, and the noncontracting physician and surgeon determines that the enrollee requires poststabilization care.

(3) A health care service plan shall not require a hospital representative or a noncontracting physician and surgeon to make more than one telephone call pursuant to Section 1262.8 to the number provided in advance by the health care service plan. The representative of the hospital that makes the telephone call may be, but is not required to be, a physician and surgeon.

(4) An enrollee who is billed by a hospital in violation of Section 1262.8 may report receipt of the bill to the health care service plan and the

department. The department shall forward that report to the State Department of Public Health.

(5) For purposes of this section, "poststabilization care" means medically necessary care provided after an emergency medical condition has been stabilized.

HISTORY:
Added Stats 1994 ch 614 § 4 (SB 1832). Amended Stats 1998 ch 1015 § 2 (AB 682), ch 1016 § 2 (SB 77); Stats 1999 ch 525 § 107 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 36 (AB 2903); Stats 2003 ch 583 § 3 (AB 1628); Stats 2008 ch 603 § 4 (AB 1203), effective January 1, 2009.

§ 1371.5. Use of emergency response system

(a) No health care service plan that provides basic health care services shall require prior authorization or refuse to pay for any ambulance or ambulance transport services, referred to in paragraph (6) of subdivision (b) of Section 1345, provided to an enrollee as a result of a "911" emergency response system request for assistance if either of the following conditions apply:

(1) The request was made for an emergency medical condition and ambulance transport services were required.

(2) An enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.

(b) As used in this section, "emergency medical condition" has the same meaning as in Section 1317.1.

(c) The determination as to whether an enrollee reasonably believed that the medical condition was an emergency medical condition that required an emergency response shall not be based solely upon a retrospective analysis of the level of care eventually provided to, or a final discharge of, the person who received emergency assistance.

(d) A health care service plan shall not be required to pay for any ambulance or ambulance transport services if the health care service plan determines that the ambulance or ambulance transport services were never performed, an emergency condition did not exist, or upon findings of fraud, incorrect billings, the provision of services that were not covered under the member's current benefit plan, or membership that was invalid at the time services were delivered for the pending emergency claim.

HISTORY:
Added Stats 1998 ch 979 § 3 (AB 984).

§ 1371.55. Services received from noncontracting air ambulance provider; "In-network cost-sharing amount" [Effective January 1, 2020]

(a)(1) Notwithstanding Section 1367.11, a health care service plan contract issued, amended, or renewed on or after January 1, 2020, shall provide that if an enrollee receives covered services from a noncontracting air ambulance provider, the enrollee shall pay no more than the same cost-sharing amount that the enrollee would pay for the same covered services received from a contracting air ambulance provider. This amount shall be referred to as the "in-network cost-sharing amount."

(2) An enrollee shall not owe the noncontracting provider more than the

in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the noncontracting provider, the plan shall inform the enrollee and the noncontracting provider of the in-network cost-sharing amount owed by the enrollee.

(b) The following shall apply for purposes of this section:

(1) Any cost sharing paid by the enrollee for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.

(3) The cost sharing paid by the enrollee pursuant to this section shall satisfy the enrollee's obligation to pay cost sharing for the health service.

(c) A noncontracting provider may advance to collections only the in-network cost-sharing amount, as determined by the plan pursuant to subdivision (a), that the enrollee failed to pay.

(d) A health care service plan or a provider may seek relief in any court for the purpose of resolving a payment dispute. A provider is not prohibited from using a health care service plan's existing dispute resolution processes.

(e) Air ambulance service providers remain subject to the balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.

HISTORY:
Added Stats 2019 ch 537 § 2 (AB 651), effective January 1, 2020.

§ 1371.8. Rescission or modification of authorization after service provided

A health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility. This section shall not be construed to expand or alter the benefits available to the enrollee or subscriber under a plan. The Legislature finds and declares that by adopting the amendments made to this section by Assembly Bill 1324 of the 2007-08 Regular Session it does not intend to instruct a court as to whether or not the amendments are existing law.

HISTORY:
Added Stats 1994 ch 614 § 5 (SB 1832). Amended Stats 2007 ch 702 § 1 (AB 1324), effective January 1, 2008.

§ 1371.9. "In-network cost-sharing amount" for services provided by noncontracting individual health professional; Exemptions

(a)(1) Except as provided in subdivision (c), a health care service plan contract issued, amended, or renewed on or after July 1, 2017, shall provide that if an enrollee receives covered services from a contracting health facility

at which, or as a result of which, the enrollee receives services provided by a noncontracting individual health professional, the enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from a contracting individual health professional. This amount shall be referred to as the "in-network cost-sharing amount."

(2) An enrollee shall not owe the noncontracting individual health professional more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the noncontracting individual health professional, the plan shall inform the enrollee and the noncontracting individual health professional of the in-network cost-sharing amount owed by the enrollee.

(3) A noncontracting individual health professional shall not bill or collect any amount from the enrollee for services subject to this section except for the in-network cost-sharing amount. Any communication from the noncontracting individual health professional to the enrollee prior to the receipt of information about the in-network cost-sharing amount pursuant to paragraph (2) shall include a notice in 12-point bold type stating that the communication is not a bill and informing the enrollee that the enrollee shall not pay until he or she is informed by his or her health care service plan of any applicable cost sharing.

(4)(A) If the noncontracting individual health professional has received more than the in-network cost-sharing amount from the enrollee for services subject to this section, the noncontracting individual health professional shall refund any overpayment to the enrollee within 30 calendar days after receiving payment from the enrollee.

(B) If the noncontracting individual health professional does not refund any overpayment to the enrollee within 30 calendar days after being informed of the enrollee's in-network cost-sharing amount, interest shall accrue at the rate of 15 percent per annum beginning with the date payment was received from the enrollee.

(C) A noncontracting individual health professional shall automatically include in his or her refund to the enrollee all interest that has accrued pursuant to this section without requiring the enrollee to submit a request for the interest amount.

(b) Except for services subject to subdivision (c), the following shall apply:

(1) Any cost sharing paid by the enrollee for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting individual health professional.

(3) The cost sharing paid by the enrollee pursuant to this section shall satisfy the enrollee's obligation to pay cost sharing for the health service and shall constitute "applicable cost sharing owed by the enrollee."

(c) For services subject to this section, if an enrollee has a health care service plan that includes coverage for out-of-network benefits, a noncontracting individual health professional may bill or collect from the enrollee the out-of-network cost sharing, if applicable, only when the enrollee consents in writing and that written consent demonstrates satisfaction of all the following criteria:

(1) At least 24 hours in advance of care, the enrollee shall consent in writing to receive services from the identified noncontracting individual health professional.

(2) The consent shall be obtained by the noncontracting individual health professional in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent shall not be obtained by the facility or any representative of the facility. The consent shall not be obtained at the time of admission or at any time when the enrollee is being prepared for surgery or any other procedure.

(3) At the time consent is provided, the noncontracting individual health professional shall give the enrollee a written estimate of the enrollee's total out-of-pocket cost of care. The written estimate shall be based on the professional's billed charges for the service to be provided. The noncontracting individual health professional shall not attempt to collect more than the estimated amount without receiving separate written consent from the enrollee or the enrollee's authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate.

(4) The consent shall advise the enrollee that he or she may elect to seek care from a contracted provider or may contact the enrollee's health care service plan in order to arrange to receive the health service from a contracted provider for lower out-of-pocket costs.

(5) The consent and estimate shall be provided to the enrollee in the language spoken by the enrollee, if the language is a Medi-Cal threshold language, as defined in subdivision (d) of Section 128552.

(6) The consent shall also advise the enrollee that any costs incurred as a result of the enrollee's use of the out-of-network benefit shall be in addition to in-network cost-sharing amounts and may not count toward the annual out-of-pocket maximum on in-network benefits or a deductible, if any, for in-network benefits.

(d) A noncontracting individual health professional who fails to comply with the requirements of subdivision (c) has not obtained written consent for purposes of this section. Under those circumstances, subdivisions (a) and (b) shall apply and subdivision (c) shall not apply.

(e)(1) A noncontracting individual health professional may advance to collections only the in-network cost-sharing amount, as determined by the plan pursuant to subdivision (a) or the out-of-network cost-sharing amount owed pursuant to subdivision (c), that the enrollee has failed to pay.

(2) The noncontracting individual health professional, or any entity acting on his or her behalf, including any assignee of the debt, shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for a minimum of 150 days after the initial billing regarding amounts owed by the enrollee under subdivision (a) or (c).

(3) With respect to an enrollee, the noncontracting individual health professional, or any entity acting on his or her behalf, including any assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills under this section.

(f) For purposes of this section and Sections 1371.30 and 1371.31, the following definitions shall apply:

(1) "Contracting health facility" means a health facility that is contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract. A contracting health care facility includes, but is not limited to, the following providers:

(A) A licensed hospital.

(B) An ambulatory surgery or other outpatient setting, as described in subdivision (a), (d), (e), (g), or (h) of Section 1248.1.

(C) A laboratory.

(D) A radiology or imaging center.

(2) "Cost sharing" includes any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the enrollee other than premium or share of premium.

(3) "Individual health professional" means a physician and surgeon or other professional who is licensed by this state to deliver or furnish health care services. For this purpose, an "individual health professional" shall not include a dentist, licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code).

(4) "In-network cost-sharing amount" means an amount no more than the same cost sharing the enrollee would pay for the same covered service received from a contracting health professional. The in-network cost-sharing amount with respect to an enrollee with coinsurance shall be based on the amount paid by the plan pursuant to paragraph (1) of subdivision (a) of Section 1371.31.

(5) "Noncontracting individual health professional" means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services and who is not contracted with the enrollee's health care service product. For this purpose, a "noncontracting individual health professional" shall not include a dentist, licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code). Application of this definition is not precluded by a noncontracting individual health professional's affiliation with a group.

(g) This section shall not be construed to require a health care service plan to cover services not required by law or by the terms and conditions of the health care service plan contract.

(h) This section shall not be construed to exempt a plan or provider from the requirements under Section 1371.4 or 1373.96, nor abrogate the holding in Prospect Medical Group, Inc. v. Northridge Emergency Medical Group (2009) 45 Cal.4th 497.

(i) If a health care service plan delegates payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, the delegated entity shall comply with this section.

(j) This section shall not apply to a Medi-Cal managed health care service plan or any other entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(k) This section shall not apply to emergency services and care, as defined in Section 1317.1.

HISTORY:
Added Stats 2016 ch 492 § 3 (AB 72), effective January 1, 2017.

§ 1372. Contracts; Use of evidence of coverage; Exception

Subject to the applicable provisions of this chapter, a plan may offer one or more plan contracts or specialized health care service plan contracts, except that a specialized health care service plan contract shall not offer one or more basic health care services except as may be permitted by rule or order of the director. Advertising, disclosure forms, contract forms, and evidences of coverage for more than one type of plan contract or specialized health care service plan contract, or both, may not be used except as authorized by the director pursuant to this chapter.

HISTORY:
Added Stats 1976 ch 652 § 3.1, effective August 28, 1976, operative July 1, 1976.
Amended Stats 1999 ch 525 § 108 (AB 78), operative July 1, 2000.

§ 1373. Required or prohibited contract provisions

(a)(1) A plan contract may not provide an exception for other coverage if the other coverage is entitlement to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or Medicaid benefits under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(2) Each plan contract shall be interpreted not to provide an exception for the Medi-Cal or Medicaid benefits.

(3) A plan contract shall not provide an exemption for enrollment because of an applicant's entitlement to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or Medicaid benefits under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(4) A plan contract may not provide that the benefits payable thereunder are subject to reduction if the individual insured has entitlement to the Medi-Cal or Medicaid benefits.

(b)(1) A plan contract that provides coverage, whether by specific benefit or by the effect of general wording, for sterilization operations or procedures shall not impose any disclaimer, restriction on, or limitation of, coverage relative to the covered individual's reason for sterilization.

(2) As used in this section, "sterilization operations or procedures" shall have the same meaning as that specified in Section 10120 of the Insurance Code.

(c) Every plan contract that provides coverage to the spouse or dependents of the subscriber or spouse shall grant immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any subscriber or spouse covered and to each minor child placed for adoption from

and after the date on which the adoptive child's birth parent or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or spouse the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the subscriber's or spouse's right to control the health care of the child placed for adoption. No plan may be entered into or amended if it contains any disclaimer, waiver, or other limitation of coverage relative to the coverage or insurability of newborn infants of, or children placed for adoption with, a subscriber or spouse covered as required by this subdivision.

(d)(1) Every plan contract that provides that coverage of a dependent child of a subscriber shall terminate upon attainment of the limiting age for dependent children specified in the plan, shall also provide that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to meet both of the following criteria:

(A) Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition.

(B) Chiefly dependent upon the subscriber for support and maintenance.

(2) The plan shall notify the subscriber that the dependent child's coverage will terminate upon attainment of the limiting age unless the subscriber submits proof of the criteria described in subparagraphs (A) and (B) of paragraph (1) to the plan within 60 days of the date of receipt of the notification. The plan shall send this notification to the subscriber at least 90 days prior to the date the child attains the limiting age. Upon receipt of a request by the subscriber for continued coverage of the child and proof of the criteria described in subparagraphs (A) and (B) of paragraph (1), the plan shall determine whether the child meets that criteria before the child attains the limiting age. If the plan fails to make the determination by that date, it shall continue coverage of the child pending its determination.

(3) The plan may subsequently request information about a dependent child whose coverage is continued beyond the limiting age under this subdivision but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

(4) If the subscriber changes carriers to another plan or to a health insurer, the new plan or insurer shall continue to provide coverage for the dependent child. The new plan or insurer may request information about the dependent child initially and not more frequently than annually thereafter to determine if the child continues to satisfy the criteria in subparagraphs (A) and (B) of paragraph (1). The subscriber shall submit the information requested by the new plan or insurer within 60 days of receiving the request.

(5)(A) Except as set forth in subparagraph (B), under no circumstances shall the limiting age be less than 26 years of age with respect to plan years beginning on or after September 23, 2010.

(B) For plan years beginning before January 1, 2014, a group health care service plan contract that qualifies as a grandfathered health plan under Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and that makes available dependent coverage of children may exclude from coverage an adult child who has not attained 26

years of age only if the adult child is eligible to enroll in an eligible employer-sponsored health plan, as defined in Section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan of a parent.

(C)(i) With respect to a child (I) whose coverage under a group or individual plan contract ended, or who was denied or not eligible for coverage under a group or individual plan contract, because under the terms of the contract the availability of dependent coverage of children ended before the attainment of 26 years of age, and (II) who becomes eligible for that coverage by reason of the application of this paragraph, the health care service plan shall give the child an opportunity to enroll that shall continue for at least 30 days. This opportunity and the notice described in clause (ii) shall be provided not later than the first day of the first plan year beginning on or after September 23, 2010, consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any additional federal guidance or regulations issued by the United States Secretary of Health and Human Services.

(ii) The health care service plan shall provide written notice stating that a dependent described in clause (i) who has not attained 26 years of age is eligible to enroll in the plan for coverage. This notice may be provided to the dependent's parent on behalf of the dependent. If the notice is included with other enrollment materials for a group plan, the notice shall be prominent.

(iii) In the case of an individual who enrolls under this subparagraph, coverage shall take effect no later than the first day of the first plan year beginning on or after September 23, 2010.

(iv) A dependent enrolling in a group health plan for coverage pursuant to this subparagraph shall be treated as a special enrollee as provided under the rules of Section 146.117(d) of Title 45 of the Code of Federal Regulations. The health care service plan shall offer the recipient of the notice all of the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. Any difference in benefits or cost-sharing requirements shall constitute a different benefit package. A dependent enrolling in a group health plan for coverage pursuant to this subparagraph shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(D) Nothing in this section shall require a health care service plan to make coverage available for a child of a child receiving dependent coverage. Nothing in this section shall be construed to modify the definition of "dependent" as used in the Revenue and Taxation Code with respect to the tax treatment of the cost of coverage.

(e) A plan contract that provides coverage, whether by specific benefit or by the effect of general wording, for both an employee and one or more covered persons dependent upon the employee and provides for an extension of the coverage for any period following a termination of employment of the employee shall also provide that this extension of coverage shall apply to dependents

upon the same terms and conditions precedent as applied to the covered employee, for the same period of time, subject to payment of premiums, if any, as required by the terms of the policy and subject to any applicable collective bargaining agreement.

(f) A group contract shall not discriminate against handicapped persons or against groups containing handicapped persons. Nothing in this subdivision shall preclude reasonable provisions in a plan contract against liability for services or reimbursement of the handicap condition or conditions relating thereto, as may be allowed by rules of the director.

(g) Every group contract shall set forth the terms and conditions under which subscribers and enrollees may remain in the plan in the event the group ceases to exist, the group contract is terminated, or an individual subscriber leaves the group, or the enrollees' eligibility status changes.

(h)(1) A health care service plan or specialized health care service plan may provide for coverage of, or for payment for, professional mental health services, or vision care services, or for the exclusion of these services. If the terms and conditions include coverage for services provided in a general acute care hospital or an acute psychiatric hospital as defined in Section 1250 and do not restrict or modify the choice of providers, the coverage shall extend to care provided by a psychiatric health facility as defined in Section 1250.2 operating pursuant to licensure by the State Department of Health Care Services. A health care service plan that offers outpatient mental health services but does not cover these services in all of its group contracts shall communicate to prospective group contractholders as to the availability of outpatient coverage for the treatment of mental or nervous disorders.

(2) No plan shall prohibit the member from selecting any psychologist who is licensed pursuant to the Psychology Licensing Law (Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code), any optometrist who is the holder of a certificate issued pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code or, upon referral by a physician and surgeon licensed pursuant to the Medical Practice Act (Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code), (A) any marriage and family therapist who is the holder of a license under Section 4980.50 of the Business and Professions Code, (B) any licensed clinical social worker who is the holder of a license under Section 4996 of the Business and Professions Code, (C) any registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, who possesses a master's degree in psychiatric-mental health nursing and is listed as a psychiatric-mental health nurse by the Board of Registered Nursing, (D) any advanced practice registered nurse certified as a clinical nurse specialist pursuant to Article 9 (commencing with Section 2838) of Chapter 6 of Division 2 of the Business and Professions Code who participates in expert clinical practice in the specialty of psychiatric-mental health nursing, to perform the particular services covered under the terms of the plan, and the certificate holder is expressly authorized by law to perform these services, or (E) any professional clinical counselor who is the holder of a license under Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code.

(3) Nothing in this section shall be construed to allow any certificate holder or licensee enumerated in this section to perform professional mental health services beyond his or her field or fields of competence as established by his or her education, training, and experience.

(4) For the purposes of this section:

(A) "Marriage and family therapist" means a licensed marriage and family therapist who has received specific instruction in assessment, diagnosis, prognosis, and counseling, and psychotherapeutic treatment of premarital, marriage, family, and child relationship dysfunctions, which is equivalent to the instruction required for licensure on January 1, 1981.

(B) "Professional clinical counselor" means a licensed professional clinical counselor who has received specific instruction in assessment, diagnosis, prognosis, counseling, and psychotherapeutic treatment of mental and emotional disorders, which is equivalent to the instruction required for licensure on January 1, 2012.

(5) Nothing in this section shall be construed to allow a member to select and obtain mental health or psychological or vision care services from a certificate holder or licenseholder who is not directly affiliated with or under contract to the health care service plan or specialized health care service plan to which the member belongs. All health care service plans and individual practice associations that offer mental health benefits shall make reasonable efforts to make available to their members the services of licensed psychologists. However, a failure of a plan or association to comply with the requirements of the preceding sentence shall not constitute a misdemeanor.

(6) As used in this subdivision, "individual practice association" means an entity as defined in subsection (5) of Section 1307 of the federal Public Health Service Act (42 U.S.C. Sec. 300e-1(5)).

(7) Health care service plan coverage for professional mental health services may include community residential treatment services that are alternatives to inpatient care and that are directly affiliated with the plan or to which enrollees are referred by providers affiliated with the plan.

(i) If the plan utilizes arbitration to settle disputes, the plan contracts shall set forth the type of disputes subject to arbitration, the process to be utilized, and how it is to be initiated.

(j) A plan contract that provides benefits that accrue after a certain time of confinement in a health care facility shall specify what constitutes a day of confinement or the number of consecutive hours of confinement that are requisite to the commencement of benefits.

(k) If a plan provides coverage for a dependent child who is over 26 years of age and enrolled as a full-time student at a secondary or postsecondary educational institution, the following shall apply:

(1) Any break in the school calendar shall not disqualify the dependent child from coverage.

(2) If the dependent child takes a medical leave of absence, and the nature of the dependent child's injury, illness, or condition would render the dependent child incapable of self-sustaining employment, the provisions of subdivision (d) shall apply if the dependent child is chiefly dependent on the subscriber for support and maintenance.

(3)(A) If the dependent child takes a medical leave of absence from school, but the nature of the dependent child's injury, illness, or condition does not meet the requirements of paragraph (2), the dependent child's coverage shall not terminate for a period not to exceed 12 months or until the date on which the coverage is scheduled to terminate pursuant to the terms and conditions of the plan, whichever comes first. The period of coverage under this paragraph shall commence on the first day of the medical leave of absence from the school or on the date the physician and surgeon determines the illness prevented the dependent child from attending school, whichever comes first. Any break in the school calendar shall not disqualify the dependent child from coverage under this paragraph.

(B) Documentation or certification of the medical necessity for a leave of absence from school shall be submitted to the plan at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the start date of the medical leave of absence from school and shall be considered prima facie evidence of entitlement to coverage under this paragraph.

(4) This subdivision shall not apply to a specialized health care service plan or to a Medicare supplement plan.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1976 ch 1185 § 94; Stats 1978 ch 648 § 1; Stats 1980 ch 11 § 1, ch 973 § 1, ch 1235 § 2, ch 1313 § 14.5; Stats 1981 ch 267 § 1, effective August 25, 1981; Stats 1982 ch 121 § 1; Stats 1983 ch 928 § 9, ch 1259 § 1.5; Stats 1984 ch 1366 § 1, ch 1367 § 1.5; Stats 1987 ch 265 § 1; Stats 1989 ch 1104 § 39; Stats 1990 ch 57 § 8 (AB 365), effective April 20, 1990; Stats 1993 ch 987 § 2 (SB 1221); Stats 1994 ch 147 § 7 (AB 2377), effective July 9, 1994; Stats 1999 ch 525 § 109 (AB 78), operative July 1, 2000; Stats 2001 ch 420 § 3 (AB 1253), effective October 2, 2001; Stats 2002 ch 1013 § 84 (SB 2026); Stats 2007 ch 617 § 3 (AB 910), effective January 1, 2008; Stats 2008 ch 390 § 1 (SB 1168), effective January 1, 2009; Stats 2010 ch 660 § 1 (SB 1088), effective January 1, 2011; Stats 2011 ch 381 § 30 (SB 146), effective January 1, 2012; Stats 2012 ch 34 § 14 (SB 1009), effective June 27, 2012; Stats 2013 ch 23 § 14 (AB 82), effective June 27, 2013.

§ 1373.1. Conversion provisions

Every group plan entered into, amended, or renewed on or after January 1, 1977, which provides hospital, medical, or surgical expense benefits for employees or subscribers and their dependents, and which contains provisions granting the employee or subscriber the right to convert the coverage in the event of termination of employment or membership, shall include in such conversion provisions the same conversion rights and conditions to a covered dependent spouse of the employee or subscriber in the event the covered dependent spouse ceases to be a qualified family member by reason of termination of marriage or death of the employee or subscriber. Such conversion rights shall not require a physical examination or a statement of health.

HISTORY:
Added Stats 1976 ch 1173 § 1.

§ 1373.2. Conversion rights of dependent spouse upon change of status

Every group health care service plan entered into, amended, or renewed on or after January 1, 1976, which provides hospital, medical, or surgical expense

benefits for employees or subscribers and their dependents and which contains provisions granting the employee or subscriber the right to convert the coverage in the event of termination of employment or membership, shall include in such conversion provisions the same conversion rights and conditions to a covered dependent spouse of the employee or subscriber in the event the covered dependent spouse ceases to be a qualified family member by reason of termination of marriage.

HISTORY:
Added Stats 1976 ch 1079 § 41.

§ 1373.3. Selection of primary care physician

An enrollee shall not be prohibited from selecting as a primary care physician any available primary care physician who contracts with the plan in the service area where the enrollee lives or works. This section shall apply to any plan contract issued, amended, renewed, or delivered on or after January 1, 1996.

HISTORY:
Added Stats 1995 ch 515 § 2 (SB 1151).

§ 1373.4. Limitation on copayments and deductibles for specified maternity services

(a) No health care service plan contract that is issued, amended, renewed, or delivered on or after July 1, 2003, that provides maternity coverage shall do either of the following:

(1) Contain a copayment or deductible for inpatient hospital maternity services that exceeds the most common amount of the copayment or deductible contained in the contract for inpatient services provided for other covered medical conditions.

(2) Contain a copayment or deductible for ambulatory care maternity services that exceeds the most common amount of the copayment or deductible contained in the contract for ambulatory care services provided for other covered medical conditions.

(b) No health care service plan that provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions as to involuntary complications of pregnancy, unless the provisions apply generally to all benefits paid under the plan.

(c) If the pregnancy is interrupted, the maternity deductible charged for prenatal care and delivery shall be based on the value of the medical services received, providing it is never more than two-thirds of the plan's maternity deductible.

(d) For purposes of this section, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

(e) This section shall not permit copayments or deductibles in the Medi-Cal program that are not otherwise authorized under state or federal law.

(f) This section shall become operative on July 1, 2003.

HISTORY:
Added Stats 2002 ch 880 § 3 (SB 1411), operative July 1, 2003.

§ 1373.5. Coverage of spouses covered under terms of same master contract; Maximum contractual benefits

When spouses are both employed as employees, and both have enrolled themselves and their eligible family members under a group health care service plan provided by their respective employers, and each spouse is covered as an employee under the terms of the same master contract, each spouse may claim on his or her behalf, or on behalf of his or her enrolled dependents, the combined maximum contractual benefits to which an employee is entitled under the terms of the master contract, not to exceed in the aggregate 100 percent of the charge for the covered expense or service.

This section shall apply to every group plan entered into, delivered, amended, or renewed in this state on or after January 1, 1978.

HISTORY:
Added Stats 1977 ch 616 § 1. Amended Stats 2016 ch 50 § 52 (SB 1005), effective January 1, 2017.

§ 1373.6. Conversion coverage

This section does not apply to a specialized health care service plan contract or to a plan contract that primarily or solely supplements Medicare. The director may adopt rules consistent with federal law to govern the discontinuance and replacement of plan contracts that primarily or solely supplement Medicare.

(a)(1) Every group contract entered into, amended, or renewed on or after September 1, 2003, that provides hospital, medical, or surgical expense benefits for employees or members shall provide that an employee or member whose coverage under the group contract has been terminated by the employer shall be entitled to convert to nongroup membership, without evidence of insurability, subject to the terms and conditions of this section.

(2) If the health care service plan provides coverage under an individual health care service plan contract, other than conversion coverage under this section, it shall offer one of the two plans that it is required to offer to a federally eligible defined individual pursuant to Section 1366.35. The plan shall provide this coverage at the same rate established under Section 1399.805 for a federally eligible defined individual. A health care service plan that is federally qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) may charge a rate for the coverage that is consistent with the provisions of that act.

(3) If the health care service plan does not provide coverage under an individual health care service plan contract, it shall offer a health benefit plan contract that is the same as a health benefit contract offered to a federally eligible defined individual pursuant to Section 1366.35. The health care service plan may offer either the most popular health maintenance organization model plan or the most popular preferred provider organization plan, each of which has the greatest number of enrolled individuals for its type of plan as of January 1 of the prior year, as reported

by plans that provide coverage under an individual health care service plan contract to the department or the Department of Insurance by January 31, 2003, and annually thereafter. A health care service plan subject to this paragraph shall provide this coverage with the same cost-sharing terms and at the same premium as a health care service plan providing coverage to that individual under an individual health care service plan contract pursuant to Section 1399.805. The health care service plan shall file the health benefit plan it will offer, including the premium it will charge and the cost-sharing terms of the plan, with the Department of Managed Health Care.

(b) A conversion contract shall not be required to be made available to an employee or member if termination of his or her coverage under the group contract occurred for any of the following reasons:

(1) The group contract terminated or an employer's participation terminated and the group contract is replaced by similar coverage under another group contract within 15 days of the date of termination of the group coverage or the subscriber's participation.

(2) The employee or member failed to pay amounts due the health care service plan.

(3) The employee or member was terminated by the health care service plan from the plan for good cause.

(4) The employee or member knowingly furnished incorrect information or otherwise improperly obtained the benefits of the plan.

(5) The employer's hospital, medical, or surgical expense benefit program is self-insured.

(c) A conversion contract is not required to be issued to any person if any of the following facts are present:

(1) The person is covered by or is eligible for benefits under Title XVIII of the United States Social Security Act.

(2) The person is covered by or is eligible for hospital, medical, or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured.

(3) The person is covered for similar benefits by an individual policy or contract.

(4) The person has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.

(d) Benefits of a conversion contract shall meet the requirements for benefits under this chapter.

(e) Unless waived in writing by the plan, written application and first premium payment for the conversion contract shall be made not later than 63 days after termination from the group. A conversion contract shall be issued by the plan which shall be effective on the day following the termination of coverage under the group contract if the written application and the first premium payment for the conversion contract are made to the plan not later than 63 days after the termination of coverage, unless these requirements are waived in writing by the plan.

(f) The conversion contract shall cover the employee or member and his or her dependents who were covered under the group contract on the date of their termination from the group.

(g) A notification of the availability of the conversion coverage shall be included in each evidence of coverage. However, it shall be the sole responsibility of the employer to notify its employees of the availability, terms, and conditions of the conversion coverage which responsibility shall be satisfied by notification within 15 days of termination of group coverage. Group coverage shall not be deemed terminated until the expiration of any continuation of the group coverage. For purposes of this subdivision, the employer shall not be deemed the agent of the plan for purposes of notification of the availability, terms, and conditions of conversion coverage.

(h) As used in this section, "hospital, medical, or surgical benefits under state or federal law" do not include benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or Title XIX of the United States Social Security Act.

(i) Every group contract entered into, amended, or renewed before September 1, 2003, shall be subject to the provisions of this section as it read prior to its amendment by Assembly Bill 1401 of the 2001-02 Regular Session.

(j)(1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plan contracts previously issued pursuant to this section to federally eligible defined individuals.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment.

(3) For purposes of this subdivision, the following definitions apply:

(A) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(B) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care Education and Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

HISTORY:

Added Stats 1981 ch 1096 § 1, operative January 1, 1983. Amended Stats 1982 ch 1038 § 1, effective September 14, 1982, ch 1186 § 1.5; Stats 1983 ch 642 § 1; Stats 1984 ch 914 § 1; Stats 1992 ch 287 § 4 (SB 925), effective July 21, 1992; Stats 2002 ch 794 § 5 (AB 1401); Stats 2013 ch 441 § 5 (AB 1180), effective October 1, 2013.

§ 1373.62. [Section repealed 2008.]

HISTORY:

Added Stats 2002 ch 794 § 6 (AB 1401), operative September 1, 2003, inoperative September 1, 2007, repealed January 1, 2008. Amended Stats 2006 ch 683 § 1 (SB 1702), effective January 1, 2007, operative until December 31, 2007. Repealed, January 1, 2008, by its own terms. The repealed section related to standard benefit plan, and pilot program.

§ 1373.620. Required notices for health care service plans

(a)(1) At least 60 days prior to the plan renewal date, a health care service

plan that does not otherwise issue individual health care service plan contracts shall issue the notice described in paragraph (2) to any subscriber enrolled in an individual health benefit plan contract issued pursuant to Section 1373.6 that is not a grandfathered health plan.

(2) The notice shall be in at least 12-point type and shall include all of the following:

(A) Notice that, as of the renewal date, the individual plan contract will not be renewed.

(B) The availability of individual health coverage through Covered California, including at least all of the following:

(i) That, beginning on January 1, 2014, individuals seeking coverage may not be denied coverage based on health status.

(ii) That the premium rates for coverage offered by a health care service plan or a health insurer cannot be based on an individual's health status.

(iii) That individuals obtaining coverage through Covered California may, depending upon income, be eligible for premium subsidies and cost-sharing subsidies.

(iv) That individuals seeking coverage must obtain this coverage during an open or special enrollment period, and a description of the open and special enrollment periods that may apply.

(b)(1) At least 60 days prior to the plan renewal date, a health care service plan that issues individual health care service plan contracts shall issue the notice described in paragraph (2) to a subscriber enrolled in an individual health benefit plan contract issued pursuant to Section 1366.35 or 1373.6 that is not a grandfathered health plan.

(2) The notice shall be in at least 12-point type and shall include all of the following:

(A) Notice that, as of the renewal date, the individual plan contract will not be renewed.

(B) Information regarding the individual health plan contract that the health plan will issue as of January 1, 2014, which the health plan has reasonably concluded is the most comparable to the individual's current plan. The notice shall include information on premiums for the possible replacement plan and instructions that the individual can continue their coverage by paying the premium stated by the due date.

(C) Notice of the availability of other individual health coverage through Covered California, including at least all of the following:

(i) That, beginning on January 1, 2014, individuals seeking coverage may not be denied coverage based on health status.

(ii) That the premium rates for coverage offered by a health care service plan or a health insurer cannot be based on an individual's health status.

(iii) That individuals obtaining coverage through Covered California may, depending upon income, be eligible for premium subsidies and cost-sharing subsidies.

(iv) That individuals seeking coverage must obtain this coverage during an open or special enrollment period, and a description of the open and special enrollment periods that may apply.

(c) No later than September 1, 2013, the department, in consultation with the Department of Insurance, shall adopt uniform model notices that health plans shall use to comply with subdivisions (a) and (b) and Sections 1366.50, 1373.622, and 1399.861. Use of the model notices shall not require prior approval by the department. The model notices adopted by the department for purposes of this section shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The director may modify the wording of these model notices specifically for the purposes of clarity, readability, and accuracy.

(d) The notices required in this section are vital documents, pursuant to clause (iii) of subparagraph (B) of paragraph (1) of subdivision (b) of Section 1367.04, and shall be subject to the applicable requirements of that section.

(e) For purposes of this section, the following definitions shall apply:

(1) "Covered California" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(2) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

HISTORY:
Added Stats 2013 ch 441 § 6 (AB 1180), effective October 1, 2013.

§ 1373.621. Additional benefits for former employee meeting tenure and age requirements and for employee's spouse or former spouse; Applicability

(a) Except for a specialized health care service plan, every health care service plan contract that is issued, amended, delivered, or renewed in this state on or after January 1, 1999, that provides hospital, medical, or surgical expense coverage under an employer-sponsored group plan for an employer subject to COBRA, as defined in subdivision (e), or an employer group for which the plan is required to offer Cal-COBRA coverage, as defined in subdivision (f), including a carrier providing replacement coverage under Section 1399.63, shall further offer the former employee the opportunity to continue benefits as required under subdivision (b), and shall further offer the former spouse of an employee or former employee the opportunity to continue benefits as required under subdivision (c).

(b)(1) In the event a former employee who worked for the employer for at least five years prior to the date of termination of employment and who is 60 years of age or older on the date employment ends is entitled to and so elects to continue benefits under COBRA or Cal-COBRA for himself or herself and for any spouse, the employee or spouse may further continue benefits beyond the date coverage under COBRA or Cal-COBRA ends, as set forth in paragraph (2). Except as otherwise specified, continuation coverage shall be under the same benefit terms and conditions as if the continuation coverage under COBRA or Cal-COBRA had remained in force. For the employee or spouse, continuation coverage following the end of COBRA or Cal-COBRA is

subject to payment of premiums to the health care service plan. Individuals ineligible for COBRA or Cal-COBRA, or who are eligible but have not elected or exhausted continuation coverage under federal COBRA or Cal-COBRA, are not entitled to continuation coverage under this section. Premiums for continuation coverage under this section shall be billed by, and remitted to, the health care service plan in accordance with subdivision (d). Failure to pay the requisite premiums may result in termination of the continuation coverage in accordance with the applicable provisions in the plan's group subscriber agreement with the former employer.

(2) The employer shall notify the former employee or spouse or both, or the former spouse of the employee or former employee, of the availability of the continuation benefits under this section in accordance with Section 2800.2 of the Labor Code. To continue health care coverage pursuant to this section, the individual shall elect to do so by notifying the plan in writing within 30 calendar days prior to the date continuation coverage under COBRA or Cal-COBRA is scheduled to end. Every health care service plan and specialized health care service plan shall provide to the employer replacing a health care service plan contract issued by the plan, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the plan reasonably required to administer the requirements of Section 2800.2 of the Labor Code.

(3) The continuation coverage shall end automatically on the earlier of (A) the date the individual reaches age 65, (B) the date the individual is covered under any group health plan not maintained by the employer or any other health plan, regardless of whether that coverage is less valuable, (C) the date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act, (D) for a spouse, five years from the date on which continuation coverage under COBRA or Cal-COBRA was scheduled to end for the spouse, or (E) the date on which the employer terminates its group subscriber agreement with the health care service plan and ceases to provide coverage for any active employees through that plan, in which case the health care service plan shall notify the former employee or spouse or both of the right to a conversion plan in accordance with Section 1373.6.

(c)(1) If a former spouse of an employee or former employee was covered as a qualified beneficiary under COBRA or Cal-COBRA, the former spouse may further continue benefits beyond the date coverage under COBRA or Cal-COBRA ends, as set forth in paragraph (2) of subdivision (b). Except as otherwise specified in this section, continuation coverage shall be under the same benefit terms and conditions as if the continuation coverage under COBRA or Cal-COBRA had remained in force. Continuation coverage following the end of COBRA or Cal-COBRA is subject to payment of premiums to the health care service plan. Premiums for continuation coverage under this section shall be billed by, and remitted to, the health care service plan in accordance with subdivision (d). Failure to pay the requisite premiums may result in termination of the continuation coverage in accordance with the applicable provisions in the plan's group subscriber agreement with the employer or former employer.

(2) The continuation coverage for the former spouse shall end automatically on the earlier of (A) the date the individual reaches 65 years of age, (B)

the date the individual is covered under any group health plan not maintained by the employer or any other health plan, regardless of whether that coverage is less valuable, (C) the date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act, (D) five years from the date on which continuation coverage under COBRA or Cal-COBRA was scheduled to end for the former spouse, or (E) the date on which the employer or former employer terminates its group subscriber agreement with the health care service plan and ceases to provide coverage for any active employees through that plan.

(d)(1) If the premium charged to the employer for a specific employee or dependent eligible under this section is adjusted for the age of the specific employee, or eligible dependent, on other than a composite basis, the rate for continuation coverage under this section shall not exceed 102 percent of the premium charged by the plan to the employer for an employee of the same age as the former employee electing continuation coverage in the case of an individual who was eligible for COBRA, and 110 percent in the case of an individual who was eligible for Cal-COBRA. If the coverage continued is that of a former spouse, the premium charged shall not exceed 102 percent of the premium charged by the plan to the employer for an employee of the same age as the former spouse selecting continuation coverage in the case of an individual who was eligible for COBRA, and 110 percent in the case of an individual who was eligible for Cal-COBRA.

(2) If the premium charged to the employer for a specific employee or dependent eligible under this section is not adjusted for age of the specific employee, or eligible dependent, then the rate for continuation coverage under this section shall not exceed 213 percent of the applicable current group rate. For purposes of this section, the "applicable current group rate" means the total premiums charged by the health care service plan for coverage for the group, divided by the relevant number of covered persons.

(3) However, in computing the premiums charged to the specific employer group, the health care service plan shall not include consideration of the specific medical care expenditures for beneficiaries receiving continuation coverage pursuant to this section.

(e) For purposes of this section, "COBRA" means Section 4980B of Title 26 of the United States Code, Section 1161 et seq. of Title 29 of the United States Code, and Section 300bb of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272), and as amended.

(f) For purposes of this section, "Cal-COBRA" means the continuation coverage that must be offered pursuant to Article 4.5 (commencing with Section 1366.20), or Article 1.7 (commencing with Section 10128.50) of Chapter 1 of Part 2 of Division 2 of the Insurance Code.

(g) For the purposes of this section, "former spouse" means either an individual who is divorced from an employee or former employee or an individual who was married to an employee or former employee at the time of the death of the employee or former employee.

(h) Every plan evidence of coverage that is issued, amended, or renewed after July 1, 1999, shall contain a description of the provisions and eligibility requirements for the continuation coverage offered pursuant to this section.

(i) This section does not apply to any individual who is not eligible for its continuation coverage prior to January 1, 2005.

HISTORY:
Added Stats 1997 ch 665 § 3 (SB 719). Amended Stats 1998 ch 107 § 12 (AB 112), effective July 6, 1998, operative January 1, 1999; Stats 2004 ch 64 § 1 (AB 254); Stats 2013 ch 441 § 7 (AB 1180), effective October 1, 2013.

§ 1373.622. Provision of coverage after termination of pilot program; Applicable rules

(a)(1) After the termination of the pilot program under Section 1373.62, a health care service plan shall continue to provide coverage under the same terms and conditions specified in Section 1376.62 as it existed on January 1, 2007, including the terms of the standard benefit plan and the subscriber payment amount, to each individual who was terminated from the program pursuant to subdivision (f) of Section 12725 of the Insurance Code during the term of the pilot program and who enrolled or applied to enroll in a standard benefit plan within 63 days of termination. The State Department of Health Care Services shall continue to pay the amount described in Section 1376.62 for each of those individuals. A health care service plan shall not be required to offer the coverage described in Section 1373.62 after the termination of the pilot program to individuals not already enrolled in the program.

(2) Notwithstanding paragraph (1) of this subdivision or Section 1373.62 as it existed on January 1, 2007, the following rules shall apply:

(A)(i) A health care service plan shall not be obligated to provide coverage to any individual pursuant to this section on or after January 1, 2014.

(ii) The State Department of Health Care Services shall not be obligated to provide any payment to any health care service plan under this section for (I) health care expenses incurred on or after January 1, 2014, or (II) the standard monthly administrative fee, as defined in Section 1373.62 as it existed on January 1, 2007, for any month after December 2013.

(B) Each health care service plan providing coverage pursuant to this section shall, on or before October 1, 2013, send a notice to each individual enrolled in a standard benefit plan that is in at least 12-point type and with, at minimum, the following information:

(i) Notice as to whether or not the plan will terminate as of January 1, 2014.

(ii) The availability of individual health coverage, including through Covered California, including at least all of the following:

(I) That, beginning on January 1, 2014, individuals seeking coverage may not be denied coverage based on health status.

(II) That the premium rates for coverage offered by a health care service plan or a health insurer cannot be based on an individual's health status.

(III) That individuals obtaining coverage through Covered California may, depending upon income, be eligible for premium subsidies and cost-sharing subsidies.

(IV) That individuals seeking coverage must obtain this coverage

during an open or special enrollment period, and a description of the open and special enrollment periods that may apply.

(C) As a condition of receiving payment for a reporting period pursuant to this section, a health care service plan shall provide the State Department of Health Care Services with a complete, final annual reconciliation report by the earlier of December 31, 2014, or an earlier date as prescribed by Section 1373.62, as it existed on January 1, 2007, for that reporting period. To the extent that it receives a complete, final reconciliation report for a reporting period by the date required pursuant to this subparagraph, the State Department of Health Care Services shall complete reconciliation with the health care service plan for that reporting period within 18 months after receiving the report.

(b) If the state fails to expend, pursuant to this section, sufficient funds for the state's contribution amount to any health care service plan, the health care service plan may increase the monthly payments that its subscribers are required to pay for any standard benefit plan to the amount that the State Department of Health Care Services would charge without a state subsidy for the same plan issued to the same individual within the program.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

HISTORY:
Added Stats 2002 ch 794 § 7 (AB 1401). Amended Stats 2013 ch 441 § 8 (AB 1180), effective October 1, 2013; Stats 2015 ch 18 § 8 (SB 75), effective June 24, 2015.

§ 1373.65. Termination of contract with provider group or general acute care hospital; Written notice; Right of enrollee to keep provider for designated time period [Effective until January 1, 2020]

(a) At least 75 days before the termination date of its contract with a provider group or a general acute care hospital, the health care service plan shall submit an enrollee block transfer filing to the department that includes the written notice the plan proposes to send to affected enrollees. The plan may not send this notice to enrollees until the department has reviewed and approved its content. If the department does not respond within seven days of the date of its receipt of the filing, the notice shall be deemed approved.

(b) At least 60 days before the termination date of a contract between a health care service plan and a provider group or a general acute care hospital, the plan shall send the written notice described in subdivision (a) by United States mail to enrollees who are assigned to the terminated provider group or hospital. A plan that is unable to comply with the timeframe because of exigent circumstances shall apply to the department for a waiver. The plan is excused from complying with this requirement only if its waiver application is granted by the department or the department does not respond within seven days of the date of its receipt of the waiver application. If the terminated provider is a hospital and the plan assigns enrollees to a provider group with exclusive admitting privileges to the hospital, the plan shall send the written notice to each enrollee who is a member of the provider group and who resides within a

15-mile radius of the terminated hospital. If the plan operates as a preferred provider organization or assigns members to a provider group with admitting privileges to hospitals in the same geographic area as the terminated hospital, the plan shall send the written notice to all enrollees who reside within a 15-mile radius of the terminated hospital.

(c) The health care service plan shall send enrollees of a preferred provider organization the written notice required by subdivision (b) only if the terminated provider is a general acute care hospital.

(d) If an individual provider terminates his or her contract or employment with a provider group that contracts with a health care service plan, the plan may require that the provider group send the notice required by subdivision (b).

(e) If, after sending the notice required by subdivision (b), a health care service plan reaches an agreement with a terminated provider to renew or enter into a new contract or to not terminate their contract, the plan shall offer each affected enrollee the option to return to that provider. If an affected enrollee does not exercise this option, the plan shall reassign the enrollee to another provider.

(f) A health care service plan and a provider shall include in all written, printed, or electronic communications sent to an enrollee that concern the contract termination or block transfer, the following statement in not less than 8-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. Please contact your HMO's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the deaf or hard of hearing hearing at 1-877-688-9891, or online at www.hmohelp.ca.gov.

(g) For purposes of this section, "provider group" means a medical group, independent practice association, or any other similar organization.

HISTORY:
Added Stats 2003 ch 591 § 3 (AB 1286). Amended Stats 2004 ch 164 § 2 (AB 1596); Stats 2016 ch 94 § 17 (AB 1709), effective January 1, 2017.

§ 1373.65. Termination of contract with provider group or general acute care hospital; Written notice; Right of enrollee to keep provider for designated time period [Effective January 1, 2020]

(a) At least 75 days before the termination date of its contract with a provider group or a general acute care hospital, the health care service plan shall submit an enrollee block transfer filing to the department that includes the written notice the plan proposes to send to affected enrollees. The plan may not send this notice to enrollees until the department has reviewed and approved its content. If the department does not respond within seven days of the date of its receipt of the filing, the notice shall be deemed approved.

(b) At least 60 days before the termination date of a contract between a health care service plan and a provider group or a general acute care hospital, the plan shall send the written notice described in subdivision (a) by United States mail to enrollees who are assigned to the terminated provider group or hospital. A plan that is unable to comply with the timeframe because of exigent

circumstances shall apply to the department for a waiver. The plan is excused from complying with this requirement only if its waiver application is granted by the department or the department does not respond within seven days of the date of its receipt of the waiver application. If the terminated provider is a hospital and the plan assigns enrollees to a provider group with exclusive admitting privileges to the hospital, the plan shall send the written notice to each enrollee who is a member of the provider group and who resides within a 15-mile radius of the terminated hospital. If the plan operates as a preferred provider organization or assigns members to a provider group with admitting privileges to hospitals in the same geographic area as the terminated hospital, the plan shall send the written notice to all enrollees who reside within a 15-mile radius of the terminated hospital.

(c) The health care service plan shall send enrollees of a preferred provider organization the written notice required by subdivision (b) only if the terminated provider is a general acute care hospital.

(d) If an individual provider terminates the provider's contract or employment with a provider group that contracts with a health care service plan, the plan may require that the provider group send the notice required by subdivision (b).

(e) If, after sending the notice required by subdivision (b), a health care service plan reaches an agreement with a terminated provider to renew or enter into a new contract or to not terminate their contract, the plan shall offer each affected enrollee the option to return to that provider. If an affected enrollee does not exercise this option, the plan shall reassign the enrollee to another provider.

(f) A health care service plan and a provider shall include in all written, printed, or electronic communications sent to an enrollee that concern the contract termination or block transfer, the following statement in not less than 8-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. Please contact your health plan's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects consumers, by telephone at its toll-free number, 1-888-466-2219, or at a TDD number for the hearing and speech impaired at 1-877-688-9891, or online at www.dmhc.ca.gov".

(g) For purposes of this section, "provider group" means a medical group, independent practice association, or any other similar organization.

HISTORY:
Added Stats 2003 ch 591 § 3 (AB 1286). Amended Stats 2004 ch 164 § 2 (AB 1596); Stats 2016 ch 94 § 17 (AB 1709), effective January 1, 2017; Stats 2019 ch 113 § 5 (AB 1802), effective January 1, 2020.

§ 1373.7. Out of state contracts; Psychologist licensure requirements

A health care service plan contract, which is written or issued for delivery outside of California and which provides benefits for California residents that are within the scope of psychological practice, shall not be deemed to prohibit persons covered under the contract from selecting a psychologist licensed in California to perform the services in California which are within the terms of the contract even though the psychologist is not licensed in the state where the contract is written or issued for delivery.

HISTORY:
Added Stats 1981 ch 558 § 1.

§ 1373.8. Contractees' right to select licensed professionals in California to perform contract services

A health care service plan contract where the plan is licensed to do business in this state and the plan provides coverage that includes California residents, but that may be written or issued for delivery outside of California, and where benefits are provided within the scope of practice of a licensed clinical social worker, a registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code who possesses a master's degree in psychiatric-mental health nursing and is listed as a psychiatric-mental health nurse by the Board of Registered Nursing, an advanced practice registered nurse who is certified as a clinical nurse specialist pursuant to Article 9 (commencing with Section 2838) of Chapter 6 of Division 2 of the Business and Professions Code who participates in expert clinical practice in the specialty of psychiatric-mental health nursing, a marriage and family therapist who is the holder of a license under Section 4980.50 of the Business and Professions Code, or a professional clinical counselor who is the holder of a license under Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code shall not be deemed to prohibit persons covered under the contract from selecting those licensed persons in California to perform the services in California that are within the terms of the contract even though the licensees are not licensed in the state where the contract is written or issued for delivery.

It is the intent of the Legislature in amending this section in the 1984 portion of the 1983-84 Legislative Session that persons covered by the contract and those providers of health care specified in this section who are licensed in California should be entitled to the benefits provided by the plan for services of those providers rendered to those persons.

HISTORY:
Added Stats 1983 ch 673 § 1. Amended Stats 1984 ch 144 § 152 (ch 540 prevails), ch 540 § 2; Stats 2001 ch 420 § 4 (AB 1253), effective October 2, 2001; Stats 2002 ch 1013 § 85 (SB 2026); Stats 2011 ch 381 § 31 (SB 146), effective January 1, 2012.

§ 1373.9. Duty to give reasonable consideration to proposals for affiliation

(a) Except in the case of a specialized health care service plan, a health care service plan which negotiates and enters into a contract with professional providers to provide services at alternative rates of payment of the type described in Sections 10133 and 11512 of the Insurance Code, shall give reasonable consideration to timely written proposals for affiliation by licensed or certified professional providers.

(b) For the purposes of this section, the following definitions are applicable:

(1) "Reasonable consideration" means consideration in good faith of the terms of proposals for affiliation prior to the time that contracts for alternative rates of payment are entered into or renewed. A plan may specify the terms and conditions of affiliation to assure cost efficiency, qualifications of providers, appropriate utilization of services, accessibility, convenience to

persons who would receive the provider's services, and consistency with the plan's basic method of operation, but shall not exclude providers because of their category of license.

(2) "Professional provider" means a holder of a certificate or license under Division 2 (commencing with Section 500) of the Business and Professions Code, or any initiative act referred to therein, except for those certified or licensed pursuant to Article 3 of Chapter 5 (commencing with Section 2050) or Chapter 11 (commencing with Section 4800), who may, within the scope of their licenses, perform the services of a specific plan benefit defined in the health care service plan's contracts with its enrollees.

(c) A plan which has an affiliation with an institutional provider or with professional providers is not required by this section to give consideration to affiliation with professional providers who hold the same category of license or certificate and propose to serve a geographic area served adequately by the affiliated providers that provide their professional services as employees or agents of that institutional or professional provider, or contract with that institutional or professional provider to provide professional services.

HISTORY:
Added Stats 1984 ch 977 § 1.

§ 1373.95. Written policy on continuity of care from health care service plan

(a)(1) A health care service plan, other than a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis, shall file a written continuity of care policy as a material modification with the department before March 31, 2004.

(2) A health care service plan shall include all of the following in its written continuity of care policy:

(A) A description of the plan's process for the block transfer of enrollees from a terminated provider group or hospital to a new provider group or hospital.

(B) A description of the manner in which the plan facilitates the completion of covered services pursuant to Section 1373.96.

(C) A template of the notice the plan proposes to send to enrollees describing its policy and informing enrollees of their right to completion of covered services.

(D) A description of the plan's process to review an enrollee's request for the completion of covered services.

(E) A provision ensuring that reasonable consideration is given to the potential clinical effect on an enrollee's treatment caused by a change of provider.

(3) If approved by the department, the provisions of the written continuity of care policy shall replace all prior continuity of care policies. The plan shall file a revision of the policy with the department if it makes a material change to it.

(b)(1) The provisions of this subdivision apply to a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis.

(2) The plan shall file with the department a written policy describing the manner in which it facilitates the continuity of care for a new enrollee who has been receiving services from a nonparticipating mental health provider for an acute, serious, or chronic mental health condition when his or her employer changed health plans. The written policy shall allow the new enrollee a reasonable transition period to continue his or her course of treatment with the nonparticipating mental health provider prior to transferring to a participating provider and shall include the provision of mental health services on a timely, appropriate, and medically necessary basis from the nonparticipating provider. The policy may provide that the length of the transition period take into account on a case-by-case basis, the severity of the enrollee's condition and the amount of time reasonably necessary to effect a safe transfer. The policy shall ensure that reasonable consideration is given to the potential clinical effect of a change of provider on the enrollee's treatment for the condition. The policy shall describe the plan's process to review an enrollee's request to continue his or her course of treatment with a nonparticipating mental health provider. Nothing in this paragraph shall be construed to require the plan to accept a nonparticipating mental health provider onto its panel for treatment of other enrollees. For purposes of the continuing treatment of the transferring enrollee, the plan may require the nonparticipating mental health provider, as a condition of the right conferred under this section, to enter into its standard mental health provider contract.

(3) A plan may require a nonparticipating mental health provider whose services are continued pursuant to the written policy, to agree in writing to the same contractual terms and conditions that are imposed upon the plan's participating providers, including location within the plan's service area, reimbursement methodologies, and rates of payment. If the plan determines that an enrollee's health care treatment should temporarily continue with his or her existing provider or nonparticipating mental health provider, the plan shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provisions of services by the existing provider or a nonparticipating mental health provider.

(4) The written policy shall not apply to an enrollee who is offered an out-of-network option or to an enrollee who had the option to continue with his or her previous specialized health care service plan that offers professional mental health services on an employer-sponsored group basis or mental health provider and instead voluntarily chose to change health plans.

(5) This subdivision shall not apply to a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis if it includes out-of-network coverage that allows the enrollee to obtain services from his or her existing mental health provider or nonparticipating mental health provider.

(c) The health care service plan, including a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis, shall provide to all new enrollees notice of its written continuity of care policy and information regarding the process for an enrollee to request

a review under the policy and shall provide, upon request, a copy of the written policy to an enrollee.

(d) Nothing in this section shall require a health care service plan or a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.

(e) The following definitions apply for the purposes of this section:

(1) "Hospital" means a general acute care hospital.

(2) "Nonparticipating mental health provider" means a psychiatrist, licensed psychologist, licensed marriage and family therapist, licensed social worker, or licensed professional clinical counselor who does not contract with the specialized health care service plan that offers professional mental health services on an employer-sponsored group basis.

(3) "Provider group" means a medical group, independent practice association, or any other similar organization.

HISTORY:
Added Stats 2003 ch 591 § 5 (AB 1286).
Amended Stats 2011 ch 381 § 32 (SB 146), effective January 1, 2012.

§ 1373.96. Completion of covered services [Effective until January 1, 2020]

(a) A health care service plan shall, at the request of an enrollee, provide for the completion of covered services as set forth in this section by a terminated provider or by a nonparticipating provider.

(b)(1) The completion of covered services shall be provided by a terminated provider to an enrollee who, at the time of the contract's termination, was receiving services from that provider for one of the conditions described in subdivision (c).

(2) The completion of covered services shall be provided by a nonparticipating provider to a newly covered enrollee who, at the time his or her coverage became effective, was receiving services from that provider for one of the conditions described in subdivision (c).

(c) The health care service plan shall provide for the completion of covered services for the following conditions:

(1) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(2) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent

with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(3) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

(4) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

(5) The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(6) Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

(d)(1) The plan may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider before termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services beyond the contract termination date.

(2) Unless otherwise agreed upon by the terminated provider and the plan or by the individual provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider. Neither the plan nor the provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.

(e)(1) The plan may require a nonparticipating provider whose services are continued pursuant to this section for a newly covered enrollee to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services.

(2) Unless otherwise agreed upon by the nonparticipating provider and the plan or by the nonparticipating provider and the provider group, the

services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider. Neither the plan nor the provider group is required to continue the services of a nonparticipating provider if the provider does not accept the payment rates provided for in this paragraph.

(f) The amount of, and the requirement for payment of, copayments, deductibles, or other cost-sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same as would be paid by the enrollee if receiving care from a provider currently contracting with or employed by the plan.

(g) If a plan delegates the responsibility of complying with this section to a provider group, the plan shall ensure that the requirements of this section are met.

(h) This section does not require a plan to provide for completion of covered services by a provider whose contract with the plan or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code, or fraud or other criminal activity.

(i) This section does not require a plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract. Except as provided in subdivision (l), this section does not apply to a newly covered enrollee covered under an individual subscriber agreement who is undergoing a course of treatment on the effective date of his or her coverage for a condition described in subdivision (c).

(j) Except as provided in subdivision (l), this section does not apply to a newly covered enrollee who is offered an out-of-network option or to a newly covered enrollee who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.

(k) The provisions contained in this section are in addition to any other responsibilities of a health care service plan to provide continuity of care pursuant to this chapter. This section does not preclude a plan from providing continuity of care beyond the requirements of this section.

(l)(1) A health care service plan shall, at the request of a newly covered enrollee under an individual health care service plan contract, arrange for the completion of covered services as set forth in this section by a nonparticipating provider for one of the conditions described in subdivision (c) if the newly covered enrollee meets both of the following:

(A) The newly covered enrollee's prior coverage was terminated under paragraph (5) or (6) of subdivision (a) of Section 1365 or subdivision (d) or (e) of Section 10273.6 of the Insurance Code, which includes circumstances when a health benefit plan is withdrawn from any portion of a market.

(B) At the time his or her coverage became effective, the newly covered enrollee was receiving services from that provider for one of the conditions described in subdivision (c).

(2) The completion of covered services required to be provided under this subdivision apply to services rendered to the newly covered enrollee on and after the effective date of his or her new coverage.

(3) A violation of this subdivision does not constitute a crime under Section 1390.

(m) Notice as to the process by which an enrollee may request completion of covered services pursuant to this section shall be provided in every disclosure form as required under Section 1363 and in any evidence of coverage issued after January 1, 2018. A plan shall provide a written copy of this information to its contracting providers and provider groups. A plan shall also provide a copy to its enrollees upon request. Notice as to the availability of the right to request completion of covered services shall be part of, accompany, or be sent simultaneously with any termination of coverage notice sent in the circumstances described in subdivision (l).

(n) The following definitions apply for the purposes of this section:

(1) "Individual provider" means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

(2) "Nonparticipating provider" means a provider who is not contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.

(3) "Provider" shall have the same meaning as set forth in subdivision (i) of Section 1345.

(4) "Provider group" means a medical group, independent practice association, or any other similar organization.

HISTORY:
Added Stats 2003 ch 591 § 7 (AB 1286). Amended Stats 2004 ch 164 § 3 (AB 1596); Stats 2014 ch 4 § 1 (AB 369), effective March 20, 2014; Stats 2017 ch 481 § 1 (SB 133), effective January 1, 2018; Stats 2018 ch 92 § 133 (SB 1289), effective January 1, 2019.

§ 1373.96. Completion of covered services [Effective January 1, 2020]

(a) A health care service plan shall, at the request of an enrollee, provide for the completion of covered services as set forth in this section by a terminated provider or by a nonparticipating provider.

(b)(1) The completion of covered services shall be provided by a terminated provider to an enrollee who, at the time of the contract's termination, was receiving services from that provider for one of the conditions described in subdivision (c).

(2) The completion of covered services shall be provided by a nonparticipating provider to a newly covered enrollee who, at the time the enrollee's coverage became effective, was receiving services from that provider for one of the conditions described in subdivision (c).

(c) The health care service plan shall provide for the completion of covered services for the following conditions:

(1) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(2)(A) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical

disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice.

(B) Completion of covered services under subparagraph (A) shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(3)(A) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

(B) For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

(4) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

(5) The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(6) Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

(d)(1) The plan may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider before termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services beyond the contract termination date.

(2) Unless otherwise agreed upon by the terminated provider and the plan or by the individual provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider. Neither the plan nor the provider group is required to

continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.

(e)(1) The plan may require a nonparticipating provider whose services are continued pursuant to this section for a newly covered enrollee to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services.

(2) Unless otherwise agreed upon by the nonparticipating provider and the plan or by the nonparticipating provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider. Neither the plan nor the provider group is required to continue the services of a nonparticipating provider if the provider does not accept the payment rates provided for in this paragraph.

(f) The amount of, and the requirement for payment of, copayments, deductibles, or other cost-sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same as would be paid by the enrollee if receiving care from a provider currently contracting with or employed by the plan.

(g) If a plan delegates the responsibility of complying with this section to a provider group, the plan shall ensure that the requirements of this section are met.

(h) This section does not require a plan to provide for completion of covered services by a provider whose contract with the plan or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code, or fraud or other criminal activity.

(i) This section does not require a plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract. Except as provided in subdivision (l), this section does not apply to a newly covered enrollee covered under an individual subscriber agreement who is undergoing a course of treatment on the effective date of their coverage for a condition described in subdivision (c).

(j) Except as provided in subdivision (l), this section does not apply to a newly covered enrollee who is offered an out-of-network option or to a newly covered enrollee who had the option to continue with their previous health plan or provider and instead voluntarily chose to change health plans.

(k) The provisions contained in this section are in addition to any other responsibilities of a health care service plan to provide continuity of care pursuant to this chapter. This section does not preclude a plan from providing continuity of care beyond the requirements of this section.

(*l*)(1) A health care service plan shall, at the request of a newly covered enrollee under an individual health care service plan contract, arrange for

the completion of covered services as set forth in this section by a nonparticipating provider for one of the conditions described in subdivision (c) if the newly covered enrollee meets both of the following:

(A) The newly covered enrollee's prior coverage was terminated under paragraph (5) or (6) of subdivision (a) of Section 1365 or subdivision (d) or (e) of Section 10273.6 of the Insurance Code, which includes circumstances when a health benefit plan is withdrawn from any portion of a market.

(B) At the time the enrollee's coverage became effective, the newly covered enrollee was receiving services from that provider for one of the conditions described in subdivision (c).

(2) The completion of covered services required to be provided under this subdivision apply to services rendered to the newly covered enrollee on and after the effective date of their new coverage.

(3) A violation of this subdivision does not constitute a crime under Section 1390.

(m) Notice as to the process by which an enrollee may request completion of covered services pursuant to this section shall be provided in every disclosure form as required under Section 1363 and in any evidence of coverage issued after January 1, 2018. A plan shall provide a written copy of this information to its contracting providers and provider groups. A plan shall also provide a copy to its enrollees upon request. Notice as to the availability of the right to request completion of covered services shall be part of, accompany, or be sent simultaneously with any termination of coverage notice sent in the circumstances described in subdivision (l).

(n) The following definitions apply for the purposes of this section:

(1) "Individual provider" means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

(2) "Maternal mental health condition" means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

(3) "Nonparticipating provider" means a provider who is not contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.

(4) "Provider" shall have the same meaning as set forth in subdivision (i) of Section 1345.

(5) "Provider group" means a medical group, independent practice association, or any other similar organization.

HISTORY:

Added Stats 2003 ch 591 § 7 (AB 1286). Amended Stats 2004 ch 164 § 3 (AB 1596); Stats 2014 ch 4 § 1 (AB 369), effective March 20, 2014; Stats 2017 ch 481 § 1 (SB 133), effective January 1, 2018; Stats 2018 ch 92 § 133 (SB 1289), effective January 1, 2019; Stats 2019 ch 776 § 1 (AB 577), effective January 1, 2020.

§ 1373.10. Acupuncture

(a) On and after January 1, 1985, every health care service plan, that is not a health maintenance organization or is not a plan that enters exclusively into

specialized health care service plan contracts, as defined by subdivision (n) of Section 1345, which provides coverage for hospital, medical, or surgical expenses, shall offer coverage to group contract holders for expenses incurred as a result of treatment by holders of certificates under Section 4938 of the Business and Professions Code, under such terms and conditions as may be agreed upon between the health care service plan and the group contract holder.

A health care service plan is not required to offer the coverage provided by this section as part of any contract covering employees of a public entity.

(b) For the purposes of this section, "health maintenance organization" or "HMO" means a public or private organization, organized under the laws of this state, which does all of the following:

(1) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, X-ray, emergency and preventive services, and out-of-area coverage.

(2) Is compensated, except for copayments, for the provision of basic health care services listed in paragraph (1) to enrolled participants on a predetermined periodic rate basis.

(3) Provides physician services primarily directly through physicians who are either employees or partners of the organization, or through arrangements with individual physicians or one or more groups of physicians, organized on a group practice or individual practice basis.

HISTORY:
Added Stats 1984 ch 1067 § 1, as H & S C § 1374.3. Amended Stats 1985 ch 84 § 1. Renumbered Stats 1986 ch 718 § 3.

§ 1373.11. Affiliation with podiatrists

A health care service plan that offers or provides one or more podiatry services, as defined in Section 2472 of the Business and Professions Code, as a specific podiatric plan benefit shall not refuse to give reasonable consideration to affiliation with podiatrists for the provision of service solely on the basis that they are podiatrists.

HISTORY:
Added Stats 1984 ch 163 § 1, as H & S C § 1373.7. Renumbered Stats 1986 ch 718 § 4.

§ 1373.12. Duty of health care service plan to consider affiliation with chiropractors

A health care service plan which offers or provides one or more chiropractic services, as defined in Section 7 of the Chiropractic Initiative Act, as a specific chiropractic plan benefit, when those services are not provided pursuant to a contract as described in subdivision (a) of Section 1373.9, shall not refuse to give reasonable consideration to affiliation with chiropractors for provision of services solely on the basis that they are chiropractors. Section 1390 shall not apply to this section.

HISTORY:
Added Stats 1991 ch 1224 § 1 (SB 1165).

§ 1373.13. Discrimination against licensed dentists; Legislative intent

(a) It is the intent of the Legislature that all persons licensed in this state to engage in the practice of dentistry shall be accorded equal professional status and privileges, without regard to the degree earned.

(b) Notwithstanding any other provision of law, no health care service plan shall discriminate, with respect to the provision of, or contracts for, professional services, against a licensed dentist solely on the basis of the educational degree held by the dentist.

HISTORY:
Added Stats 1991 ch 729 § 2 (AB 1918).

§ 1373.14. Exclusion of victims of progressive, degenerative and dementing illnesses

Except for a preexisting condition, any health care service plan, except a specialized health care service plan, which provides coverage on a group or individual basis for long-term care facility services or home-based care shall not exclude persons covered by the plan from receiving these benefits, if they are diagnosed as having any significant destruction of brain tissue with resultant loss of brain function, including, but not limited to, progressive, degenerative, and dementing illnesses, including, but not limited to, Alzheimer's disease, from the coverage offered for long-term care facility services or home-based care.

For purposes of this section, where a particular disease can be determined only with an autopsy, "diagnosed" means clinical diagnosis not dependent on pathological confirmation, but employing nationally accepted criteria.

HISTORY:
Added Stats 1987 ch 1038 § 1. Amended Stats 1988 ch 1049 § 1.

§ 1373.18. Calculation of enrollee copayments for specified contracts of health care service plan

Whenever any health care service plan, except a specialized health care service plan, negotiates and enters into a contract with providers to provide services at alternative rates of payment of the type described in Sections 10133 and 11512 of the Insurance Code, and enrollee copayments are to be based upon a percentage of the fee for services to be rendered, the amount of the enrollee copayment shall be calculated exclusively from the negotiated alternative rate for the service rendered. No health care service plan or provider, negotiating and entering into a contract pursuant to this section, shall charge or collect copayment amounts greater than those calculated in accordance with this section.

This section shall become operative on January 1, 1993.

HISTORY:
Added Stats 1991 ch 827 § 1 (SB 1085), operative January 1, 1993.

§ 1373.19. Selection of arbitrator

Any health care service plan that includes a term that requires the parties to submit to binding arbitration shall, for those cases or disputes for which the total amount of damages claimed is two hundred thousand dollars ($200,000) or less, provide for selection by the parties of a single neutral arbitrator who shall have no jurisdiction to award more than two hundred thousand dollars ($200,000). This provision shall not be subject to waiver, except that nothing in this section shall prevent the parties to an arbitration from agreeing in writing, after a case or dispute has arisen and a request for arbitration has been submitted, to use a tripartite arbitration panel that includes two party-appointed arbitrators or a panel of three neutral arbitrators, or another multiple arbitrator system mutually agreeable to the parties. The agreement shall clearly indicate, in boldface type, that "A case or dispute subject to binding arbitration has arisen between the parties and we mutually agree to waive the requirement that cases or disputes for which the total amount of damages claimed is two hundred thousand dollars ($200,000) or less be adjudicated by a single neutral arbitrator." If the parties agree to waive the requirement to use a single neutral arbitrator, the enrollee or subscriber shall have three business days to rescind the agreement. If the agreement is also signed by counsel of the enrollee or subscriber, the agreement shall be immediately binding and may not be rescinded. If the parties are unable to agree on the selection of a neutral arbitrator, and the plan does not use a professional dispute resolution organization independent of the plan that has a procedure for a rapid selection or default appointment of a neutral arbitrator, the method provided in Section 1281.6 of the Code of Civil Procedure may be utilized.

HISTORY:
Added Stats 1994 ch 653 § 4 (AB 3260).
Amended Stats 1996 ch 1093 § 1 (SB 1660).

§ 1373.20. Arbitration requirements

(a) If a plan uses arbitration to settle disputes with enrollees or subscribers, and does not use a professional dispute resolution organization independent of the plan that has a procedure for a rapid selection, or default appointment, of neutral arbitrators, the following requirements shall be met by the plan with respect to the arbitration of the disputes and shall not be subject to waiver:

(1) If the party seeking arbitration and the plan against which arbitration is sought, in cases or disputes requiring a single neutral arbitrator, are unable to select a neutral arbitrator within 30 days after service of a written demand requesting the designation, it shall be conclusively presumed that the agreed method of selection has failed and the method provided in Section 1281.6 of the Code of Civil Procedure may be utilized.

(2) In cases or disputes in which the parties have agreed to use a tripartite arbitration panel consisting of two party arbitrators and one neutral arbitrator, and the party arbitrators are unable to agree on the designation of a neutral arbitrator within 30 days after service of a written demand requesting the designation, it shall be conclusively presumed that the agreed

method of selection has failed and the method provided in Section 1281.6 of the Code of Civil Procedure may be utilized.

(b) If a court reviewing a petition filed pursuant to Section 1373.19 or subdivision (a) finds that a party has engaged in dilatory conduct intended to cause delay in proceeding under the arbitration agreement, the court, by order, may award reasonable costs, including attorney fees, incurred in connection with the filing of the petition.

(c) If a plan uses arbitration to settle disputes with enrollees or subscribers, the following requirements shall be met with respect to extreme hardship cases:

(1) The plan contract shall contain a provision for the assumption of all or a portion of an enrollee's or subscriber's share of the fees and expenses of the neutral arbitrator in cases of extreme hardship.

(2) The plan shall disclose this provision to subscribers in any evidence of coverage issued or amended after August 1, 1997.

(3) The plan shall provide enrollees, upon request, with an application for relief under this subdivision, or information on how to obtain an application from the professional dispute resolution organization that will administer the arbitration process. If the plan uses a professional dispute resolution organization independent of the plan, the provision for assumption of the arbitration fees in cases of extreme hardship shall be established and administered by the dispute resolution organization.

(4) Approval or denial of the application shall be determined by either (A) a professional dispute resolution organization independent of the plan if the plan uses a professional dispute resolution organization, or (B) a neutral arbitrator who is not assigned to hear the underlying dispute, who has been selected pursuant to paragraph (1) of subdivision (a), and whose fees and expenses are paid for by the plan.

HISTORY:
Added Stats 1996 ch 1093 § 2 (SB 1660).

§ 1373.21. Written arbitration decisions

(a) If a health care service plan uses arbitration to settle disputes with enrollees or subscribers, it shall require that an arbitration award be accompanied by a written decision to the parties that indicates the prevailing party, the amount of any award and other relevant terms of the award, and the reasons for the award rendered.

(b) A copy of any modified written decision, including the amount of the award and other relevant terms of the award, the reasons for the award rendered, the name of the arbitrator or arbitrators, but excluding the names of the enrollee, the plan, witnesses, attorneys, providers, health plan employees, and health facilities, shall be provided to the department on a quarterly basis. The department shall make these modified decisions available to the public upon request.

(c) Subdivision (b) shall not preclude the department from requesting and securing from any plan copies of complete arbitration decisions issued pursuant to subdivision (a) for the purposes of administering this chapter.

(d) If the department receives a request for information about an arbitration decision obtained by the department pursuant to subdivision (b) or (c), the

department shall not release information identifying a person or entity whose name has been or should have been removed from the arbitration decision pursuant to subdivision (b).

(e) Nothing in this section shall be construed to preclude the department, or any plan or person, from disclosing information contained in an arbitration decision if the disclosure is otherwise permitted by law.

HISTORY:
Added Stats 1998 ch 838 § 1 (SB 1702).

§ 1374. Coverage less favorable for employees than spouses

If a health care service plan entered into, amended, or renewed in this state on or after the effective date of this section provides in any manner for coverage for an employee and a covered spouse dependent on such employee, the plan shall not provide for coverage under conditions less favorable for employees than coverage provided for covered spouses dependent upon the employees.

HISTORY:
Added Stats 1976 ch 59 § 1.

§ 1374.3. Compliance with standards for insurance incident to support and for insurance coverage relating to Medi-Cal beneficiaries

Notwithstanding any other provision of this chapter or of a health care service plan contract, every health care service plan shall comply with the requirements of Chapter 7 (commencing with Section 3750) of Part 1 of Division 9 of the Family Code and Section 14124.94 of the Welfare and Institutions Code.

HISTORY:
Added Stats 1994 ch 147 § 8 (AB 2377), effective July 9, 1994. Amended Stats 1996 ch 1062 § 18 (AB 1832).

§ 1374.5. Unenforceability of lifetime waiver of mental health services coverage in nongroup contract

A health care service plan, which is issued, renewed, or amended on or after January 1, 1988, which includes mental health services coverage in nongroup contracts may not include a lifetime waiver for that coverage with respect to any applicant. The lifetime waiver of coverage provision shall be deemed unenforceable.

HISTORY:
Added Stats 1987 ch 1163 § 1.

§ 1374.51. Voluntariness of psychiatric admission not to be used when determining eligibility for reimbursement

No plan may utilize any information regarding whether an enrollee's psychiatric inpatient admission was made on a voluntary or involuntary basis for the purpose of determining eligibility for claim reimbursement.

HISTORY:
Added Stats 2001 ch 506 § 3 (AB 1424).

§ 1374.55. Coverage for treatment of infertility; "Subsidiary"

(a) On and after January 1, 1990, every health care service plan contract that is issued, amended, or renewed that covers hospital, medical, or surgical expenses on a group basis, where the plan is not a health maintenance organization as defined in Section 1373.10, shall offer coverage for the treatment of infertility, except in vitro fertilization, under those terms and conditions as may be agreed upon between the group subscriber and the plan. Every plan shall communicate the availability of that coverage to all group contractholders and to all prospective group contractholders with whom they are negotiating.

(b) For purposes of this section, "infertility" means either (1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception. "Treatment for infertility" means procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons including, but not limited to, diagnosis, diagnostic tests, medication, surgery, and gamete intrafallopian transfer. "In vitro fertilization" means the laboratory medical procedures involving the actual in vitro fertilization process.

(c) On and after January 1, 1990, every health care service plan that is a health maintenance organization, as defined in Section 1373.10, and that issues, renews, or amends a health care service plan contract that provides group coverage for hospital, medical, or surgical expenses shall offer the coverage specified in subdivision (a), according to the terms and conditions that may be agreed upon between the group subscriber and the plan to group contractholders with at least 20 employees to whom the plan is offered. The plan shall communicate the availability of the coverage to those group contractholders and prospective group contractholders with whom the plan is negotiating.

(d) This section shall not be construed to deny or restrict in any way any existing right or benefit to coverage and treatment of infertility under an existing law, plan, or policy.

(e) This section shall not be construed to require any employer that is a religious organization to offer coverage for forms of treatment of infertility in a manner inconsistent with the religious organization's religious and ethical principles.

(f)(1) This section shall not be construed to require any plan, which is a subsidiary of an entity whose owner or corporate member is a religious organization, to offer coverage for treatment of infertility in a manner inconsistent with that religious organization's religious and ethical principles.

(2) For purposes of this subdivision, "subsidiary" of a specified corporation means a corporation more than 45 percent of the voting power of which is owned directly, or indirectly through one or more subsidiaries, by the specified corporation.

(g) Consistent with Section 1365.5, coverage for the treatment of infertility shall be offered and, if purchased, provided without discrimination on the basis

of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation. Nothing in this subdivision shall be construed to interfere with the clinical judgment of a physician and surgeon.

HISTORY:
Added Stats 1989 ch 734 § 2. Amended Stats 1990 ch 830 § 1 (AB 2474), effective September 12, 1990; Stats 2013 ch 644 § 1 (AB 460), effective January 1, 2014.

§ 1374.551. Standard fertility preservation services; Basic health care service [Effective January 1, 2020]

(a) When a covered treatment may directly or indirectly cause iatrogenic infertility, standard fertility preservation services are a basic health care service, as defined in subdivision (b) of Section 1345, and are not within the scope of coverage for the treatment of infertility for the purposes of Section 1374.55.

(b) For purposes of this section, the following definitions apply:

(1) "Iatrogenic infertility" means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

(2) "May directly or indirectly cause" means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

(3) "Standard fertility preservation services" means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

(c) This section does not apply to Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services for the delivery of health care services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), Chapter 8.75 (commencing with Section 14591), or Chapter 8.9 (commencing with Section 14700) of Part 3 of Division 9 of the Welfare and Institutions Code.

HISTORY:
Added Stats 2019 ch 853 § 1 (SB 600), effective January 1, 2020.

§ 1374.56. Coverage for testing and treatment of phenylketonuria (PKU)

(a) On and after July 1, 2000, every health care service plan contract, except a specialized health care service plan contract, issued, amended, delivered, or renewed in this state that provides coverage for hospital, medical, or surgical expenses shall provide coverage for the testing and treatment of phenylketonuria (PKU) under the terms and conditions of the plan contract.

(b) Coverage for treatment of phenylketonuria (PKU) shall include those formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who

participates in or is authorized by the plan, provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).

(c) Coverage pursuant to this section is not required except to the extent that the cost of the necessary formulas and special food products exceeds the cost of a normal diet.

(d) For purposes of this section, the following definitions shall apply:

(1) "Formula" means an enteral product or enteral products for use at home that are prescribed by a physician or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, as medically necessary for the treatment of phenylketonuria (PKU).

(2) "Special food product" means a food product that is both of the following:

(A) Prescribed by a physician or nurse practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

(B) Used in place of normal food products, such as grocery store foods, used by the general population.

HISTORY:
Added Stats 1999 ch 541 § 1 (SB 148).

§ 1374.57. Exclusion of dependent child

(a) No group health care service plan that provides hospital, medical, or surgical expense benefits for employees or subscribers and their dependents shall exclude a dependent child from eligibility or benefits solely because the dependent child does not reside with the employee or subscriber.

(b) A health care service plan that provides hospital, medical, or surgical expense benefits for employees or subscribers and their dependents shall enroll, upon application by the employer or group administrator, a dependent child of the noncustodial parent when the parent is the employee or subscriber, at any time the noncustodial or custodial parent makes an application for enrollment to the employer or group administrator when a court order for medical support exists. Except as provided in Section 1374.3, the application to the employer or group administrator shall be made within 90 days of the issuance of the court order. In the case of children who are eligible for medicaid, the State Department of Health Services or the district attorney in whose jurisdiction the child resides may make that application.

(c) This section shall not be construed to require that a health care service plan enroll a dependent who resides outside the plan's geographic service area, except as provided in Section 1374.3.

(d) Notwithstanding any other provision of this section, all health care service plans shall comply with the standards set forth in Section 1374.3.

HISTORY:
Added Stats 1991 ch 1152 § 1 (AB 2118). Amended Stats 1994 ch 147 § 9 (AB 2377), effective July 9, 1994.

§ 1374.58. Group health care service plan to offer coverage for registered domestic partner equal to that provided to spouse

(a) A group health care service plan that provides hospital, medical, or surgical expense benefits shall provide equal coverage to employers or guaranteed associations, as defined in Section 1357, for the registered domestic partner of an employee or subscriber to the same extent, and subject to the same terms and conditions, as provided to a spouse of the employee or subscriber, and shall inform employers and guaranteed associations of this coverage. A plan shall not offer or provide coverage for a registered domestic partner that is not equal to the coverage provided to the spouse of an employee or subscriber, and shall not discriminate in coverage between spouses or domestic partners of a different sex and spouses or domestic partners of the same sex. The prohibitions and requirements imposed by this section are in addition to any other prohibitions and requirements imposed by law.

(b) If an employer or guaranteed association has purchased coverage for spouses and registered domestic partners pursuant to subdivision (a), a health care service plan that provides hospital, medical, or surgical expense benefits for employees or subscribers and their spouses shall enroll, upon application by the employer or group administrator, a registered domestic partner of an employee or subscriber in accordance with the terms and conditions of the group contract that apply generally to all spouses under the plan, including coordination of benefits.

(c) For purposes of this section, the term "domestic partner" shall have the same meaning as that term is used in Section 297 of the Family Code.

(d)(1) A health care service plan may require that the employee or subscriber verify the status of the domestic partnership by providing to the plan a copy of a valid Declaration of Domestic Partnership filed with the Secretary of State pursuant to Section 298 of the Family Code or an equivalent document issued by a local agency of this state, another state, or a local agency of another state under which the partnership was created. The plan may also require that the employee or subscriber notify the plan upon the termination of the domestic partnership.

(2) Notwithstanding paragraph (1), a health care service plan may require the information described in that paragraph only if it also requests from the employee or subscriber whose spouse is provided coverage, verification of marital status and notification of dissolution of the marriage.

(e) Nothing in this section shall be construed to expand the requirements of Section 4980B of Title 26 of the United States Code, Section 1161, and following, of Title 29 of the United States Code, or Section 300bb-1, and following, of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), and as those provisions may be later amended.

(f) A plan subject to this section that is issued, amended, delivered, or renewed in this state on or after January 2, 2005, shall be deemed to provide coverage for registered domestic partners that is equal to the coverage provided to a spouse of an employee or subscriber.

HISTORY:
Added Stats 2001 ch 893 § 10 (AB 25). Amended Stats 2004 ch 488 § 2 (AB 2208); Stats 2011 ch 722 § 2 (SB 757), effective January 1, 2012.

§ 1374.7. Discrimination on basis of genetic characteristics

(a) No plan shall refuse to enroll any person or accept any person as a subscriber or renew any person as a subscriber after appropriate application on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring. No plan shall require a higher rate or charge, or offer or provide different terms, conditions, or benefits, on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring.

(b) No plan shall seek information about a person's genetic characteristics for any nontherapeutic purpose.

(c) No discrimination shall be made in the fees or commissions of a solicitor or solicitor firm for an enrollment or a subscription or the renewal of an enrollment or subscription of any person on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring.

(d) "Genetic characteristics" as used in this section means either of the following:

(1) Any scientifically or medically identifiable gene or chromosome, or combination or alteration thereof, that is known to be a cause of a disease or disorder in a person or his or her offspring, or that is determined to be associated with a statistically increased risk of development of a disease or disorder, and that is presently not associated with any symptoms of any disease or disorder.

(2) Inherited characteristics that may derive from the individual or family member, that are known to be a cause of a disease or disorder in a person or his or her offspring, or that are determined to be associated with a statistically increased risk of development of a disease or disorder, and that are presently not associated with any symptoms of any disease or disorder.

HISTORY:
Added Stats 1977 ch 732 § 1. Amended Stats 1994 ch 761 § 1 (SB 1146); Stats 1995 ch 695 § 2 (SB 1020); Stats 1996 ch 532 § 2 (SB 1740), operative until January 1, 2002; Stats 1998 ch 521 § 1 (SB 1654); Stats 1999 ch 311 § 3 (SB 1185).

§ 1374.75. Discrimination by health care service plan providers against victims of domestic violence

(a) No health care service plan shall deny, refuse to enroll, refuse to renew, cancel, restrict, or otherwise terminate, exclude, or limit coverage, or charge a different rate for the same coverage, on the basis that the applicant or covered person is, has been, or may be a victim of domestic violence.

(b) Nothing in this section shall prevent a health care service plan from underwriting coverage on the basis of the medical condition of an individual so long as the consideration of the condition (1) does not take into account whether such an individual's medical condition was caused by an act of domestic violence, (2) is the same with respect to an applicant or enrollee who

is not the subject of domestic violence as with an applicant or enrollee who is the subject of domestic violence, and (3) does not violate any other act, regulation, or rule of law. The fact that an individual is, has been, or may be the subject of domestic violence shall not be considered a medical condition.

(c) As used in this section, "domestic violence" means domestic violence, as defined in Section 6211 of the Family Code.

HISTORY:
Added Stats 1995 ch 603 § 1 (AB 1973).

§ 1374.8. Disclosure to employer that employee is receiving services

(a) A health care service plan shall not release any information to an employer that would directly or indirectly indicate to the employer that an employee is receiving or has received services from a health care provider covered by the plan unless authorized to do so by the employee. An insurer that has, pursuant to an agreement, assumed the responsibility to pay compensation pursuant to Article 3 (commencing with Section 3750) of Chapter 4 of Part 1 of Division 4 of the Labor Code, shall not be considered an employer for the purposes of this section.

(b) Nothing in this section prohibits a health care service plan from releasing relevant information described in this section for the purposes set forth in Chapter 12 (commencing with Section 1871) of Part 2 of Division 1 of the Insurance Code.

(c) Nothing in this section prohibits a health care service plan from releasing relevant information described in this section for the purposes set forth in Section 1385.10.

HISTORY:
Added Stats 1994 ch 614 § 7 (SB 1832). Amended Stats 2014 ch 577 § 1 (SB 1182), effective January 1, 2015.

§ 1374.9. Administrative penalties for discrimination on basis of genetic characteristics

For violations of Section 1374.7, the director may, after appropriate notice and opportunity for hearing, by order, levy administrative penalties as follows:

(a) Any health care service plan that violates Section 1374.7, or that violates any rule or order adopted or issued pursuant to this section, is liable for administrative penalties of not less than two thousand five hundred dollars ($2,500) for each first violation, and of not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000) for each second violation, and of not less than fifteen thousand dollars ($15,000) and not more than one hundred thousand dollars ($100,000) for each subsequent violation.

(b) The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(c) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the director to enforce the provisions of this chapter.

HISTORY:
Added Stats 1995 ch 695 § 3 (SB 1020). Amended Stats 1999 ch 525 § 111 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 40 (AB 2903); Stats 2002 ch 760 § 4 (AB 3048); Stats 2008 ch 607 § 7 (SB 1379), effective September 30, 2008.

§ 1374.10. Inclusion of benefits for home health care

(a) Every health care service plan that covers hospital, medical or surgical expenses and which is not qualified as a health maintenance organization under Title XIII of the federal Public Health Service Act (42 U.S.C. Sec. 300e, et seq.) shall make available and offer to include in every group contract entered into on or after January 1, 1979, benefits for home health care as set forth in this section provided by a licensed home health agency subject to the right of the subscriber group to reject the benefits or to select any alternative level of benefits as may be offered by the health care service plan.

In rural areas where there are no licensed home health agencies or in which the supply of home health agency services does not meet the needs of the community, the services of visiting nurses, if available, shall be offered under the health care service plan subject to the terms and conditions set forth in subdivision (b).

(b) As used in this section:

(1) "Home health care" means the continued care and treatment of a covered person who is under the direct care and supervision of a physician but only if (i) continued hospitalization would have been required if home health care were not provided, (ii) the home health treatment plan is established and approved by a physician within 14 days after an inpatient hospital confinement has ended and such treatment plan is for the same or related condition for which the covered person was hospitalized, and (iii) home health care commences within 14 days after the hospital confinement has ended. "Home health services" consist of, but shall not be limited to, the following: (i) part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse; (ii) part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or occupational therapist; (iii) physical, occupational or speech therapy; and (iv) medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent such charges or costs would have been covered under the plan if the covered person had remained in the hospital.

(2) "Home health agency" means a public or private agency or organization licensed by the State Department of Health Services in accordance with the provisions of Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code.

(c) The plan may contain a limitation on the number of home health visits for which benefits are payable, but the number of such visits shall not be less than 100 in any calendar year or in any continuous 12-month period for each person covered under the plan. Except for a home health aide, each visit by a representative of a home health agency shall be considered as one home health care visit. A visit of four hours or less by a home health aide shall be considered as one home health visit.

(d) Home health benefits in this section shall be subject to all other provisions of this chapter. In addition, such benefits may be subject to an annual deductible of not more than fifty dollars ($50) for each person covered under a plan, and may be subject to a coinsurance provision which provides coverage of not less than 80 percent of the reasonable charges for such services.

(e) Nothing in this section shall preclude a plan offering other health care benefits provided in the home.

(f) Nothing in this section shall relieve any plan from providing all basic health care services as required by subdivision (i) of Section 1367 except that a plan subject to this section may fulfill that requirement with respect to home health services in connection with any particular group contract by providing benefits for home health care as set forth in this section if the subscriber group has not rejected such benefits.

HISTORY:
Added Stats 1978 ch 1130 § 1.

§ 1374.11. Prisoners' claims

No health care service plan shall deny a claim for hospital, medical, surgical, dental, or optometric services for the sole reason that the individual served was confined in a city or county jail or was a juvenile detained in any facility, if such individual is otherwise entitled to reimbursement for such services under such contract and incurs expense for the services so provided during confinement. This provision shall apply to any health care service plan contract entered into or renewed on or after July 1, 1980, whether or not such contract contains any provision terminating benefits under such plan upon an individual's confinement in a city or county jail or juvenile detention facility.

HISTORY:
Added Stats 1980 ch 90 § 1, effective May 9, 1980.

§ 1374.12. Restrictions on liability for expenses incurred while in state hospital

No health care service plan contract issued, entered into, or renewed on or after July 1, 1984, shall be deemed to contain any provision restricting the liability of the plan with respect to expenses solely because the expenses were incurred while the member was in a state hospital, if the policy, contract, or agreement would have paid for the services but for the fact that they were provided in a state hospital. Nothing in this section shall be deemed to require a plan to pay a state hospital for covered expenses incurred by a member at a rate or charge higher than the plan would pay for such services to a hospital with which the plan has entered a contract providing for alternative rates of payment or limiting payments for services secured by members.

HISTORY:
Added Stats 1983 ch 796 § 1, effective September 14, 1983.

§ 1374.13. Telehealth; Restrictions; Construction [Effective until January 1, 2020]

(a) For the purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code shall apply.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the health care provider.

(c) No health care service plan shall require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups.

(d) No health care service plan shall limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups.

(e) The requirements of this section shall also apply to health care service plan and Medi-Cal managed care plan contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(f) Notwithstanding any other provision, this section shall not be interpreted to authorize a health care service plan to require the use of telehealth when the health care provider has determined that it is not appropriate.

HISTORY:
Added Stats 2011 ch 547 § 6 (AB 415), effective January 1, 2012. Amended Stats 2012 ch 782 § 6 (AB 1733), effective January 1, 2013.

§ 1374.13. Telehealth; Restrictions; Construction [Effective January 1, 2020]

(a) For the purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the health care provider.

(c) A health care service plan shall not require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups, and pursuant to Section 1374.14.

(d) A health care service plan shall not limit the type of setting where services are provided for the patient or by the health care provider before

payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups, and pursuant to Section 1374.14.

(e) This section shall also apply to health care service plan contracts and Medi-Cal managed care plan contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(f) Notwithstanding any other law, this section does not authorize a health care service plan to require the use of telehealth if the health care provider has determined that it is not appropriate.

HISTORY:
Added Stats 2011 ch 547 § 6 (AB 415), effective January 1, 2012. Amended Stats 2012 ch 782 § 6 (AB 1733), effective January 1, 2013; Stats 2019 ch 867 § 2 (AB 744), effective January 1, 2020.

§ 1374.14. Telehealth services reimbursement [Effective January 1, 2020]

(a)(1) A contract issued, amended, or renewed on or after January 1, 2021, between a health care service plan and a health care provider for the provision of health care services to an enrollee or subscriber shall specify that the health care service plan shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an enrollee or subscriber appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(2) This section does not limit the ability of a health care service plan and a health care provider to negotiate the rate of reimbursement for a health care service provided pursuant to a contract subject to this section. Services that are the same, as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health care service plan and the provider shall ensure the rate is consistent with subdivision (h) of Section 1367.

(3) This section does not require telehealth reimbursement to be unbundled from other capitated or bundled, risk-based payments.

(b)(1) A health care service plan contract issued, amended, or renewed on or after January 1, 2021, shall specify that the health care service plan shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

(2) This section does not alter the obligation of a health care service plan to ensure that enrollees have access to all covered services through an

adequate network of contracted providers, as required under Sections 1367, 1367.03, and 1367.035, and the regulations promulgated thereunder.

(3) This section does not require a health care service plan to cover telehealth services provided by an out-of-network provider, unless coverage is required under other provisions of law.

(c) A health care service plan may offer a contract containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, provided that the copayment or coinsurance does not exceed the copayment or coinsurance applicable if the same services were delivered through in-person diagnosis, consultation, or treatment. This subdivision does not require cost sharing for services provided through telehealth.

(d) Services provided through telehealth and covered pursuant to this chapter shall be subject to the same deductible and annual or lifetime dollar maximum as equivalent services that are not provided through telehealth.

(e) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

(f) This section shall not apply to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

HISTORY:
Added Stats 2019 ch 867 § 3 (AB 744), effective January 1, 2020.

§ 1374.15. Disclosure of method used in calculating contract payment rates

Any health care service plan shall, upon request by any public entity or political subdivision of the state with whom it has entered into a contract, disclose within a reasonable time period, not to exceed 60 calendar days, the method and data used in calculating the rates of payment for the contract.

HISTORY:
Added Stats 1991 ch 898 § 2 (SB 118).

§ 1374.16. Standing referral to specialist

(a) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, and the plan medical director or his or her designee, that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by the plan or its contracting provider, medical group, or independent practice association. The treatment plan may limit the number of visits to the specialist, limit the

period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the enrollee.

(b) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate the enrollee's health care. The referral shall be made if the primary care physician, in consultation with the specialist or specialty care center if any, and the plan medical director or his or her designee determines that this specialized medical care is medically necessary for the enrollee. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, specialist or specialty care center, and enrollee, if a treatment plan is deemed necessary to describe the course of care. A treatment plan may be deemed to be not necessary provided that the appropriate referral to a specialist or specialty care center is approved by the plan or its contracting provider, medical group, or independent practice association. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the enrollee in the same manner as the enrollee's primary care physician, subject to the terms of the treatment plan.

(c) The determinations described in subdivisions (a) and (b) shall be made within three business days of the date the request for the determination is made by the enrollee or the enrollee's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or his or her designee.

(d) Subdivisions (a) and (b) do not require a health care service plan to refer to a specialist who, or to a specialty care center that, is not employed by or under contract with the health care service plan to provide health care services to its enrollees, unless there is no specialist within the plan network that is appropriate to provide treatment to the enrollee, as determined by the primary care physician in consultation with the plan medical director as documented in the treatment plan developed pursuant to subdivision (a) or (b).

(e) For the purposes of this section, "specialty care center" means a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

(f) As used in this section, a "standing referral" means a referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

(g) This section shall become operative on (1) January 1, 2004, or (2) the date of adoption of an accreditation or designation by an agency of the state or federal government or by a voluntary national health organization of an HIV or AIDS specialist, whichever date is earlier.

HISTORY:
Added Stats 2000 ch 426 § 2 (AB 2168).

§ 1374.17. Prohibition against denial of coverage for organ or tissue transplantation services based on HIV status

(a) A health care service plan shall not deny coverage that is otherwise available under the plan contract for the costs of solid organ or other tissue transplantation services based upon the enrollee or subscriber being infected with the human immunodeficiency virus.

(b) Notwithstanding any other provision of law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing, subject to the terms and conditions of the plan contract and consistent with sound clinical processes and guidelines.

HISTORY:
Added Stats 2005 ch 419 § 1 (AB 228), effective January 1, 2006.

§ 1374.19. Service plan or contract covering dental services; Coordination of benefits required

(a) This section shall only apply to a health care service plan covering dental services or a specialized health care service plan contract covering dental service pursuant to this chapter.

(b) For purposes of this section, the following terms have the following meanings:

(1) "Coordination of benefits" means the method by which a health care service plan covering dental services or a specialized health care service plan contract, covering dental services, and one or more other health care service plans, specialized health care service plans, or disability insurers, covering dental services, pay their respective reimbursements for dental benefits when an enrollee is covered by multiple health care service plans or specialized health care services plan contracts, or a combination thereof, or a combination of health care service plans or specialized health care service plan contracts and disability insurers.

(2) "Primary dental benefit plan" means a health care service plan or specialized health care service plan contract regulated pursuant to this chapter or a dental insurance policy issued by a disability insurer regulated pursuant to Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code that provides an enrollee or insured with primary dental coverage.

(3) "Secondary dental benefit plan" means a health care service plan or specialized health care service plan contract regulated pursuant to this chapter or a dental insurance policy issued by a disability insurer regulated pursuant to Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code that provides an enrollee or insured with secondary dental coverage.

(c) A health care service plan covering dental services or a specialized health care service plan issuing a specialized health care service plan contract covering dental services shall declare its coordination of benefits policy

prominently in its evidence of coverage or contract with both enrollee and subscriber.

(d) When a primary dental benefit plan is coordinating its benefits with one or more secondary dental benefits plans, it shall pay the maximum amount required by its contract with the enrollee or subscriber.

(e) A health care service plan covering dental services or a specialized health care service plan contract covering dental services, when acting as a secondary dental benefit plan, shall pay the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the enrollee's total out-of-pocket cost payable under the primary dental benefit plan for benefits covered under the secondary plan.

(f) Nothing in this section is intended to conflict with or modify the way in which a health care service plan covering dental services or a specialized health care service plan covering dental services determines which dental benefit plan is primary and which is secondary in coordinating benefits with another plan or insurer pursuant to existing state law or regulation.

HISTORY:
Added Stats 2007 ch 164 § 2 (AB 895), effective January 1, 2008.

§ 1374.193. Service plan or contract covering dental services; Third party access to provider network contract, dental services, or contractual discounts [Effective January 1, 2020]

(a) A health care service plan that issues, sells, renews, or offers a plan contract covering dental services, including a specialized health care service plan contract covering dental services, or a contracting entity may grant a third party access to a provider network contract, or a provider's dental services or contractual discounts provided pursuant to a provider network contract if the requirements of subdivisions (b) and (c) are met.

(b) A health care service plan that issues, sells, renews, or offers a plan contract covering dental services may grant a third party access to a provider network contract if, at the time the provider network contract is entered into, and at any time a notice is sent to a health care provider as required under Section 1375.7, the provider network contract allows a provider to choose not to participate in third-party access to the provider network contract. The third-party access provision of the provider network contract shall be clearly identified. A plan shall not grant third-party access to the provider network contract of a provider that does not participate in third-party access to the provider network contract.

(c) A contracting entity may grant a third party access to a provider network contract, or a provider's dental services or contractual discounts provided pursuant to a provider network contract, if all of the following are met:

(1) The provider network contract specifically states that the contracting entity may enter into an agreement with a third party that would allow the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity, and when the contracting entity is a health care service plan, the provider chose to participate in third-party access at the time the provider network contract was entered into.

(2) If the contracting entity is a health care service plan, the third-party

access provision of the provider network contract shall clearly identify in the plan contract and notice to the provider, as required pursuant to Section 1375.7, the following language conspicuously placed on the first page of the document in 12-point underlined type:

This contract grants third-party access to the provider network. The provider network contracting entity has entered into an agreement with other dental plans or third parties that allows the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity. The list of all third parties with access to this provider network can be found at (insert internet website as identified in paragraph (4)). You have the right to choose not to participate in third-party access. To exercise your right to not participate in the third-party access, submit your written or electronic request to the health care service plan.

(3) The contracting entity identifies prior to signing the contract, in writing or electronic form to the provider, all third parties in existence as of the date the provider network contract is entered into.

(4) The contracting entity identifies all third parties in existence in a list on its internet website that is updated at least once every 90 days.

(5)(A) The contracting entity requires a third party to identify the source of the discount on all written or electronic remittance advices or explanations of payment under which a discount is taken.

(B) This paragraph does not apply to electronic transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(6) A third party's right to a provider's discounted rate ceases as of the termination date of the provider network contract.

(7) The contracting entity makes available a copy of the provider network contract relied on in the adjudication of a claim to a participating provider within 30 days of a request from the provider.

(d) A provider is not bound by or required to perform dental treatment or services under a provider network contract granted to a third party in violation of this section.

(e) This section does not apply if any of the following criteria are met:

(1) The provider network contract is for dental services provided to a beneficiary of the federal Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) or the federal Medicaid program pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(2) Access to a provider network contract is granted to a health care service plan that issues, sells, renews, or offers a plan contract covering dental services, including a specialized health care service plan contract covering dental services, or a contracting entity operating under the same brand licensee program as the contracting entity.

(3) Access to a provider network contract is granted to an affiliate of a contracting entity. A list of the contracting entity's affiliates shall be made available to a provider in writing or electronic form before access is granted to a third party pursuant to subdivision (b).

(f) The director shall adopt regulations as are necessary to implement and enforce this section in accordance with the rulemaking provisions of the

Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(g) As used in this section:

(1) "Contracting entity" means a person or entity that enters into direct contracts with providers for the delivery of dental services in the ordinary course of business, including a health care service plan or third-party administrator.

(2) "Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease. "Dental services" does not include services delivered by a provider that are billed as medical expenses under a health care service plan contract or specialized health care service plan contract.

(3) "Provider" means an individual or entity that provides dental services or supplies, as defined by the health care service plan contract or specialized health care service plan contract, including a dentist or physician, but not a physician organization that leases or rents its network to a third party.

(4) "Provider network contract" means a contract between a contracting entity and a provider entered into on or after January 1, 2020, that specifies the rights and responsibilities of the contracting entity and provides for the delivery and payment of dental services to an enrollee.

(5) "Third party" means a person or entity that enters into a contract with a contracting entity or with another third party to gain access to the dental services or contractual discounts of a provider network contract. "Third party" does not include an employer or other group for whom the health care service plan, specialized health care service plan, or contracting entity provides administrative services, including the payment of claims.

HISTORY:
Added Stats 2019 ch 540 § 1 (AB 954), effective January 1, 2020.

§ 1374.195. Covered dental services; Contracts; Charge for services; Evidence of coverage and disclosure form; Required statement

(a) With respect to a contract between a health care service plan or specialized health care service plan and a dentist to provide covered dental services to enrollees of the plan, the contract shall not require a dentist to accept an amount set by the plan as payment for dental care services provided to an enrollee that are not covered services under the enrollee's plan contract. This subdivision shall only apply to provider contracts issued, amended, or renewed on or after January 1, 2011.

(b) A provider shall not charge more for dental services that are not covered services under a plan contract than his or her usual and customary rate for those services. The department shall not be required to enforce this subdivision.

(c) The evidence of coverage and disclosure form, or combined evidence of coverage and disclosure form, for every health care service plan contract covering dental services, or specialized health care service plan contract covering dental services, that is issued, amended, or renewed on or after July 1, 2011, shall include the following statement:

IMPORTANT: If you opt to receive dental services that are not covered

services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at [insert appropriate telephone number] or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

(d) For purposes of this section, "covered services" or "covered dental services" means dental care services for which the plan is obligated to pay pursuant to an enrollee's plan contract, or for which the plan would be obligated to pay pursuant to an enrollee's plan contract but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, or alternative benefit payments.

HISTORY:
Added Stats 2010 ch 673 § 1 (AB 2275), effective January 1, 2011.

ARTICLE 5.5

Health Care Service Plan Coverage Contract Changes

Section
1374.20. Prohibitions on changing premium rates of health care service plan; Exemptions.
1374.21. Notice of change in premium rates or coverage [Effective until January 1, 2020].
1374.21. Notice of change in premium rates or coverage [Effective January 1, 2020].
1374.22. Delivery of notice; Contents.
1374.23. Time of delivery of notice for specified plans.
1374.24. Limitation on liability of plan.
1374.25. Proof of mailing of notice.
1374.255. Prohibition against changing cost-sharing design during plan year; Applicability.
1374.26. Adoption of regulations.
1374.27. Penalties for violation.
1374.28. Suspension of authority of plan to transact business.
1374.29. Purpose of article.

HISTORY: Added Stats 1990 ch 949 § 1. Heading amended Stats 2002 ch 336 § 2.

§ 1374.20. Prohibitions on changing premium rates of health care service plan; Exemptions

(a) No group health care service plan shall change the premium rates or applicable copayments or coinsurances or deductibles for the length of the contract, except as specified in subdivision (b), during any of the following time periods:

(1) After the group contractholder has delivered written notice of acceptance of the contract.

(2) After the start of the employer's annual open enrollment period.

(3) After the receipt of payment of the premium for the first month of coverage in accordance with the contract effective date.

(b) Changes to the premium rates or applicable copayments or coinsurances

or deductibles of a contract shall, subject to the plan meeting the requirements of this article, be allowed in any of the following circumstances:

(1) When authorized or required in the group contract.

(2) When the contract was agreed to under a preliminary agreement that states that it is subject to execution of a definitive agreement.

(3) When the plan and contractholder mutually agree in writing.

HISTORY:
Added Stats 2002 ch 336 § 4 (AB 2052).

§ 1374.21. Notice of change in premium rates or coverage [Effective until January 1, 2020]

(a)(1) A change in premium rates or changes in coverage stated in a group health care service plan contract shall not become effective unless the plan has delivered in writing a notice indicating the change or changes at least 60 days prior to the contract renewal effective date.

(2) The notice delivered pursuant to paragraph (1) for large group health plans shall also include the following information:

(A) Whether the rate proposed to be in effect is greater than the average rate increase for individual market products negotiated by the California Health Benefit Exchange for the most recent calendar year for which the rates are final.

(B) Whether the rate proposed to be in effect is greater than the average rate increase negotiated by the Board of Administration of the Public Employees' Retirement System for the most recent calendar year for which the rates are final.

(C) Whether the rate change includes any portion of the excise tax paid by the health plan.

(b) A health care service plan that declines to offer coverage to or denies enrollment for a large group applying for coverage shall, at the time of the denial of coverage, provide the applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

(c)(1) For small group health care service plan contracts, if the department determines that a rate is unreasonable or not justified consistent with Article 6.2 (commencing with Section 1385.01), the plan shall notify the contractholder of this determination. This notification may be included in the notice required in subdivision (a).

(2) The notification to the contractholder shall be developed by the department and shall include the following statements in 14-point type:

(A) The Department of Managed Health Care has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the plan.

(B) The contractholder has the option to obtain other coverage from this plan or another plan, or to keep this coverage.

(C) Small business purchasers may want to contact Covered California at www.coveredca.com for help in understanding available options.

(3) In developing the notification, the department shall take into consideration that this notice is required to be provided to a small group applicant pursuant to subdivision (g) of Section 1385.03.

(4) The development of the notification required under this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(5) The plan may include in the notification to the contractholder the Internet Web site address at which the plan's final justification for implementing an increase that has been determined to be unreasonable by the director may be found pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations.

(6) The notice shall also be provided to the solicitor for the contractholder, if any, so that the solicitor may assist the purchaser in finding other coverage.

HISTORY:
Added Stats 1990 ch 949 § 1 (SB 2616). Amended Stats 2010 ch 661 § 2 (SB 1163), effective January 1, 2011; Stats 2014 ch 572 § 9 (SB 959), effective January 1, 2015; Stats 2015 ch 801 § 1 (SB 546), effective January 1, 2016; Stats 2016 ch 498 § 1 (SB 908), effective January 1, 2017.

§ 1374.21. Notice of change in premium rates or coverage [Effective January 1, 2020]

(a)(1) A change in premium rates or changes in coverage stated in a small group health care service plan contract shall not become effective unless the plan has delivered in writing a notice indicating the change or changes at least 60 days prior to the contract renewal effective date.

(2) A change on premium rates or changes in coverage stated in a large group health care service plan contract shall not become effective unless the plan has delivered a written notice indicating the change or changes at least 120 days before the contract renewal effective date. The notice for large group health plans shall include the following information:

(A) Whether the rate proposed to be in effect is greater than the average rate increase for individual market products negotiated by the California Health Benefit Exchange for the most recent calendar year for which the rates are final.

(B) Whether the rate proposed to be in effect is greater than the average rate increase negotiated by the Board of Administration of the Public Employees' Retirement System for the most recent calendar year for which the rates are final or greater than the average rate increase for coverage offered in the large group market, as filed pursuant to Section 1385.045.

(C) Whether the rate change includes any portion of the excise tax paid by the health plan.

(D) How to obtain the rate filing required under Article 6.2 (commencing with Section 1385.01).

(E) How to apply to the department to have the proposed rate reviewed by the department if a request is made within 30 days of the notice.

(b) A health care service plan that declines to offer coverage to or denies enrollment for a large group applying for coverage shall, at the time of the denial of coverage, provide the applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

(c)(1) For group health care service plan contracts, if the department determines that a rate is unreasonable or not justified consistent with

Article 6.2 (commencing with Section 1385.01), the plan shall notify the contractholder of this determination. This notification may be included in the notice required in subdivision (a).

(2) The notification to the contractholder shall be developed by the department and shall include the following statements in 14-point type:

(A) The Department of Managed Health Care has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the plan.

(B) The contractholder has the option to obtain other coverage from this plan or another plan, or to keep this coverage.

(C) Small business purchasers may want to contact Covered California at www.coveredca.com for help in understanding available options.

(3) In developing the notification, the department shall take into consideration that this notice is required to be provided to a small group applicant pursuant to subdivision (g) of Section 1385.03.

(4) The development of the notification required under this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(5) The plan may include in the notification to the contractholder the internet website address at which the plan's final justification for implementing an increase that has been determined to be unreasonable by the director may be found pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations..

(6) The notice shall also be provided to the solicitor for the contractholder, if any, so that the solicitor may assist the purchaser in finding other coverage.

HISTORY:
Added Stats 1990 ch 949 § 1 (SB 2616). Amended Stats 2010 ch 661 § 2 (SB 1163), effective January 1, 2011; Stats 2014 ch 572 § 9 (SB 959), effective January 1, 2015; Stats 2015 ch 801 § 1 (SB 546), effective January 1, 2016; Stats 2016 ch 498 § 1 (SB 908), effective January 1, 2017; Stats 2019 ch 807 § 1 (AB 731), effective January 1, 2020.

§ 1374.22. Delivery of notice; Contents

(a) The written notice described in subdivision (a) of Section 1374.21 shall be delivered by mail at the last known address at least 60 days prior to the renewal effective date to the group contract holder.

(b) The written notice shall state in italics and in 12-point type the actual dollar amount and the specific percentage of the premium rate increase. Further, the notice shall describe in plain understandable English and highlighted in italics any changes in the plan design or change in benefits with reduction in benefits, waivers, exclusions, or conditions.

(c) The written notice shall specify in a minimum of 10-point bold typeface the reason or reasons for premium rate changes, plan design, or plan benefit changes.

HISTORY:
Added Stats 1990 ch 949 § 1 (SB 2616). Amended Stats 2010 ch 661 § 3 (SB 1163), effective January 1, 2011.

§ 1374.23. Time of delivery of notice for specified plans

Notwithstanding subdivision (a) of Section 1374.22, if the plan does not guarantee either premium rates or plan design or benefits for any specified time period greater than 180 days, it shall deliver the written notice by mail to the group contract holder at least 30 days prior to the group contract renewal effective date.

HISTORY:
Added Stats 1990 ch 949 § 1 (SB 2616).

§ 1374.24. Limitation on liability of plan

There shall be no liability on the part of, and no cause of action of any nature shall arise against, any health care service plan required to provide the notice or its authorized representatives, or agents, for any statement made, unless shown to have been made with malice in fact, by any of them in (a) any written notice or in any other oral or written communication specifying the reasons for the notice, (b) any communication providing information pertaining to that notice, or (c) evidence submitted at any court proceeding or informal inquiry in which that notice is at issue.

HISTORY:
Added Stats 1990 ch 949 § 1 (SB 2616).

§ 1374.25. Proof of mailing of notice

Proof of mailing a notice and the reason therefor to the appropriate entity or individual at the most current policy or plan address shall be sufficient proof of the notice required by this chapter.

HISTORY:
Added Stats 1990 ch 949 § 1 (SB 2616).

§ 1374.255. Prohibition against changing cost-sharing design during plan year; Applicability

(a) This section shall apply to grandfathered health care service plan contracts and nongrandfathered health care service plan contracts in the individual or small group markets that are issued, amended, or renewed on or after January 1, 2017.

(b) Notwithstanding paragraph (1) of subdivision (b) of Section 1374.20, a health care service plan contract shall not change the cost-sharing design during the plan year, except when required by state or federal law.

(c) For purposes of this section, the following definitions shall apply:

(1) "Cost sharing" includes any copayment, coinsurance, deductible, or any other form of cost sharing by the enrollee other than the premium or share of premium.

(2) "Plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health care service plan contracts in the individual market, "plan year" means the calendar year.

(3) "Cost-sharing design" means the amount or proportion of cost sharing applied to a covered benefit.

HISTORY:
Added Stats 2016 ch 192 § 1 (SB 923), effective January 1, 2017.

§ 1374.26. Adoption of regulations

The director may, as required by this article, or from time to time as conditions warrant, pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, adopt reasonable regulations, and amendments and additions thereto, as are necessary to administer this article.

HISTORY:
Added Stats 1990 ch 949 § 1 (SB 2616). Amended Stats 1999 ch 525 § 112 (AB 78), operative July 1, 2000.

§ 1374.27. Penalties for violation

The director may levy administrative penalties and may suspend or revoke the license or licenses issued to any health care service plan, after notice and hearing, to have violated this article or a regulation adopted pursuant to the authority of this article. Notice of hearing shall be accomplished and a hearing conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the director shall have all of the powers granted therein.

The remedies available to the director pursuant to this article are not exclusive, and may be sought and employed in any combination with other remedies deemed advisable by the director to enforce the provisions of this article.

HISTORY:
Added Stats 1990 ch 949 § 1 (SB 2616). Amended Stats 1999 ch 525 § 113 (AB 78), operative July 1, 2000.

§ 1374.28. Suspension of authority of plan to transact business

In addition to any other penalty provided by law or the availability of any administrative procedure, if a health care service plan, after notice and hearing, is found to have violated this article, or regulations adopted pursuant to this article, or knowingly permits any person to do so, the director may suspend the authority of the plan to transact business.

HISTORY:
Added Stats 1990 ch 949 § 1 (SB 2616). Amended Stats 1999 ch 525 § 114 (AB 78), operative July 1, 2000.

§ 1374.29. Purpose of article

The purpose of this article is to promote the public interest, to prevent unfair and unlawful health care business practices, and to promote adequate consumer and employer advance notice of changes in the cost of health coverage in order to allow for comparative shopping and to reduce the cost of health coverage.

HISTORY:
Added Stats 1990 ch 949 § 1, as H & S C § 1374.20. Amended and renumbered by Stats 2002 ch 336 § 3 (AB 2052).

ARTICLE 5.55

Appeals Seeking Independent Medical Reviews

Section
1374.30. Establishment of Independent Medical Review System; Participation; Conditions for application for independent review; Forms.
1374.31. Imminent threat to health; Expeditious review.
1374.32. Medical review organizations.
1374.33. Analysis and determination.
1374.34. Prompt implementation of decision; Review and audit.
1374.35. Reimbursement of costs.
1374.36. Report on implementation of article.

HISTORY: Added Stats 1999 ch 533 § 1.

§ 1374.30. Establishment of Independent Medical Review System; Participation; Conditions for application for independent review; Forms

(a) Commencing January 1, 2001, there is hereby established in the department the Independent Medical Review System.

(b) For the purposes of this chapter, "disputed health care service" means any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision. A disputed health care service does not include services provided by a specialized health care service plan, except to the extent that the service (1) involves the practice of medicine, or (2) is provided pursuant to a contract with a health care service plan that covers hospital, medical, or surgical benefits. If a plan, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the statement of decision shall clearly specify the provision in the contract that excludes that coverage.

(c) For the purposes of this chapter, "coverage decision" means the approval or denial of health care services by a plan, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract. A "coverage decision" does not encompass a plan or contracting provider decision regarding a disputed health care service.

(d)(1) All enrollee grievances involving a disputed health care service are eligible for review under the Independent Medical Review System if the requirements of this article are met. If the department finds that an enrollee grievance involving a disputed health care service does not meet the requirements of this article for review under the Independent Medical Review System, the enrollee request for review shall be treated as a request for the department to review the grievance pursuant to subdivision (b) of Section 1368. All other enrollee grievances, including grievances involving coverage decisions, remain eligible for review by the department pursuant to subdivision (b) of Section 1368.

(2) In any case in which an enrollee or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical necessity, the department shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review as provided under this article or pursuant to subdivision (b) of Section 1368.

(3) The department shall be the final arbiter when there is a question as to whether an enrollee grievance is a disputed health care service or a coverage decision. The department shall establish a process to complete an initial screening of an enrollee grievance. If there appears to be any medical necessity issue, the grievance shall be resolved pursuant to an independent medical review as provided under this article or pursuant to subdivision (b) of Section 1368.

(e) Every health care service plan contract that is issued, amended, renewed, or delivered in this state on or after January 1, 2000, shall, effective January 1, 2001, provide an enrollee with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the plan, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. For purposes of this article, an enrollee may designate an agent to act on his or her behalf, as described in paragraph (2) of subdivision (b) of Section 1368. The provider may join with or otherwise assist the enrollee in seeking an independent medical review, and may advocate on behalf of the enrollee.

(f) Medi-Cal beneficiaries enrolled in a health care service plan shall not be excluded from participation. Medicare beneficiaries enrolled in a health care service plan shall not be excluded unless expressly preempted by federal law. Reviews of cases for Medi-Cal enrollees shall be conducted in accordance with statutes and regulations for the Medi-Cal program.

(g) The department may seek to integrate the quality of care and consumer protection provisions, including remedies, of the Independent Medical Review System with related dispute resolution procedures of other health care agency programs, including the Medicare and Medi-Cal programs, in a way that minimizes the potential for duplication, conflict, and added costs. Nothing in this subdivision shall be construed to limit any rights conferred upon enrollees under this chapter.

(h) The independent medical review process authorized by this article is in addition to any other procedures or remedies that may be available.

(i) Every health care service plan shall prominently display in every plan member handbook or relevant informational brochure, in every plan contract, on enrollee evidence of coverage forms, on copies of plan procedures for resolving grievances, on letters of denials issued by either the plan or its contracting organization, on the grievance forms required under Section 1368, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the plan, or by one of its contracting providers.

(j) An enrollee may apply to the department for an independent medical review when all of the following conditions are met:

(1)(A) The enrollee's provider has recommended a health care service as medically necessary, or

(B) The enrollee has received urgent care or emergency services that a provider determined was medically necessary, or

(C) The enrollee, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the enrollee seeks independent review. The plan shall expedite access to an in-plan provider upon request of an enrollee. The in-plan provider need not recommend the disputed health care service as a condition for the enrollee to be eligible for an independent review.

For purposes of this article, the enrollee's provider may be an out-of-plan provider. However, the plan shall have no liability for payment of services provided by an out-of-plan provider, except as provided pursuant to subdivision (c) of Section 1374.34.

(2) The disputed health care service has been denied, modified, or delayed by the plan, or by one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary.

(3) The enrollee has filed a grievance with the plan or its contracting provider pursuant to Section 1368, and the disputed decision is upheld or the grievance remains unresolved after 30 days. The enrollee shall not be required to participate in the plan's grievance process for more than 30 days. In the case of a grievance that requires expedited review pursuant to Section 1368.01, the enrollee shall not be required to participate in the plan's grievance process for more than three days.

(k) An enrollee may apply to the department for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically necessary, within six months of any of the qualifying periods or events under subdivision (j). The director may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

(*l*) The enrollee shall pay no application or processing fees of any kind.

(m) As part of its notification to the enrollee regarding a disposition of the enrollee's grievance that denies, modifies, or delays health care services, the plan shall provide the enrollee with a one-page application form approved by the department, and an addressed envelope, which the enrollee may return to initiate an independent medical review. The plan shall include on the form any information required by the department to facilitate the completion of the independent medical review, such as the enrollee's diagnosis or condition, the nature of the disputed health care service sought by the enrollee, a means to identify the enrollee's case, and any other material information. The form shall also include the following:

(1) Notice that a decision not to participate in the independent medical review process may cause the enrollee to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service.

(2) A statement indicating the enrollee's consent to obtain any necessary medical records from the plan, any of its contracting providers, and any out-of-plan provider the enrollee may have consulted on the matter, to be signed by the enrollee.

(3) Notice of the enrollee's right to provide information or documentation, either directly or through the enrollee's provider, regarding any of the following:

(A) A provider recommendation indicating that the disputed health care service is medically necessary for the enrollee's medical condition.

(B) Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the enrollee's medical condition.

(C) Reasonable information supporting the enrollee's position that the disputed health care service is or was medically necessary for the enrollee's medical condition, including all information provided to the enrollee by the plan or any of its contracting providers, still in the possession of the enrollee, concerning a plan or provider decision regarding disputed health care services, and a copy of any materials the enrollee submitted to the plan, still in the possession of the enrollee, in support of the grievance, as well as any additional material that the enrollee believes is relevant.

(4) A section designed to collect information on the enrollee's ethnicity, race, and primary language spoken that includes both of the following:

(A) A statement of intent indicating that the information is used for statistics only, in order to ensure that all enrollees get the best care possible.

(B) A statement indicating that providing this information is optional and will not affect the independent medical review process in any way.

(n) Upon notice from the department that the health care service plan's enrollee has applied for an independent medical review, the plan or its contracting providers shall provide to the independent medical review organization designated by the department a copy of all of the following documents within three business days of the plan's receipt of the department's notice of a request by an enrollee for an independent review:

(1)(A) A copy of all of the enrollee's medical records in the possession of the plan or its contracting providers relevant to each of the following:

(i) The enrollee's medical condition.

(ii) The health care services being provided by the plan and its contracting providers for the condition.

(iii) The disputed health care services requested by the enrollee for the condition.

(B) Any newly developed or discovered relevant medical records in the possession of the plan or its contracting providers after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The plan shall concurrently provide a copy of medical records required by this subparagraph to the enrollee or the enrollee's provider, if authorized by the enrollee, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

(2) A copy of all information provided to the enrollee by the plan and any of its contracting providers concerning plan and provider decisions regarding

the enrollee's condition and care, and a copy of any materials the enrollee or the enrollee's provider submitted to the plan and to the plan's contracting providers in support of the enrollee's request for disputed health care services. This documentation shall include the written response to the enrollee's grievance, required by paragraph (4) of subdivision (a) of Section 1368. The confidentiality of any enrollee medical information shall be maintained pursuant to applicable state and federal laws.

(3) A copy of any other relevant documents or information used by the plan or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the plan and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity. The plan shall concurrently provide a copy of documents required by this paragraph, except for any information found by the director to be legally privileged information, to the enrollee and the enrollee's provider. The department and the independent medical review organization shall maintain the confidentiality of any information found by the director to be the proprietary information of the plan.

(o) This section shall become operative on July 1, 2015.

HISTORY:
Added Stats 2012 ch 872 § 2 (SB 1410), effective January 1, 2013, operative July 1, 2015.

§ 1374.31. Imminent threat to health; Expeditious review

(a) If there is an imminent and serious threat to the health of the enrollee, as specified in subdivision (c) of Section 1374.33, all necessary information and documents shall be delivered to an independent medical review organization within 24 hours of approval of the request for review. In reviewing a request for review, the department may waive the requirement that the enrollee follow the plan's grievance process in extraordinary and compelling cases, where the director finds that the enrollee has acted reasonably.

(b) The department shall expeditiously review requests and immediately notify the enrollee in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. The plan shall promptly issue a notification to the enrollee, after submitting all of the required material to the independent medical review organization, that includes an annotated list of documents submitted and offer the enrollee the opportunity to request copies of those documents from the plan. The department shall promptly approve enrollee requests whenever the enrollee's plan has agreed that the case is eligible for an independent medical review. The department shall not refer coverage decisions for independent review. To the extent an enrollee request for independent review is not approved by the department, the enrollee request shall be treated as an immediate request for the department to review the grievance pursuant to subdivision (b) of Section 1368.

(c) An independent medical review organization, specified in Section 1374.32, shall conduct the review in accordance with Section 1374.33 and any regulations or orders of the director adopted pursuant thereto. The organization's review shall be limited to an examination of the medical necessity of the

disputed health care services and shall not include any consideration of coverage decisions or other contractual issues.

HISTORY:
Added Stats 1999 ch 533 § 1 (AB 55).

§ 1374.32. Medical review organizations

(a) The department shall contract with one or more independent medical review organizations in the state to conduct reviews for purposes of this article. The independent medical review organizations shall be independent of any health care service plan doing business in this state. The director may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this article, that an organization shall be required to meet in order to qualify for participation in the Independent Medical Review System and to assist the department in carrying out its responsibilities.

(b) The independent medical review organizations and the medical professionals retained to conduct reviews shall be deemed to be medical consultants for purposes of Section 43.98 of the Civil Code.

(c) The independent medical review organization, any experts it designates to conduct a review, or any officer, director, or employee of the independent medical review organization shall not have any material professional, familial, or financial affiliation, as determined by the director, with any of the following:

(1) The plan.

(2) Any officer, director, or employee of the plan.

(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the plan, would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the enrollee whose treatment is under review, or the alternative therapy, if any, recommended by the plan.

(6) The enrollee or the enrollee's immediate family.

(d) In order to contract with the department for purposes of this article, an independent medical review organization shall meet all of the following requirements:

(1) The organization shall not be an affiliate or a subsidiary of, nor in any way be owned or controlled by, a health plan or a trade association of health plans. A board member, director, officer, or employee of the independent medical review organization shall not serve as a board member, director, or employee of a health care service plan. A board member, director, or officer of a health plan or a trade association of health plans shall not serve as a board member, director, officer, or employee of an independent medical review organization.

(2) The organization shall submit to the department the following information upon initial application to contract for purposes of this article and, except as otherwise provided, annually thereafter upon any change to any of the following information:

(A) The names of all stockholders and owners of more than 5 percent of any stock or options, if a publicly held organization.

(B) The names of all holders of bonds or notes in excess of one hundred thousand dollars ($100,000), if any.

(C) The names of all corporations and organizations that the independent medical review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business.

(D) The names and biographical sketches of all directors, officers, and executives of the independent medical review organization, as well as a statement regarding any past or present relationships the directors, officers, and executives may have with any health care service plan, disability insurer, managed care organization, provider group, or board or committee of a plan, managed care organization, or provider group.

(E)(i) The percentage of revenue the independent medical review organization receives from expert reviews, including, but not limited to, external medical reviews, quality assurance reviews, and utilization reviews.

(ii) The names of any health care service plan or provider group for which the independent medical review organization provides review services, including, but not limited to, utilization review, quality assurance review, and external medical review. Any change in this information shall be reported to the department within five business days of the change.

(F) A description of the review process including, but not limited to, the method of selecting expert reviewers and matching the expert reviewers to specific cases.

(G) A description of the system the independent medical review organization uses to identify and recruit medical professionals to review treatment and treatment recommendation decisions, the number of medical professionals credentialed, and the types of cases and areas of expertise that the medical professionals are credentialed to review.

(H) A description of how the independent medical review organization ensures compliance with the conflict-of-interest provisions of this section.

(3) The organization shall demonstrate that it has a quality assurance mechanism in place that does the following:

(A) Ensures that the medical professionals retained are appropriately credentialed and privileged.

(B) Ensures that the reviews provided by the medical professionals are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensures that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical conditions and the medical necessity of treatments or therapies in question.

(D) Ensures the confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(E) Ensures the independence of the medical professionals retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensures adequate screening for conflicts of interest, pursuant to paragraph (5).

(4) Medical professionals selected by independent medical review organizations to review medical treatment decisions shall be physicians or other appropriate providers who meet the following minimum requirements:

(A) The medical professional shall be a clinician expert in the treatment of the enrollee's medical condition and knowledgeable about the proposed treatment through recent or current actual clinical experience treating patients with the same or a similar medical condition as the enrollee.

(B) Notwithstanding any other provision of law, the medical professional shall hold a nonrestricted license in any state of the United States, and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review. The independent medical review organization shall give preference to the use of a physician licensed in California as the reviewer, except when training and experience with the issue under review reasonably requires the use of an out-of-state reviewer.

(C) The medical professional shall have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions, taken or pending by any hospital, government, or regulatory body.

(5) Neither the expert reviewer, nor the independent medical review organization, shall have any material professional, material familial, or material financial affiliation with any of the following:

(A) The plan or a provider group of the plan, except that an academic medical center under contract to the plan to provide services to enrollees may qualify as an independent medical review organization provided it will not provide the service and provided the center is not the developer or manufacturer of the proposed treatment.

(B) Any officer, director, or management employee of the plan.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the treatment.

(D) The institution at which the treatment would be provided.

(E) The development or manufacture of the treatment proposed for the enrollee whose condition is under review.

(F) The enrollee or the enrollee's immediate family.

(6) For purposes of this section, the following terms shall have the following meanings:

(A) "Material familial affiliation" means any relationship as a spouse, child, parent, sibling, spouse's parent, or child's spouse.

(B) "Material professional affiliation" means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the independent medical review organization. "Material professional affiliation" does not include affiliations that are limited to staff privileges at a health facility.

(C) "Material financial affiliation" means any financial interest of more than 5 percent of total annual revenue or total annual income of an independent medical review organization or individual to which this subdivision applies. "Material financial affiliation" does not include payment by the plan to the independent medical review organization for the services required by this section, nor does "material financial affiliation" include an expert's participation as a contracting plan provider where the expert is affiliated with an academic medical center or a National Cancer Institute-designated clinical cancer research center.

(e) The department shall provide, upon the request of any interested person, a copy of all nonproprietary information, as determined by the director, filed with it by an independent medical review organization seeking to contract under this article. The department may charge a nominal fee to the interested person for photocopying the requested information.

(f) This section shall become operative on July 1, 2015.

HISTORY:
Added Stats 2012 ch 872 § 4 (SB 1410), effective January 1, 2013, operative July 1, 2015.

§ 1374.33. Analysis and determination

(a) Upon receipt of information and documents related to a case, the medical professional reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the enrollee, provider reports, as well as any other information submitted to the organization as authorized by the department or requested from any of the parties to the dispute by the reviewers. If reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (b).

(b) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the enrollee and any of the following:

(1) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(2) Nationally recognized professional standards.

(3) Expert opinion.

(4) Generally accepted standards of medical practice.

(5) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(c) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the director. If the disputed health care service has not been provided and the enrollee's provider or the department certifies in writing that an imminent and serious threat to the health of the enrollee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the enrollee, the analyses and determinations of

the reviewers shall be expedited and rendered within three days of the receipt of the information. Subject to the approval of the department, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the director for up to three days in extraordinary circumstances or for good cause.

(d) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the enrollee's medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (b) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(e) The independent medical review organization shall provide the director, the plan, the enrollee, and the enrollee's provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization, except in cases where the reviewer is called to testify and in response to court orders. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(f) The director shall immediately adopt the determination of the independent medical review organization, and shall promptly issue a written decision to the parties that shall be binding on the plan.

(g) After removing the names of the parties, including, but not limited to, the enrollee, all medical providers, the plan, and any of the plan's employees or contractors, director decisions adopting a determination of an independent medical review organization shall be made available by the department to the public upon request, at the department's cost and after considering applicable laws governing disclosure of public records, confidentiality, and personal privacy.

(h)(1) Information regarding each director decision provided by the database referenced in subdivision (g) shall include all of the following:

(A) Enrollee demographic profile information, including age and gender.

(B) The enrollee diagnosis and disputed health care service.

(C) Whether the independent medical review was for medically necessary services pursuant to this article or for experimental or investigational therapies pursuant to Section 1370.4.

(D) Whether the independent medical review was standard or expedited.

(E) Length of time from the receipt by the independent medical review organization of the application for review and supporting documentation to the rendering of a determination by the independent medical review organization in writing.

(F) Length of time from receipt by the department of the independent

medical review application to the issuance of the director's determination in writing to the parties that is binding on the health care service plan.

(G) Credentials and qualifications of the reviewer or reviewers.

(H) The nature of the statutory criteria set forth in subdivision (b) that the reviewer or reviewers used to make the case decision.

(I) The final result of the determination.

(J) The year the determination was made.

(K) A detailed case summary that includes the specific standards, criteria, and medical and scientific evidence, if any, that led to the case decision.

(2) The database referenced in subdivision (g) shall be accompanied by all of the following:

(A) The annual rate of independent medical review among the total enrolled population.

(B) The annual rate of independent medical review cases by health care service plan.

(C) The number, type, and resolution of independent medical review cases by health care service plan.

(D) The number, type, and resolution of independent medical review cases by ethnicity, race, and primary language spoken.

(i) This section shall become operative on July 1, 2015.

HISTORY:
Added Stats 2012 ch 872 § 6 (SB 1410), effective January 1, 2013, operative July 1, 2015.

§ 1374.34. Prompt implementation of decision; Review and audit

(a) Upon receiving the decision adopted by the director pursuant to Section 1374.33 that a disputed health care service is medically necessary, the plan shall promptly implement the decision. In the case of reimbursement for services already rendered, the plan shall reimburse the provider or enrollee, whichever applies, within five working days. In the case of services not yet rendered, the plan shall authorize the services within five working days of receipt of the written decision from the director, or sooner if appropriate for the nature of the enrollee's medical condition, and shall inform the enrollee and provider of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of Section 1367.01.

(b) A plan shall not engage in any conduct that has the effect of prolonging the independent review process. The engaging in that conduct or the failure of the plan to promptly implement the decision is a violation of this chapter and, in addition to any other fines, penalties, and other remedies available to the director under this chapter, the plan shall be subject to an administrative penalty of not less than five thousand dollars ($5,000) for each day that the decision is not implemented. The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(c) The director shall require the plan to promptly reimburse the enrollee for any reasonable costs associated with those services when the director finds that the disputed health care services were a covered benefit under the terms and conditions of the health care service plan contract, and the services are found by the independent medical review organization to have been medically

necessary pursuant to Section 1374.33, and either the enrollee's decision to secure the services outside of the plan provider network was reasonable under the emergency or urgent medical circumstances, or the health care service plan contract does not require or provide prior authorization before the health care services are provided to the enrollee.

(d) In addition to requiring plan compliance regarding subdivisions (a), (b), and (c) the director shall review individual cases submitted for independent medical review to determine whether any enforcement actions, including penalties, may be appropriate. In particular, where substantial harm, as defined in Section 3428 of the Civil Code, to an enrollee has already occurred because of the decision of a plan, or one of its contracting providers, to delay, deny, or modify covered health care services that an independent medical review determines to be medically necessary pursuant to Section 1374.33, the director shall impose penalties.

(e) Pursuant to Section 1368.04, the director shall perform an annual audit of independent medical review cases for the dual purposes of education and the opportunity to determine if any investigative or enforcement actions should be undertaken by the department, particularly if a plan repeatedly fails to act promptly and reasonably to resolve grievances associated with a delay, denial, or modification of medically necessary health care services when the obligation of the plan to provide those health care services to enrollees or subscribers is reasonably clear.

(f) A plan's provision of prescription drugs to a Medi-Cal beneficiary pursuant to paragraph (5) of subdivision (b) of Section 14105.33 of the Welfare and Institutions Code and in accordance with the State Department of Health Care Services coverage policies shall not be a ground for an enforcement action. Nothing in this article is intended to limit a plan's responsibility to provide medically necessary health care services pursuant to this chapter.

HISTORY:

Added Stats 1999 ch 542 § 10 (SB 189), operative January 1, 2001, as H & S C § 13933. Amended and renumbered by Stats 2000 ch 1067 § 17 (SB 2094); Amended Stats 2003 ch 579 § 1 (AB 1496); Stats 2008 ch 607 § 8 (SB 1379), effective September 30, 2008; Stats 2014 ch 40 § 1 (SB 870), effective June 20, 2014.

§ 1374.35. Reimbursement of costs

(a) After considering the results of a competitive bidding process and any other relevant information on program costs, the director shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews, which may vary depending on the type of medical condition under review and on other relevant factors.

(b) The costs of the independent medical review system for enrollees shall be borne by health care service plans pursuant to an assessment fee system established by the director. In determining the amount to be assessed, the director shall consider all appropriations available for the support of this chapter, and existing fees paid to the department. The director may adjust fees upward or downward, on a schedule set by the department, to address shortages or overpayments, and to reflect utilization of the independent review process.

HISTORY:
Added Stats 1999 ch 533 § 1 (AB 55).

§ 1374.36. Report on implementation of article

(a) The director shall submit to the Legislature by March 1, 2002, a report on the initial implementation of this article. The report shall include a description of assessments imposed on plans to implement this article, increased staffing and other resources attributable to these new responsibilities, and any redirection of existing staff and resources to carry out these responsibilities. A single copy of the report shall be made available at no cost to members of the public upon request. The department may recover the cost of additional copies that are requested.

(b) This section shall become operative on January 1, 2001, and then only if Assembly Bill 55 of the 1999-2000 Regular Session is enacted.

HISTORY:
Added Stats 1999 ch 542 § 11 (SB 189), operative January 1, 2001.

ARTICLE 5.6

Point-of-Service Health Care Service Plan Contracts

Section
1374.60. Definitions.
1374.62. Application to risk transferred through reinsurance.
1374.64. Plan criteria.
1374.65. Plan contract requirements.
1374.66. Allowable plan provisions.
1374.67. Limitations.
1374.68. Requirements.
1374.69. Notice of material modification.
1374.70. [Section repealed 1995.]
1374.71. Notice of material modification; Exemption.
1374.72. Health plan to cover mental illness and emotional disturbance.
1374.73. Coverage for behavioral health treatment for pervasive developmental disorder or autism.
1374.74. Autism Advisory Task Force; Duties; Report.
1374.76. Provision of covered mental health and substance use disorder benefits.

HISTORY: Added Stats 1993 ch 987 § 3.

§ 1374.60. Definitions

For purpose of this article, the following definitions shall apply:

(a) A "point-of-service plan contract" means any plan contract offered by a health care service plan whereby the health care service plan assumes financial risk for both "in-network coverage or services" and "out-of-network coverage or services."

The term "point-of-service plan contract" shall not apply to a plan contract where the out-of-network coverage or service is underwritten by an insurance company admitted in this state or is provided by a self-insured employer and is offered in conjunction with in-network coverage or services provided pursuant to a health care service plan contract.

(b) "Out-of-network coverage or services" means health care services

received either from (1) providers who are not employed by, under contract with, or otherwise affiliated with the health care service plan, except for health care services received from these providers in an emergency or when referred or authorized by the plan under procedures specifically reviewed and approved by the director or (2) providers who are employed by, under contract with, or otherwise affiliated with a health care service plan in instances when the "in-network coverage or services" requirements for care set forth in the health care service plan's approved evidence of coverage are not met.

(c) "In-network coverage or services" means all of the following:

(1) All the health care services provided or offered under the requirements of this chapter that are received from a provider employed by, under contract with, or otherwise affiliated with the health care service plan and in accordance with the procedures set forth in the plan's approved evidence of coverage.

(2) Health care services received from a provider not affiliated with the health care service plan when the plan arranges for the enrollee to receive services from that provider.

(3) Out-of-area emergency care provided in accordance with the procedures set by the health care service plan to be followed in securing these services.

HISTORY:
Added Stats 1993 ch 987 § 3 (SB 1221). Amended Stats 1999 ch 525 § 115 (AB 78), operative July 1, 2000.

§ 1374.62. Application to risk transferred through reinsurance

A point-of-service plan contract, in which any risk for out-of-network coverage or services is transferred from a health care service plan through reinsurance, shall be subject to this article.

HISTORY:
Added Stats 1993 ch 987 § 3 (SB 1221).

§ 1374.64. Plan criteria

(a) Only a plan that has been licensed under this chapter and in operation in this state for a period of five years or more, or a plan licensed under this chapter and operating in this state for a period of five or more years under a combination of (1) licensure under this chapter and (2) pursuant to a certificate of authority issued by the Department of Insurance may offer a point-of-service contract. A specialized health care service plan shall not offer a point-of-service plan contract unless this plan was formerly registered under the Knox-Mills Health Plan Act (Article 2.5 (commencing with Section 12530) of Chapter 6 of Part 2 of Division 3 of Title 2 of the Government Code), as repealed by Chapter 941 of the Statutes of 1975, and offered point-of-service plan contracts previously approved by the director on July 1, 1976, and on September 1, 1993.

(b) A plan may offer a point-of-service plan contract only if the director has not found the plan to be in violation of any requirements, including administrative capacity, under this chapter or the rules adopted thereunder and the plan meets, at a minimum, the following financial criteria:

(1) The minimum financial criteria for a plan that maintains a minimum net worth of at least five million dollars ($5,000,000) shall be:

(A)(i) Initial tangible net equity so that the plan is not required to file monthly reports with the director as required by Section 1300.84.3(d)(1)(G) of Title 28 of the California Code of Regulations and then have and maintain adjusted tangible net equity to be determined pursuant to either of the following:

(I) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(1) or (2) of Title 28 of the California Code of Regulations, multiply 130 percent times the sum resulting from the addition of the plan's tangible net equity required by Section 1300.76(a)(1) or (2) of Title 28 of the California Code of Regulations and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees.

(II) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(3) of Title 28 of the California Code of Regulations, recalculate the plan's tangible net equity under Section 1300.76(a)(3) of Title 28 of the California Code of Regulations excluding the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees, add together the number resulting from this recalculation and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees, and multiply this sum times 130 percent, provided that the product of this multiplication must exceed 130 percent of the tangible net equity required by Section 1300.76(a)(3) of Title 28 of the California Code of Regulations so that the plan is not required to file monthly reports to the director as required by Section 1300.84.3(d)(1)(G) of Title 28 of the California Code of Regulations.

(ii) The failure of a plan offering a point-of-service plan contract under this article to maintain adjusted tangible net equity as determined by this subdivision shall require the filing of monthly reports with the director pursuant to Section 1300.84.3(d) of Title 28 of the California Code of Regulations, in addition to any other requirements that may be imposed by the director on a plan under this article and chapter.

(iii) The calculation of tangible net equity under any report to be filed by a plan offering a point-of-service plan contract under this article and required of a plan pursuant to Section 1384, and the regulations adopted thereunder, shall be on the basis of adjusted tangible net equity as determined under this subdivision.

(B) Demonstrates adequate working capital, including (i) a current ratio (current assets divided by current liabilities) of at least 1:1, after excluding obligations of officers, directors, owners, or affiliates, or (ii) evidence that the plan is now meeting its obligations on a timely basis and has been doing so for at least the preceding two years. Short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions

with nonaffiliates shall not be excluded. For purposes of this subdivision, an obligation is considered short term if the repayment schedule is 30 days or fewer.

(C) Demonstrates a trend of positive earnings over the previous eight fiscal quarters.

(2) The minimum financial criteria for a plan that maintains a minimum net worth of at least one million five hundred thousand dollars ($1,500,000) but less than five million dollars ($5,000,000) shall be:

(A)(i) Initial tangible net equity so that the plan is not required to file monthly reports with the director as required by Section 1300.84.3(d)(1)(G) of Title 28 of the California Code of Regulations and then have and maintain adjusted tangible net equity to be determined pursuant to either of the following:

(I) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(1) or (2) of Title 28 of the California Code of Regulations, multiply 130 percent times the sum resulting from the addition of the plan's tangible net equity required by Section 1300.76(a)(1) or (2) of Title 28 of the California Code of Regulations and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees.

(II) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(3) of Title 28 of the California Code of Regulations, recalculate the plan's tangible net equity under Section 1300.76(a)(3) excluding the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees, add together the number resulting from this recalculation and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees, and multiply this sum times 130 percent, provided that the product of this multiplication must exceed 130 percent of the tangible net equity required by Section 1300.76(a)(3) of Title 28 of the California Code of Regulations so that the plan is not required to file monthly reports to the director as required by Section 1300.84.3(d)(1)(G) of Title 28 of the California Code of Regulations.

(ii) The failure of a plan offering a point-of-service plan contract under this article to maintain adjusted tangible net equity as determined by this subdivision shall require the filing of monthly reports with the director pursuant to Section 1300.84.3(d) of Title 28 of the California Code of Regulations, in addition to any other requirements that may be imposed by the director on a plan under this article and chapter.

(iii) The calculation of tangible net equity under any report to be filed by a plan offering a point-of-service plan contract under this article and required of a plan pursuant to Section 1384, and the regulations adopted thereunder, shall be on the basis of adjusted tangible net equity as determined under this subdivision.

(B) Demonstrates adequate working capital, including (i) a current ratio (current assets divided by current liabilities) of at least 1:1, after

excluding obligations of officers, directors, owners, or affiliates or (ii) evidence that the plan is now meeting its obligations on a timely basis and has been doing so for at least the preceding two years. Short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates shall not be excluded. For purposes of this subdivision, an obligation is considered short term if the repayment schedule is 30 days or fewer.

(C) Demonstrates a trend of positive earnings over the previous eight fiscal quarters.

(D) Demonstrates to the director that it has obtained insurance for the cost of providing any point-of-service enrollee with out-of-network covered health care services, the aggregate value of which exceeds five thousand dollars ($5,000) in any year. This insurance shall obligate the insurer to continue to provide care for the period in which a premium was paid in the event a plan becomes insolvent. Where a plan cannot obtain insurance as required by this subparagraph, then a plan may demonstrate to the director that it has made other arrangements, acceptable to the director, for the cost of providing enrollees out-of-network health care services; but in this case the expenditure for total out-of-network costs for all enrollees in all point-of-service contracts shall be limited to a percentage, acceptable to the director, not to exceed 15 percent of total health care expenditures for all its enrollees.

(c) Within 30 days of the close of each month a plan offering point-of-service plan contracts under paragraph (2) of subdivision (b) shall file with the director a monthly financial report consisting of a balance sheet and statement of operations of the plan, which need not be certified, and a calculation of the adjusted tangible net equity required under subparagraph (A). The financial statements shall be prepared on a basis consistent with the financial statements furnished by the plan pursuant to Section 1300.84.2 of Title 28 of the California Code of Regulations. A plan shall also make special reports to the director as the director may from time to time require. Each report to be filed by a plan pursuant to this subdivision shall be verified by a principal officer of the plan as set forth in Section 1300.84.2(e) of Title 28 of the California Code of Regulations.

(d) If it appears to the director that a plan does not have sufficient financial viability, or organizational and administrative capacity to ensure the delivery of health care services to its enrollees, the director may, by written order, direct the plan to discontinue the offering of a point-of-service plan contract. The order shall be effective immediately.

HISTORY:
Added Stats 1993 ch 987 § 3 (SB 1221). Amended Stats 1999 ch 525 § 116 (AB 78), operative July 1, 2000; Stats 2009 ch 298 § 5 (AB 1540), effective January 1, 2010.

§ 1374.65. Plan contract requirements

Point-of-service plan contracts shall:

(a) Provide incentives, including financial incentives, for enrollees to use in-network coverage or services.

(b) Only offer coverage or services obtained out-of-network if it also provides coverage or services on an in-network basis.

(c) Shall not consider the following to be out-of-network coverage or services:

(1) Health care services received from a provider not affiliated with the health care service plan when the plan arranges for the enrollee to receive services from that provider.

(2) Out-of-area emergency care provided in accordance with the procedures set by the health care service plan to be followed in securing these services.

HISTORY:
Added Stats 1993 ch 987 § 3 (SB 1221).

§ 1374.66. Allowable plan provisions

Any health care service plan that offers a point-of-service plan contract may do all of the following:

(a) Limit or exclude coverage for specific types of services or conditions when obtained out-of-plan.

(b) Include annual out-of-pocket limits, copayments, and annual and lifetime maximum benefit limits for out-of-network coverage or services that are different or separate from any amounts or limits applied to in-network coverage or services, and may impose a deductible on coverage for out-of-network coverage or services.

(c) To the extent permitted under this chapter, may limit the groups to which a point-of-service plan contract is offered, and may adopt nondiscriminatory renewal guidelines under which one or more point-of-service plan contracts would be replaced with other than point-of-service plan contracts. If a point-of-service plan contract is sold to a group, then the group shall offer it to all members of that group who are eligible for coverage by the health care service plan.

(d) Treat as out-of-network services those services that an enrollee obtains from a provider affiliated with the plan, but not in accordance with the authorization procedures set forth in the health care service plan's approved evidence of coverage.

(e) Contracts between health care service plans and medical providers, for the purpose of providing medical services under point-of-service contracts, may include risk-sharing arrangements for out-of-network services, but only if the risk sharing arrangements meet all of the following conditions:

(1) The contracting medical provider agrees to participate in risk-sharing arrangements applicable to out-of-network services.

(2) If the medical provider is reimbursed on a capitated or prepaid basis, the contract shall clearly disclose the capitation or prepayment amount to be paid to the medical provider for in-network services received by enrollees under point-of-service contracts.

(3) Any capitation or prepayment amounts paid to the medical provider shall not place the medical provider directly at risk for or directly transfer liability for out-of-network services received by enrollees under point-of-service contracts.

(4) The risk-sharing arrangements for out-of-network services may provide a bonus or incentive to the medical provider to attempt to reduce the utilization of out-of-network services, but shall not place the medical provider at risk for any amounts in excess of the amounts used by the plan to budget for or fund the risk-sharing pool for out-of-network services.

(5) The contract between the medical provider and the plan shall clearly disclose the mathematical method by which funding for the risk-sharing arrangement is established, the mathematical method by which and the extent to which payments for out-of-network services are debited against the risk-sharing funds, and the method by which the risk-sharing arrangement is reconciled on no less than an annual basis.

(6) The contract is approved by the director.

HISTORY:
Added Stats 1993 ch 987 § 3 (SB 1221). Amended Stats 1999 ch 525 § 117 (AB 78), operative July 1, 2000.

§ 1374.67. Limitations

A health care service plan offering a point-of-service plan contract is subject to the following limitations:

(a) A health care service plan shall limit its offering of point-of-service plan contracts so that no more than 50 percent of the plan's total premium revenue in any fiscal quarter is earned from point-of-service plan contracts.

(b) A health care service plan offering a point-of-service plan contract shall not expend in any fiscal-year quarter more than 20 percent of its total health care expenditures for all its enrollees for out-of-network services for point-of-service enrollees.

(c) If the amount specified in subdivision (a) or (b) is exceeded by 2 percent in any quarter, the health care service plan shall come into compliance with subdivisions (a) and (b) by the end of the next following quarter. If compliance with the amount specified in subdivisions (a) and (b) is not demonstrated in the health care service plan's next quarterly report, the director may prohibit the health care service plan from offering a point-of-service plan contract to new groups, or may require the health care service plan to amend one or more of its point-of-service contracts at the time of renewal to delete some or all of the out-of-network coverage or services as may be necessary for the plan to demonstrate compliance to the director's satisfaction.

(d) The limitation imposed by this section shall not apply to a plan which in substantial part indemnified subscribers and enrollees pursuant to contracts issued under such plan's former registration under the Knox-Mills Health Plan Act in 1975 and as of that date, and on September 1, 1993, was offering point-of-service plan contracts previously approved by the director.

HISTORY:
Added Stats 1993 ch 987 § 3 (SB 1221). Amended Stats 1999 ch 525 § 118 (AB 78), operative July 1, 2000.

§ 1374.68. Requirements

A health care service plan that offers a point-of-service plan contract shall do all of the following:

(a) Deposit with the director or, at the discretion of the director, with any organization or trustee acceptable to the director through which a custodial or controlled account is maintained, cash, securities, or any combination of these, which is acceptable to the director, that at all times have a fair market value equal to the greater of either one of the following:

(1) Two hundred thousand dollars ($200,000).

(2) One hundred twenty percent of the plan's current monthly claims payable plus incurred but not reported balance for coverage out-of-network coverage or services provided under point-of-service contracts.

(b) Track out-of-network point-of-service utilization separately from in-network utilization.

(c) Record point-of-service utilization in a manner that will permit utilization and cost reporting as the director may require.

(d) Demonstrate to the satisfaction of the director that the health care service plan has the fiscal, administrative, and marketing capacity to control its point-of-service plan contract enrollment, utilization, and costs so as not to jeopardize the financial viability or organizational and administrative capacity of the health care service plan.

(e) Maintain the deposit required under subdivision (a) in a manner agreed to by the director, subject to subdivision (a) of Section 1377 and any regulations adopted thereunder.

(f) Any deposit made pursuant to this section shall be a credit against any deposit required by subdivision (a) of Section 1377.

HISTORY:
Added Stats 1993 ch 987 § 3 (SB 1221). Amended Stats 1999 ch 525 § 119 (AB 78), operative July 1, 2000.

§ 1374.69. Notice of material modification

At least 20 business days prior to offering a point-of-service plan contract, a health care service plan shall file a notice of material modification in accordance with Section 1352. The notice of material modification shall include, but not be limited to, provisions specifying how the health care service plan shall accomplish all of the following:

(a) Design the benefit levels and conditions of coverage for in-network coverage and services and out-of-network point-of-service utilization.

(b) Provide or arrange for the provision of adequate systems to do all of the following:

(1) Process and pay claims for all out-of-network coverage and services.

(2) Generate accurate financial and utilization data and reports on a timely basis, so that it and any authorized regulatory agency can evaluate the health care service plan's experience with point-of-service plan contracts and monitor compliance with point-of-service plan contract projections established by the health care service plan and regulatory requirements.

(3) Track and monitor the quality of health care obtained out-of-network by plan enrollees to the extent reasonable and possible.

(4) Respond promptly to enrollee grievances and complaints, written or oral, including those regarding services obtained out-of-network.

(5) Meet the requirements for a point-of-service plan contract set forth

in this section and any additional requirements that may be required by the director.

(c) Comply initially and on an ongoing basis with the requirements of this article.

(d) This section shall become operative July 1, 1995.

HISTORY:
Added Stats 1993 ch 987 § 3 (SB 1221), operative July 1, 1995. Amended Stats 1999 ch 525 § 120 (AB 78), operative July 1, 2000.

§ 1374.70. [Section repealed 1995.]

HISTORY:
Added Stats 1993 ch 987 § 3 (SB 1221), operative until July 1, 1995. Repealed, operative July 1, 1995, by its own terms. The repealed section related to notice of material modification.

§ 1374.71. Notice of material modification; Exemption

No plan formerly registered under the Knox-Mills Health Plan Act (Article 2.5 (commencing with Section 12530) of Chapter 6 of Part 2 of Division 3 of Title 2 of the Government Code) in 1975 shall be required to file a notice of material modification under Section 1374.69 or 1374.70 for any point-of-service plan contract previously approved by the director under this chapter and offered by plan on or before September 1, 1993.

HISTORY:
Added Stats 1993 ch 987 § 3 (SB 1221). Amended Stats 1999 ch 525 § 121 (AB 78), operative July 1, 2000.

§ 1374.72. Health plan to cover mental illness and emotional disturbance

(a) Every health care service plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(b) These benefits shall include the following:

(1) Outpatient services.

(2) Inpatient hospital services.

(3) Partial hospital services.

(4) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:

(1) Maximum lifetime benefits.

(2) Copayments.

(3) Individual and family deductibles.

(d) For the purposes of this section, “severe mental illnesses” shall include:

(1) Schizophrenia.

(2) Schizoaffective disorder.

(3) Bipolar disorder (manic-depressive illness).

(4) Major depressive disorders.

(5) Panic disorder.
(6) Obsessive-compulsive disorder.
(7) Pervasive developmental disorder or autism.
(8) Anorexia nervosa.
(9) Bulimia nervosa.

(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

(f) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Division 9 of Part 3 of the Welfare and Institutions Code, between the State Department of Health Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(g)(1) For the purpose of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(3) Notwithstanding any other provision of law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

(h) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.

HISTORY:
Added Stats 1999 ch 534 § 2 (AB 88).
Amended Stats 2002 ch 791 § 7 (SB 842).

§ 1374.73. Coverage for behavioral health treatment for pervasive developmental disorder or autism

(a)(1) Every health care service plan contract that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July

1, 2012. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 1374.72.

(2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health plans will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(3) This section shall not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individual service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing regulations.

(b) Every health care service plan subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise or employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A health care service plan is not prevented from selectively contracting with providers within these requirements.

(c) For the purposes of this section, the following definitions shall apply:

(1) "Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:

(i) A qualified autism service provider.

(ii) A qualified autism service professional supervised by the qualified autism service provider.

(iii) A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.

(C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section

4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

(i) Describes the patient's behavioral health impairments or developmental challenges that are to be treated.

(ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.

(iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.

(2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 1374.72.

(3) "Qualified autism service provider" means either of the following:

(A) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.

(B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

(4) "Qualified autism service professional" means an individual who meets all of the following criteria:

(A) Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.

(B) Is supervised by a qualified autism service provider.

(C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.

(D) Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.

(E) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing

with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(F) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

(5) "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:

(A) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.

(B) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.

(C) Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.

(D) Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.

(E) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

(d) This section shall not apply to the following:

(1) A specialized health care service plan that does not deliver mental health or behavioral health services to enrollees.

(2) A health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(e) This section does not limit the obligation to provide services under Section 1374.72.

(f) As provided in Section 1374.72 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

HISTORY:

Added Stats 2011 ch 650 § 1 (SB 946), effective January 1, 2012, inoperative July 1, 2014, repealed January 1, 2015. Amended Stats 2013 ch 680 § 1 (SB 126), effective January 1, 2014, repealed January 1, 2017; Stats 2016 ch 493 § 1 (AB 796), effective January 1, 2017; Stats 2017 ch 385 § 1 (AB 1074), effective January 1, 2018.

§ 1374.74. Autism Advisory Task Force; Duties; Report

(a) The department, in consultation with the Department of Insurance, shall convene an Autism Advisory Task Force by February 1, 2012, in collaboration with other agencies, departments, advocates, autism experts, health plan and health insurer representatives, and other entities and stakeholders that it deems appropriate. The Autism Advisory Task Force shall develop recommendations regarding behavioral health treatment that is medically necessary for the treatment of individuals with autism or pervasive developmental disorder. The Autism Advisory Task Force shall address all of the following:

(1) Interventions that have been scientifically validated and have demonstrated clinical efficacy.

(2) Interventions that have measurable treatment outcomes.

(3) Patient selection, monitoring, and duration of therapy.

(4) Qualifications, training, and supervision of providers.

(5) Adequate networks of providers.

(b) The Autism Advisory Task Force shall also develop recommendations regarding the education, training, and experience requirements that unlicensed individuals providing autism services shall meet in order to secure a license from the state.

(c) The department shall submit a report of the Autism Advisory Task Force to the Governor, the President pro Tempore of the Senate, the Speaker of the Assembly, and the Senate and Assembly Committees on Health by December 31, 2012, on which date the task force shall cease to exist.

HISTORY:
Added Stats 2011 ch 650 § 2 (SB 946), effective January 1, 2012. Amended Stats 2012 ch 162 § 82 (SB 1171), effective January 1, 2013.

§ 1374.76. Provision of covered mental health and substance use disorder benefits

(a) No later than January 1, 2015, a large group health care service plan contract shall provide all covered mental health and substance use disorder benefits in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(b) No later than January 1, 2015, an individual or small group health care service plan contract shall provide all covered mental health and substance use disorder benefits in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26), and Section 1367.005.

(c) Until January 1, 2016, the director may issue guidance to health care service plans regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Any guidance issued pursuant to this subdivision shall be effective only until the director adopts regulations pursuant to the Administrative Procedure Act. The department shall consult with the Department of Insurance in issuing guidance under this subdivision.

HISTORY:
Added Stats 2014 ch 31 § 8 (SB 857), effective June 20, 2014.

ARTICLE 6

Operation and Renewal Requirements and Procedures

Section
1375. [Section repealed 1978.]
1375.1. Contents of plan.
1375.2. Transitionally licensed plans.
1375.3. Meet and confer with director prior to filing petition for bankruptcy; Information to ensure continuity of care.
1375.4. Required provisions for contract between health care service plan and risk-bearing organization; Regulations; Sanctions for plan's failure to comply with contractual requirements; Report; Exemption.
1375.5. Contract provision requiring risk-bearing organization to be at financial risk for provision of health care services.
1375.6. Contract provision requiring provider to accept certain rates or methods of payment.
1375.7. Health Care Providers' Bill of Rights.
1375.8. Written request by provider to assume financial risk allowed when negotiating initial contract or renewing existing contract.
1375.9. Health care service plan; Primary care physician to enrollee ratios.
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1377. Reserves or insurance to be maintained by certain plans for payments to subscribers or providers.
1378. Administrative costs.
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1383.15. Second opinion.
1384. Audit reports and financial statements.
1385. Books of account.

HISTORY: Added Stats 1975 ch 941 § 2, operative July 1, 1976.

§ 1375. [Section repealed 1978.]

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1976 ch 652 § 3.2, effective August 28, 1976, operative July 1, 1976; Stats 1977 ch 818 § 11, effective September 16, 1977; Repealed Stats 1978 ch 285 § 6, effective June 23, 1978. The repealed section related to subsequent provider of services.

§ 1375.1. Contents of plan

(a) Every plan shall have and shall demonstrate to the director that it has all of the following:

(1) A fiscally sound operation and adequate provision against the risk of insolvency.

(2) Assumed full financial risk on a prospective basis for the provision of covered health care services, except that a plan may obtain insurance or make other arrangements for the cost of providing to any subscriber or enrollee covered health care services, the aggregate value of which exceeds five thousand dollars ($5,000) in any year, for the cost of covered health care

services provided to its members other than through the plan because medical necessity required their provision before they could be secured through the plan, and for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for that fiscal year.

(3) A procedure for prompt payment or denial of provider and subscriber or enrollee claims, including those telehealth services, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, covered by the plan. Except as provided in Section 1371, a procedure meeting the requirements of Subchapter G of the regulations (29 C.F.R. Part 2560) under Public Law 93-406 (88 Stats. 829-1035, 29 U.S.C. Secs. 1001 et seq.) shall satisfy this requirement.

(b) In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the following:

(1) The financial soundness of the plan's arrangements for health care services and the schedule of rates and charges used by the plan.

(2) The adequacy of working capital.

(3) Agreements with providers for the provision of health care services.

(c) For the purposes of this section, "covered health care services" means health care services provided under all plan contracts.

HISTORY:
Added Stats 1976 ch 652 § 3.3, effective August 28, 1976, operative July 1, 1976. Amended Stats 1977 ch 818 § 12, effective September 16, 1977; Stats 1983 ch 611 § 4; Stats 1985 ch 908 § 1; Stats 1986 ch 957 § 2; Stats 1996 ch 864 § 7 (SB 1665); Stats 1999 ch 525 § 122 (AB 78), operative July 1, 2000; Stats 2012 ch 782 § 7 (AB 1733), effective January 1, 2013.

§ 1375.2. Transitionally licensed plans

On and after October 1, 1977, every plan operating under a transitional license shall have a fiscally sound operation.

HISTORY:
Added Stats 1977 ch 818 § 13, effective September 16, 1977.

§ 1375.3. Meet and confer with director prior to filing petition for bankruptcy; Information to ensure continuity of care

(a) A health care service plan shall meet and confer with the director and his or her designated representatives at least 10 business days prior to filing a petition commencing a case for bankruptcy under Title 11 of the United States Code, except under extraordinary circumstances. If extraordinary circumstances preclude a meet and confer with the director within the 10-day time period prior to the filing of a petition for bankruptcy, the plan shall meet and confer with the department at least 24 hours prior to filing the petition. A plan shall notify the department concurrently upon filing the petition. These meetings shall be deemed confidential.

(b) At the director's request, a plan shall provide within the time period specified by the department, information to assist in ensuring continuity of care and uninterrupted access to health care services for plan subscribers and enrollees. The information may include, but is not limited to, the following:

(1) A list of all providers with which the plan contracts and material

information regarding the contracts including, but not limited to, the grounds for termination of the contract and the term remaining on the contract.

(2) A list of employer groups who subscribe with the plan.

(3) A list of the enrollees of the plan.

(4) A list of enrollees undergoing current treatment and a description of the authorized treatment for the enrollee.

(5) A list of all brokers and agents involved in the negotiation of subscriber contracts.

(6) A list of all enrollees who contract as individual subscribers for coverage by the plan.

(c) Notwithstanding subdivision (a), nothing in this section shall preclude the director from exercising powers and duties authorized under this chapter.

HISTORY:
Added Stats 2002 ch 928 § 2 (SB 398).

§ 1375.4. Required provisions for contract between health care service plan and risk-bearing organization; Regulations; Sanctions for plan's failure to comply with contractual requirements; Report; Exemption

(a) Every contract between a health care service plan and a risk-bearing organization that is issued, amended, renewed, or delivered in this state on or after July 1, 2000, shall include provisions concerning the following, as to the risk-bearing organization's administrative and financial capacity, which shall be effective as of January 1, 2001:

(1) A requirement that the risk-bearing organization furnish financial information to the health care service plan or the plan's designated agent and meet any other financial requirements that assist the health care service plan in maintaining the financial viability of its arrangements for the provision of health care services in a manner that does not adversely affect the integrity of the contract negotiation process.

(2) A requirement that the health care service plan disclose information to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the financial risk assumed under the contract.

(3) A requirement that the health care service plans provide payments of all risk arrangements, excluding capitation, within 180 days after close of the fiscal year.

(b) In accordance with subdivision (a) of Section 1344, the director shall adopt regulations on or before June 30, 2000, to implement this section which shall, at a minimum, provide for the following:

(1)(A) A process for reviewing or grading risk-bearing organizations based on the following criteria:

(i) The risk-bearing organization meets criterion 1 if it reimburses, contests, or denies claims for health care services it has provided, arranged, or for which it is otherwise financially responsible in accordance with the timeframes and other requirements described in Section 1371 and in accordance with any other applicable state and federal laws and regulations.

(ii) The risk-bearing organization meets criterion 2 if it estimates its liability for incurred but not reported claims pursuant to a method that has not been held objectionable by the director, records the estimate at least quarterly as an accrual in its books and records, and appropriately reflects this accrual in its financial statements.

(iii) The risk-bearing organization meets criterion 3 if it maintains at all times a positive tangible net equity, as defined in subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.

(iv) The risk-bearing organization meets criterion 4 if it maintains at all times a positive level of working capital (excess of current assets over current liabilities).

(B) A risk-bearing organization may reduce its liabilities for purposes of calculating tangible net equity, pursuant to clause (iii) of subparagraph (A), and working capital, pursuant to clause (iv) of subparagraph (A), by the amount of any liabilities the payment of which is guaranteed by a sponsoring organization pursuant to a qualified guarantee. A sponsoring organization is one that has a tangible net equity of a level to be established by the director that is in excess of all amounts that it has guaranteed to any person or entity. A qualified guarantee is one that meets all of the following:

(i) It is approved by a board resolution of the sponsoring organization.

(ii) The sponsoring organization agrees to submit audited annual financial statements to the plan within 120 days of the end of the sponsoring organization's fiscal year.

(iii) The guarantee is unconditional except for a maximum monetary limit.

(iv) The guarantee is not limited in duration with respect to liabilities arising during the term of the guarantee.

(v) The guarantee provides for six months' advance notice to the plan prior to its cancellation.

(2) The information required from risk-bearing organizations to assist in reviewing or grading these risk-bearing organizations, including balance sheets, claims reports, and designated annual, quarterly, or monthly financial statements prepared in accordance with generally accepted accounting principles, to be used in a manner, and to the extent necessary, provided to a single external party as approved by the director to the extent that it does not adversely affect the integrity of the contract negotiation process between the health care service plan and the risk-bearing organizations.

(3) Audits to be conducted in accordance with generally accepted auditing standards and in a manner that avoids duplication of review of the risk-bearing organization.

(4) A process for corrective action plans, as mutually agreed upon by the health care service plan and the risk-bearing organization and as approved by the director, for cases where the review or grading indicates deficiencies that need to be corrected by the risk-bearing organization, and contingency plans to ensure the delivery of health care services if the corrective action fails. The corrective action plan shall be approved by the director and standardized, to the extent possible, to meet the needs of the director and all health care service plans contracting with the risk-bearing organization. If

the health care service plan and the risk-bearing organization are unable to determine a mutually agreeable corrective action plan, the director shall determine the corrective action plan.

(5) The disclosure of information by health care service plans to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the risk assumed under the contract, including:

(A) Enrollee information monthly.

(B) Risk arrangement information, information pertaining to any pharmacy risk assumed under the contract, information regarding incentive payments, and information on income and expenses assigned to the risk-bearing organization quarterly.

(6) Periodic reports from each health care service plan to the director that include information concerning the risk-bearing organizations and the type and amount of financial risk assumed by them, and, if deemed necessary and appropriate by the director, a registration process for the risk-bearing organizations.

(7) The confidentiality of financial and other records to be produced, disclosed, or otherwise made available, unless as otherwise determined by the director.

(c) The failure by a health care service plan to comply with the contractual requirements pursuant to this section shall constitute grounds for disciplinary action. The director shall, as appropriate, within 60 days after receipt of documented violation from a risk-bearing organization, investigate and take enforcement action against a health care service plan that fails to comply with these requirements and shall periodically evaluate contracts between health care service plans and risk-bearing organizations to determine if any audit, evaluation, or enforcement actions should be undertaken by the department.

(d) The Financial Solvency Standards Board established in Section 1347.15 shall study and report to the director on or before January 1, 2001, regarding all of the following:

(1) The feasibility of requiring that there be in force insurance coverage commensurate with the financial risk assumed by the risk-bearing organization to protect against financial losses.

(2) The appropriateness of different risk-bearing arrangements between health care service plans and risk-bearing organizations.

(3) The appropriateness of the four criteria specified in paragraph (1) of subdivision (b).

(e) This section shall not apply to specialized health care service plans.

(f) For purposes of this section, "provider organization" means a medical group, independent practice association, or other entity that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a plan.

(g)(1) For purposes of this section, a "risk-bearing organization" means a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (*l*) of Section 1206, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a health care service plan, and that does all of the following:

(A) Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees.

(B) Receives compensation for those services on any capitated or fixed periodic payment basis.

(C) Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization. Nothing in this subparagraph in any way limits, alters, or abrogates any responsibility of a health care service plan under existing law.

(2) Notwithstanding paragraph (1), risk-bearing organizations shall not be deemed to include a provider organization that meets either of the following requirements:

(A) The health care service plan files with the department consolidated financial statements that include the provider organization.

(B) The health care service plan is the only health care service plan with which the provider organization contracts for arranging or providing health care services and, during the previous and current fiscal years, the provider organization's maximum potential expenses for providing or arranging for health care services did not exceed 115 percent of its maximum potential revenue for providing or arranging for those services.

(h) For purposes of this section, "claims" include, but are not limited to, contractual obligations to pay capitation or payments on a managed hospital payment basis.

HISTORY:
Added Stats 1999 ch 529 § 3 (SB 260). Amended Stats 2000 ch 1067 § 14 (SB 2094); Stats 2009 ch 298 § 6 (AB 1540), effective January 1, 2010.

§ 1375.5. Contract provision requiring risk-bearing organization to be at financial risk for provision of health care services

No contract between a risk-bearing organization and a health care service plan that is issued, amended, delivered, or renewed in this state on or after July 1, 2000, shall include any provision that requires the risk-bearing organization to be at financial risk for the provision of health care services, unless the provision has first been negotiated and agreed to between the health care service plan and the risk-bearing organization.

This section shall not prevent a risk-bearing organization from accepting the financial risk pursuant to a contract that meets the requirements of Section 1375.4.

HISTORY:
Added Stats 1999 ch 529 § 4 (SB 260). Amended Stats 2002 ch 798 § 1 (AB 2420).

§ 1375.6. Contract provision requiring provider to accept certain rates or methods of payment

No contract between a risk-bearing organization and a health care service plan that is issued, amended, delivered, or renewed in this state on or after July 1, 2000, shall include any provision that requires a provider to accept

rates or methods of payment specified in contracts with health care service plan affiliates or nonaffiliates unless the provision has been first negotiated and agreed to between the health care service plan and the risk-bearing organization.

HISTORY:
Added Stats 1999 ch 529 § 5 (SB 260).

§ 1375.7. Health Care Providers' Bill of Rights

(a) This section shall be known and may be cited as the Health Care Providers' Bill of Rights.

(b) No contract issued, amended, or renewed on or after January 1, 2003, between a plan and a health care provider for the provision of health care services to a plan enrollee or subscriber shall contain any of the following terms:

(1)(A) Authority for the plan to change a material term of the contract, unless the change has first been negotiated and agreed to by the provider and the plan or the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. If a change is made by amending a manual, policy, or procedure document referenced in the contract, the plan shall provide 45 business days' notice to the provider, and the provider has the right to negotiate and agree to the change. If the plan and the provider cannot agree to the change to a manual, policy, or procedure document, the provider has the right to terminate the contract prior to the implementation of the change. In any event, the plan shall provide at least 45 business days' notice of its intent to change a material term, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter timeframe for compliance. However, if the parties mutually agree, the 45-business day notice requirement may be waived. Nothing in this subparagraph limits the ability of the parties to mutually agree to the proposed change at any time after the provider has received notice of the proposed change.

(B) If a contract between a provider and a plan provides benefits to enrollees or subscribers through a preferred provider arrangement, the contract may contain provisions permitting a material change to the contract by the plan if the plan provides at least 45 business days' notice to the provider of the change and the provider has the right to terminate the contract prior to the implementation of the change.

(C) If a contract between a noninstitutional provider and a plan provides benefits to enrollees or subscribers covered under the Medi-Cal or Healthy Families Program and compensates the provider on a fee-for-service basis, the contract may contain provisions permitting a material change to the contract by the plan, if the following requirements are met:

(i) The plan gives the provider a minimum of 90 business days' notice of its intent to change a material term of the contract.

(ii) The plan clearly gives the provider the right to exercise his or her intent to negotiate and agree to the change within 30 business days of the provider's receipt of the notice described in clause (i).

(iii) The plan clearly gives the provider the right to terminate the contract within 90 business days from the date of the provider's receipt of the notice described in clause (i) if the provider does not exercise the right to negotiate the change or no agreement is reached, as described in clause (ii).

(iv) The material change becomes effective 90 business days from the date of the notice described in clause (i) if the provider does not exercise his or her right to negotiate the change, as described in clause (ii), or to terminate the contract, as described in clause (iii).

(2) A provision that requires a health care provider to accept additional patients beyond the contracted number or in the absence of a number if, in the reasonable professional judgment of the provider, accepting additional patients would endanger patients' access to, or continuity of, care.

(3) A requirement to comply with quality improvement or utilization management programs or procedures of a plan, unless the requirement is fully disclosed to the health care provider at least 15 business days prior to the provider executing the contract. However, the plan may make a change to the quality improvement or utilization management programs or procedures at any time if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. A change to the quality improvement or utilization management programs or procedures shall be made pursuant to paragraph (1).

(4) A provision that waives or conflicts with any provision of this chapter. A provision in the contract that allows the plan to provide professional liability or other coverage or to assume the cost of defending the provider in an action relating to professional liability or other action is not in conflict with, or in violation of, this chapter.

(5) A requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

(c) With respect to a health care service plan contract covering dental services or a specialized health care service plan contract covering dental services, all of the following shall apply:

(1) If a material change is made to the health care service plan's rules, guidelines, policies, or procedures concerning dental provider contracting or coverage of or payment for dental services, the plan shall provide at least 45 business days' written notice to the dentists contracting with the health care service plan to provide services under the plan's individual or group plan contracts, including specialized health care service plan contracts, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter timeframe for compliance. For purposes of this paragraph, written notice shall include notice by electronic mail or facsimile transmission. This paragraph shall apply in addition to the other applicable requirements imposed under this section, except that it shall not apply where notice of the proposed change is required to be provided pursuant to subparagraph (C) of paragraph (1) of subdivision (b).

(2) For purposes of paragraph (1), a material change made to a health care service plan's rules, guidelines, policies, or procedures concerning dental

provider contracting or coverage of or payment for dental services is a change to the system by which the plan adjudicates and pays claims for treatment that would reasonably be expected to cause delays or disruptions in processing claims or making eligibility determinations, or a change to the general coverage or general policies of the plan that affect rates and fees paid to providers.

(3) A plan that automatically renews a contract with a dental provider shall annually make available to the provider, within 60 days following a request by the provider, either online, via email, or in paper form, a copy of its current contract and a summary of the changes described in paragraph (1) of subdivision (b) that have been made since the contract was issued or last renewed.

(4) This subdivision shall not apply to a health care service plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for the provision of professional medical services to the enrollees of the plan.

(d)(1) When a contracting agent sells, leases, or transfers a health provider's contract to a payor, the rights and obligations of the provider shall be governed by the underlying contract between the health care provider and the contracting agent.

(2) For purposes of this subdivision, the following terms shall have the following meanings:

(A) "Contracting agent" has the meaning set forth in paragraph (2) of subdivision (d) of Section 1395.6.

(B) "Payor" has the meaning set forth in paragraph (3) of subdivision (d) of Section 1395.6.

(e) Any contract provision that violates subdivision (b), (c), or (d) shall be void, unlawful, and unenforceable.

(f) The department shall compile the information submitted by plans pursuant to subdivision (h) of Section 1367 into a report and submit the report to the Governor and the Legislature by March 15 of each calendar year.

(g) Nothing in this section shall be construed or applied as setting the rate of payment to be included in contracts between plans and health care providers.

(h) For purposes of this section the following definitions apply:

(1) "Health care provider" means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

(2) "Material" means a provision in a contract to which a reasonable person would attach importance in determining the action to be taken upon the provision.

HISTORY:
Added Stats 2002 ch 925 § 1 (AB 2907). Amended Stats 2003 ch 203 § 2 (AB 175); Stats 2004 ch 183 § 189 (AB 3082), ch 348 § 1 (AB 2429) (ch 348 prevails); Stats 2012 ch 447 § 1, effective January 1, 2013.

§ 1375.8. Written request by provider to assume financial risk allowed when negotiating initial contract or renewing existing contract

(a) The Legislature finds the following:

(1) Because of the nature and cost of certain medical items, the financial risk of these items is better retained by the health care service plan than by a health care service provider.

(2) Allowing a health care service provider to take the financial risk for the items described in this section only if the provider specifically requests in writing to assume that risk, will assist in maintaining patient access to health care service providers.

(b)(1) Notwithstanding Section 1375.5, no health care service plan contract that is issued, amended, delivered, or renewed in this state on or after July 1, 2003, shall require or allow a health care service provider to assume or be at any financial risk for any item described in subparagraphs (A) to (F), inclusive, of paragraph (2) when covered under the applicable plan contract and administered in the office of a physician and surgeon or prescribed by a physician and surgeon for self-administration by the patient. "Self-administration," for the purposes of this section, means an injectable medication that can be safely given intramuscularly, or in the muscle, or subcutaneously, or under the skin, by the patient or his or her family member.

(2) The items described in subparagraphs (A) to (F), inclusive, shall, instead, be reimbursed on a fee-for-service basis at the negotiated contract rate or through an alternate funding mechanism mutually agreed to by the health care service plan and the health care service provider, subject to any applicable copayment or deductible, by the health care service plan.

(A) Injectable chemotherapeutic medications and injectable adjunct pharmaceutical therapies for side effects.

(B) Injectable medications or blood products used for hemophilia.

(C) Injectable medications related to transplant services.

(D) Adult vaccines.

(E) Self-injectable medications.

(F) Other injectable medication or medication in an implantable dosage form costing more than two hundred fifty dollars ($250) per dose.

(3) Notwithstanding the provisions of paragraphs (1) and (2), a health care service provider may assume financial risk for the items described in subparagraphs (A) to (F), inclusive, of paragraph (2) after making the request in writing at the time of negotiating an initial contract or renewing a contract with a health care service plan. No health care service plan may request or require that as a condition of the contract agreement a health care service provider shall request to assume the financial risk for any of those items.

(c) The following definitions apply for the purposes of this section:

(1) "Financial risk" means any contractual financial agreement between a health care service provider and a health care service plan for services rendered to a patient or enrollee if the reimbursement from a health care service plan is other than a fee for service rate structure. "Financial risk" includes, but is not limited to, capitation payments, case rates, and risk pools.

(2) "Health care service provider" means an individual, partnership, group, or corporation lawfully licensed or organized under Division 2 (commencing with Section 500) of the Business and Professions Code, unless specifically exempt from those provisions, or licensed under Section 1204 or

exempt from licensure under Section 1206 that delivers, furnishes, or otherwise arranges for or provides health care services. "Health care service provider" does not include a health facility as defined in Section 1250, a hospice, a surgical center, or a home infusion provider.

(d) This section shall not preclude any payment by a health care service plan to a health care service provider for the performance of any services related to quality measures and programs.

(e) This section shall not apply to a contract that is between a health care service plan and a health care service provider or a provider organization that meets either of the requirements set forth in paragraph (2) of subdivision (g) of Section 1375.4 or to a contract between licensed health care service plans or to a contract between a health care service plan and a health care service plan with waivers.

HISTORY:
Added Stats 2002 ch 798 § 2 (AB 2420).

§ 1375.9. Health care service plan; Primary care physician to enrollee ratios

(a) A health care service plan shall ensure that there is at least one full-time equivalent primary care physician for every 2,000 enrollees of the plan. The number of enrollees per primary care physician may be increased by up to 1,000 additional enrollees for each full-time equivalent nonphysician medical practitioner supervised by that primary care physician.

(b) This section shall not require a primary care physician to accept an assignment of enrollees by a health care service plan without his or her approval, or that would be contrary to paragraph (2) of subdivision (b) of Section 1375.7.

(c) This section does not modify subdivision (e) of Section 2836.1 of the Business and Professions Code or subdivision (b) of Section 3516 of the Business and Professions Code.

(d) For purposes of this section, a primary care provider includes a "nonphysician medical practitioner," which is defined as a physician assistant performing services under the supervision of a primary care physician in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code or a nurse practitioner performing services in collaboration with a physician pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

HISTORY:
Added Stats 2013 ch 684 § 1 (SB 494), effective January 1, 2014, repealed January 1, 2019. Amended Stats 2014 ch 71 § 85 (SB 1304), effective January 1, 2015, repealed January 1, 2019; Stats 2018 ch 152 § 1 (SB 997), effective January 1, 2019.

§ 1376. Rules and regulations; Surety bond

(a) No plan shall conduct any activity regulated by this chapter in contravention of such rules and regulations as the director may prescribe as necessary or appropriate in the public interest or for the protection of plans, subscribers, and enrollees to provide safeguards with respect to the financial responsibility of plans. Such rules and regulations may require a minimum

capital or net worth, limitations on indebtedness, procedures for the handling of funds or assets, including segregation of funds, assets and net worth, the maintenance of appropriate insurance and a fidelity bond and the maintenance of a surety bond in an amount not exceeding fifty thousand dollars ($50,000).

(b) The surety bond referred to in subdivision (a) shall be conditioned upon compliance by the licensee with the provisions of this chapter and the rules and regulations adopted pursuant to this chapter and orders issued under this chapter. Every surety bond shall provide that no suit may be maintained to enforce any liability thereon unless brought within two years after the act upon which such suit is based.

(c) For purposes of computing any minimum capital requirement which may be prescribed by the rules and regulations of the director under subdivision (a), any operating cost assistance or direct loan made to a plan by the United States Department of Health and Human Services pursuant to Public Law 93–222, as amended, may be treated as a subordinated loan, notwithstanding any express terms thereof to the contrary.

(d) Each solicitor and solicitor firm shall handle funds received for the account of plans, subscribers, or groups in accordance with such rules as the director may adopt pursuant to this subdivision.

(e) The director may, by regulation, designate requirements of this section or regulations adopted pursuant to this section, from which public entities and political subdivisions of the state shall be exempt.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1976 ch 652 § 4, effective August 28, 1976, operative July 1, 1976; Stats 1977 ch 818 § 14, effective September 16, 1977; Stats 1979 ch 1083 § 9; Stats 1980 ch 1031 § 3; Stats 1982 ch 517 § 267, ch 1323 § 2; Stats 1983 ch 18 § 24, effective April 21, 1983; Stats 1999 ch 525 § 123 (AB 78), operative July 1, 2000.

§ 1376.1. Exemption of county or city plan from deposit requirements related to financial responsibility

The deposit requirements of Section 1300.76.1 of Title 28 of the California Code of Regulations shall not apply to any plan operated by a county, or city and county, if both of the following apply:

(a) All of the evidence of indebtedness of the county, or city and county, has been rated "A" or better by Moody's Investors Service, Inc. or Standard & Poor's Corporation, based on a rating conducted during the immediately preceding 12 months.

(b) The county, or city and county, has cash or cash equivalents in an amount equal to fifty million dollars ($50,000,000) or more, based on its audited financial statements for the immediately preceding fiscal year. For purposes of this subdivision, the term "equivalents" shall have the same meaning as in Section 1300.77 of Title 28 of the California Code of Regulations.

HISTORY:
Added Stats 1992 ch 600 § 1 (AB 2354). Amended Stats 2009 ch 298 § 7 (AB 1540), effective January 1, 2010.

§ 1377. Reserves or insurance to be maintained by certain plans for payments to subscribers or providers

(a) Every plan which reimburses providers of health care services that do not contract in writing with the plan to provide health care services, or which reimburses its subscribers or enrollees for costs incurred in having received health care services from providers that do not contract in writing with the plan, in an amount which exceeds 10 percent of its total costs for health care services for the immediately preceding six months, shall comply with the requirements set forth in either paragraph (1) or (2):

(1)(A) Place with the director, or with any organization or trustee acceptable to the director through which a custodial or controlled account is maintained, a noncontracting provider insolvency deposit consisting of cash or securities that are acceptable to the director that at all times have a fair market value in an amount at least equal to 120 percent of the sum of the following:

(i) All claims for noncontracting provider services received for reimbursement, but not yet processed.

(ii) All claims for noncontracting provider services denied for reimbursement during the previous 45 days.

(iii) All claims for noncontracting provider services approved for reimbursement, but not yet paid.

(iv) An estimate of claims for noncontracting provider services incurred, but not reported.

(B) Each plan licensed pursuant to this chapter prior to January 1, 1991, shall, upon that date, make a deposit of 50 percent of the amount required by subparagraph (A), and shall maintain additional cash or cash equivalents as defined by rule of the director, in the amount of 50 percent of the amount required by subparagraph (A), and shall make a deposit of 100 percent of the amount required by subparagraph (A) by January 1, 1992.

(C) The amount of the deposit shall be reasonably estimated as of the first day of the month and maintained for the remainder of the month.

(D) The deposit required by this paragraph is in addition to the deposit that may be required by rule of the director and is an allowable asset of the plan in the determination of tangible net equity as defined in subdivision (b) of Section 1300.76 of Title 28 of the California Code of Regulations. All income from the deposit shall be an asset of the plan and may be withdrawn by the plan at any time.

(E) A health care service plan that has made a deposit may withdraw that deposit or any part of the deposit if (i) a substitute deposit of cash or securities of equal amount and value is made, (ii) the fair market value exceeds the amount of the required deposit, or (iii) the required deposit under this paragraph is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the director, but approval shall not be required for the withdrawal of earned income.

(F) The deposit required under this section is in trust and may be used only as provided by this section. The director or, if a receiver has been

appointed, the receiver shall use the deposit of an insolvent health care service plan, as defined in Sections 1394.7 and 1394.8, for payment of covered claims for services rendered by noncontracting providers under circumstances covered by the plan. All claims determined by the director or receiver, in his or her discretion, to be eligible for reimbursement under this section shall be paid on a pro rata basis based on assets available from the deposit to pay the ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health care service plan. The director may also use the deposit of an insolvent health care service plan for payment of any administrative costs associated with the administration of this section. The department, the director, and any employee of the department shall not be liable, as provided by Section 820.2 of the Government Code, for an injury resulting from an exercise of discretion pursuant to this section. Nothing in this section shall be construed to provide immunity for the acts of a receiver, except when the director is acting as a receiver.

(G) The director may, by regulation, prescribe the time, manner, and form for filing claims.

(H) The director may permit a plan to meet a portion of this requirement by a deposit of tangible assets acceptable to the director, the fair market value of which shall be determined on at least an annual basis by the director. The plan shall bear the cost of any appraisal or valuations required hereunder by the director.

(2) Maintain adequate insurance, or a guaranty arrangement approved in writing by the director, to pay for any loss to providers, subscribers, or enrollees claiming reimbursement due to the insolvency of the plan.

(b) Whenever the reimbursements described in this section exceed 10 percent of the plan's total costs for health care services over the immediately preceding six months, the plan shall file a written report with the director containing the information necessary to determine compliance with subdivision (a) no later than 30 business days from the first day of the month. Upon an adequate showing by the plan that the requirements of this section should be waived or reduced, the director may waive or reduce these requirements to an amount as the director deems sufficient to protect subscribers and enrollees of the plan consistent with the intent and purpose of this chapter.

(c) Every plan which reimburses providers of health care service on a fee-for-services basis; or which directly reimburses its subscribers or enrollees, to an extent exceeding 10 percent of its total payments for health care services, shall estimate and record in the books of account a liability for incurred and unreported claims. Upon a determination by the director that the estimate is inadequate, the director may require the plan to increase its estimate of incurred and unreported claims. Every plan shall promptly report to the director whenever these reimbursables exceed 10 percent of its total expenditures for health care services.

As used herein, the term "fee-for-services" refers to the situation where the amount of reimbursement paid by the plan to providers of service is determined by the amount and type of service rendered by the provider of service.

(d) In the event an insolvent plan covered by this section fails to pay a noncontracting provider sums for covered services owed, the provider shall

first look to the uncovered expenditures insolvency deposit or the insurance or guaranty arrangement maintained by the plan for payment. When a plan becomes insolvent, in no event shall a noncontracting provider, or agent, trustee, or assignee thereof, attempt to collect from the subscriber or enrollee sums owed for covered services by the plan or maintain any action at law against a subscriber or enrollee to collect sums owed by the plan for covered services without having first attempted to obtain reimbursement from the plan.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1985 ch 908 § 2; Stats 1990 ch 1043 § 7 (SB 785); Stats 1991 ch 422 § 2 (SB 244); Stats 1999 ch 525 § 124 (AB 78), operative July 1, 2000; Stats 2009 ch 298 § 8 (AB 1540), effective January 1, 2010.

§ 1378. Administrative costs

No plan shall expend for administrative costs in any fiscal year an excessive amount of the aggregate dues, fees and other periodic payments received by the plan for providing health care services to its subscribers or enrollees. The term "administrative costs," as used herein, includes costs incurred in connection with the solicitation of subscribers or enrollees for the plan.

This section shall not preclude a plan from expending additional sums of money for administrative costs provided such money is not derived from revenue obtained from subscribers or enrollees of the plan.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976.

§ 1379. Contracts with health care providers

(a) Every contract between a plan and a provider of health care services shall be in writing, and shall set forth that in the event the plan fails to pay for health care services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan.

(b) In the event that the contract has not been reduced to writing as required by this chapter or that the contract fails to contain the required prohibition, the contracting provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the plan.

(c) No contracting provider, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the plan.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976.

§ 1379.5. Contract between plan and health care provider who provides health care services in Mexico; Requirements; Plan's obligations

(a) On and after July 1, 2008, every contract between a plan and a health care provider who provides health care services in Mexico to an enrollee of the plan shall require the health care provider knowing of, or in attendance on, a case or suspected case of any disease or condition listed in subdivision (j) of

Section 2500 of Title 17 of the California Code of Regulations to report the case to the health officer of the jurisdiction in California where the patient in the case resides, or if the patient resides in Mexico and is employed in California, the contract shall require a health care provider to report the case to the health officer of the jurisdiction where the patient in the case is employed. The contract provision shall require the health care provider to make the report in accordance with subdivision (d) of Section 2500 of Title 17 of the California Code of Regulations, except that for reports in cases where the patient resides in Mexico the contract shall require the report to be made to the health officer of the jurisdiction where the patient is employed.

(b) For purposes of this section, the terms "case," "health care provider," "health officer," "in attendance," and "suspected case" shall have the same meanings as set forth in subdivision (a) of Section 2500 of Title 17 of the California Code of Regulations.

(c) A plan's obligations under this section shall be limited to the following:

(1) Ensuring that the contracts executed by providers who provide health care services in Mexico satisfy the requirements set forth in subdivision (a).

(2) Giving the following written notice to the provider at the time the signed contract is delivered:

"This contract contains specific requirements regarding reporting of actual or suspected diseases or conditions to California health officers."

HISTORY:
Added Stats 2007 ch 385 § 1 (AB 328), effective January 1, 2008.

§ 1380. Surveys of health delivery systems

(a) The department shall conduct periodically an onsite medical survey of the health delivery system of each plan. The survey shall include a review of the procedures for obtaining health services, the procedures for regulating utilization, peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the plan in providing health care benefits and meeting the health needs of the subscribers and enrollees.

(b) The survey shall be conducted by a panel of qualified health professionals experienced in evaluating the delivery of prepaid health care. The department shall be authorized to contract with professional organizations or outside personnel to conduct medical surveys and these contracts shall be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. These organizations or personnel shall have demonstrated the ability to objectively evaluate the delivery of health care by plans or health maintenance organizations.

(c) Surveys performed pursuant to this section shall be conducted as often as deemed necessary by the director to assure the protection of subscribers and enrollees, but not less frequently than once every three years. Nothing in this section shall be construed to require the survey team to visit each clinic, hospital office, or facility of the plan. To avoid duplication, the director shall employ, but is not bound by, the following:

(1) For hospital-based health care service plans, to the extent necessary to

satisfy the requirements of this section, the findings of inspections conducted pursuant to Section 1279.

(2) For health care service plans contracting with the State Department of Health Services pursuant to the Waxman-Duffy Prepaid Health Plan Act, the findings of reviews conducted pursuant to Section 14456 of the Welfare and Institutions Code.

(3) To the extent feasible, reviews of providers conducted by professional standards review organizations, and surveys and audits conducted by other governmental entities.

(d) Nothing in this section shall be construed to require the medical survey team to review peer review proceedings and records conducted and compiled under Section 1370 or medical records. However, the director shall be authorized to require onsite review of these peer review proceedings and records or medical records where necessary to determine that quality health care is being delivered to subscribers and enrollees. Where medical record review is authorized, the survey team shall insure that the confidentiality of physician-patient relationship is safeguarded in accordance with existing law and neither the survey team nor the director or the director's staff may be compelled to disclose this information except in accordance with the physician-patient relationship. The director shall ensure that the confidentiality of the peer review proceedings and records is maintained. The disclosure of the peer review proceedings and records to the director or the medical survey team shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to Sections 1370 and 1370.1.

(e) The procedures and standards utilized by the survey team shall be made available to the plans prior to the conducting of medical surveys.

(f) During the survey the members of the survey team shall examine the complaint files kept by the plan pursuant to Section 1368. The survey report issued pursuant to subdivision (i) shall include a discussion of the plan's record for handling complaints.

(g) During the survey the members of the survey team shall offer such advice and assistance to the plan as deemed appropriate.

(h)(1) Survey results shall be publicly reported by the director as quickly as possible but no later than 180 days following the completion of the survey unless the director determines, in his or her discretion, that additional time is reasonably necessary to fully and fairly report the survey results. The director shall provide the plan with an overview of survey findings and notify the plan of deficiencies found by the survey team at least 90 days prior to the release of the public report.

(2) Reports on all surveys, deficiencies, and correction plans shall be open to public inspection except that no surveys, deficiencies, or correction plans shall be made public unless the plan has had an opportunity to review the report and file a response within 45 days of the date that the department provided the report to the plan. After reviewing the plan's response, the director shall issue a final report that excludes any survey information and legal findings and conclusions determined by the director to be in error, describes compliance efforts, identifies deficiencies that have been corrected by the plan by the time of the director's receipt of the plan's 45-day response, and describes remedial actions for deficiencies requiring longer periods to the remedy required by the director or proposed by the plan.

(3) The final report shall not include a description of "acceptable" or of "compliance" for any uncorrected deficiency.

(4) Upon making the final report available to the public, a single copy of a summary of the final report's findings shall be made available free of charge by the department to members of the public, upon request. Additional copies of the summary may be provided at the department's cost. The summary shall include a discussion of compliance efforts, corrected deficiencies, and proposed remedial actions.

(5) If requested by the plan, the director shall append the plan's response to the final report issued pursuant to paragraph (2), and shall append to the summary issued pursuant to paragraph (4) a brief statement provided by the plan summarizing its response to the report. The plan may modify its response or statement at any time and provide modified copies to the department for public distribution no later than 10 days from the date of notification from the department that the final report will be made available to the public. The plan may file an addendum to its response or statement at any time after the final report has been made available to the public. The addendum to the response or statement shall also be made available to the public.

(6) Any information determined by the director to be confidential pursuant to statutes relating to the disclosure of records, including the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), shall not be made public.

(i)(1) The director shall give the plan a reasonable time to correct deficiencies. Failure on the part of the plan to comply to the director's satisfaction shall constitute cause for disciplinary action against the plan.

(2) No later than 18 months following release of the final report required by subdivision (h), the department shall conduct a follow-up review to determine and report on the status of the plan's efforts to correct deficiencies. The department's follow-up report shall identify any deficiencies reported pursuant to subdivision (h) that have not been corrected to the satisfaction of the director.

(3) If requested by the plan, the director shall append the plan's response to the follow-up report issued pursuant to paragraph (2). The plan may modify its response at any time and provide modified copies to the department for public distribution no later than 10 days from the date of notification from the department that the follow-up report will be made available to the public. The plan may file an addendum to its response at any time after the follow-up report has been made available to the public. The addendum to the response or statement shall also be made available to the public.

(j) The director shall provide to the plan and to the executive officer of the Board of Dental Examiners a copy of information relating to the quality of care of any licensed dental provider contained in any report described in subdivisions (h) and (i) that, in the judgment of the director, indicates clearly excessive treatment, incompetent treatment, grossly negligent treatment, repeated negligent acts, or unnecessary treatment. Any confidential information provided by the director shall not be made public pursuant to this subdivision. Notwithstanding any other provision of law, the disclosure of this information

to the plan and to the executive officer shall not operate as a waiver of confidentiality. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the State of California, the Department of Managed Health Care, the Director of the Department of Managed Health Care, the Board of Dental Examiners, or any officer, agent, employee, consultant, or contractor of the state or the department or the board for the release of any false or unauthorized information pursuant to this section, unless the release of that information is made with knowledge and malice.

(k) Nothing in this section shall be construed as affecting the director's authority pursuant to Article 7 (commencing with Section 1386) or Article 8 (commencing with Section 1390) of this chapter.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1977 ch 1252 § 252, operative July 1, 1978; Stats 1992 ch 175 § 1 (SB 1002); Stats 1993 ch 464 § 3 (AB 502); Stats 1995 ch 789 § 6 (SB 689); Stats 1999 ch 525 § 125 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 41 (AB 2903).

§ 1380.1. Legislative findings and declarations; Standards for uniform medical quality audit system

(a) The Legislature finds and declares as follows:

(1) Multiple medical quality audits of health care providers, as many as 25 for some physician offices, increase costs for health care providers and health plans, and thus ultimately increase costs for the purchaser and the consumer, and result in the direction of limited health care resources to administrative costs instead of to patient care.

(2) Streamlining the multiple medical quality audits required by health care service plans and insurers is vital to increasing the resources directed to patient care.

(3) Few legislative proposals affecting health care services have the potential of benefiting all of the affected parties, including health plans, health care providers, purchasers, and consumers, through a reduction in administrative costs but without negatively affecting patient care.

(b) The Advisory Committee on Managed Care shall recommend to the director standards for a uniform medical quality audit system, which shall include a single periodic medical quality audit. The director shall publish proposed regulations in that regard on or before January 1, 2002.

(c) In developing those standards, the Advisory Committee on Managed Care shall seek comment from a broad and balanced range of interested parties.

(d) The recommendations shall include all of the following:

(1) Standards that will serve as the basis of the single periodic medical quality audit necessary to meet the criteria of this section.

(2) Standards that will not be covered by the single periodic medical quality audit and that may be audited directly by health care service plans.

(3) A list of those private sector accreditation organizations, if any, that have or can develop systems comparable to the recommended system, and the capability and expertise to accredit, audit, or credential providers.

(e)(1) The director may approve private sector accreditation organizations as qualified organizations to perform the single periodic medical quality audits.

(2) Audits shall be conducted at least annually.

(f) The single medical quality audit shall not prevent licensed health care service plans from developing performance criteria or conducting separate audits for governmental or regulatory purposes, purchasers, or to address consumer complaints and grievances, management changes, or plan initiatives to improve or monitor quality.

HISTORY:
Added Stats 2000 ch 856 § 2 (SB 2136).

§ 1380.3. Coordination of surveys

The department shall coordinate the surveys conducted pursuant to Section 1380 with the State Department of Health Care Services, to the extent possible, in order to allow for simultaneous oversight of Medi-Cal managed care plans by both departments, provided that this coordination does not result in a delay of the surveys required under Section 1380 or in the failure of the department to conduct those surveys.

HISTORY:
Added Stats 2014 ch 573 § 4 (SB 964), effective January 1, 2015.

§ 1381. Records; Location and inspection

(a) All records, books, and papers of a plan, management company, solicitor, solicitor firm, and any provider or subcontractor providing health care or other services to a plan, management company, solicitor, or solicitor firm shall be open to inspection during normal business hours by the director.

(b) To the extent feasible, all such records, books, and papers described in subdivision (a) shall be located in this state. In examining such records outside this state, the director shall consider the cost to the plan, consistent with the effectiveness of the director's examination, and may upon reasonable notice require that such records, books and papers, or a specified portion thereof, be made available for examination in this state, or that a true and accurate copy of such records, books and papers, or a specified portion thereof, be furnished to the director.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1979 ch 1083 § 10; Stats 1999 ch 525 § 128 (AB 78), operative July 1, 2000.

§ 1382. Examinations of fiscal and administrative affairs of plans

(a) The director shall conduct an examination of the fiscal and administrative affairs of any health care service plan, and each person with whom the plan has made arrangements for administrative, management, or financial services, as often as deemed necessary to protect the interest of subscribers or enrollees, but not less frequently than once every five years.

(b) The expense of conducting any additional or nonroutine examinations pursuant to this section, and the expense of conducting any additional or nonroutine medical surveys pursuant to Section 1380 shall be charged against the plan being examined or surveyed. The amount shall include the actual

salaries or compensation paid to the persons making the examination or survey, the expenses incurred in the course thereof, and overhead costs in connection therewith as fixed by the director. In determining the cost of examinations or surveys, the director may use the estimated average hourly cost for all persons performing examinations or surveys of plans for the fiscal year. The amount charged shall be remitted by the plan to the director. If recovery of these costs cannot be made from the plan, these costs may be added to, but subject to the limitation of, the assessment provided for in subdivision (b) of Section 1356.

(c) Reports of all examinations shall be open to public inspection, except that no examination shall be made public, unless the plan has had an opportunity to review the examination report and file a statement or response within 45 days of the date that the department provided the report to the plan. After reviewing the plan's response, the director shall issue a final report that excludes any survey information, legal findings, or conclusions determined by the director to be in error, describes compliance efforts, identifies deficiencies that have been corrected by the plan on or before the time the director receives the plan's response, and describes remedial actions for deficiencies requiring longer periods for the remedy required by the director or proposed by the plan.

(d) If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public.

(e) Notwithstanding subdivision (c), any health care service plan that contracts with the State Department of Health Services to provide service to Medi-Cal beneficiaries pursuant to Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code may make a written request to the director to permit the State Department of Health Services to review its examination report.

(f) Upon receipt of the written request described in subdivision (e), the director may, consistent with Section 6254.5 of the Government Code, permit the State Department of Health Services to review the plan's examination report.

(g) Nothing in this section shall be construed as affecting the director's authority pursuant to Article 7 (commencing with Section 1386) or Article 8 (commencing with Section 1390).

HISTORY:

Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1976 ch 652 § 5, effective August 28, 1976, operative July 1, 1976; Stats 1979 ch 1061 § 1, operative July 1, 1980; Stats 1985 ch 908 § 3; Stats 1986 ch 718 § 5; Stats 1989 ch 845 § 3; Stats 1991 ch 722 § 5 (AB 1669); Stats 1992 ch 1021 § 2 (SB 1643); Stats 1998 ch 215 § 1 (AB 1377); Stats 1999 ch 525 § 129 (AB 78), operative July 1, 2000.

§ 1383. Annual report to department

Every plan that is a health maintenance organization qualified under Section 1310(d) of Title XIII of the federal Public Health Service Act, shall provide the department with a copy of the reports the plan files annually with

the United States Department of Health, Education, and Welfare pursuant to Title XIII of the federal Public Health Service Act.

HISTORY:
Added Stats 1979 ch 1083 § 11.5.

§ 1383.1. Policy on second medical opinion

(a) On or before July 1, 1997, every health care service plan shall file with the department a written policy, which is not subject to approval or disapproval by the department, describing the manner in which the plan determines if a second medical opinion is medically necessary and appropriate. Notice of the policy and information regarding the manner in which an enrollee may receive a second medical opinion shall be provided to all enrollees in the plan's evidence of coverage. The written policy shall describe the manner in which requests for a second medical opinion are reviewed by the plan.

(b) This section shall not apply to any health care service plan contract authorized under Article 5.6 (commencing with Section 1374.60).

(c) Nothing in this section shall require a health care service plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract, nor to provide services through providers who are not under contract with the plan.

HISTORY:
Added Stats 1996 ch 1091 § 1 (AB 3251).
Amended Stats 1998 ch 215 § 2 (AB 1377).

§ 1383.15. Second opinion

(a) When requested by an enrollee or participating health professional who is treating an enrollee, a health care service plan shall provide or authorize a second opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

(1) If the enrollee questions the reasonableness or necessity of recommended surgical procedures.

(2) If the enrollee questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

(3) If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the enrollee requests an additional diagnosis.

(4) If the treatment plan in progress is not improving the medical condition of the enrollee within an appropriate period of time given the diagnosis and plan of care, and the enrollee requests a second opinion regarding the diagnosis or continuance of the treatment.

(5) If the enrollee has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

(b) For purposes of this section, an appropriately qualified health care professional is a primary care physician or specialist who is acting within his

or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion. For purposes of a specialized health care service plan, an appropriately qualified health care professional is a licensed health care provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

(c) If an enrollee or participating health professional who is treating an enrollee requests a second opinion pursuant to this section, an authorization or denial shall be provided in an expeditious manner. When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the enrollee's ability to regain maximum function, the second opinion shall be authorized or denied in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the request, whenever possible. Each plan shall file with the Department of Managed Health Care timelines for responding to requests for second opinions for cases involving emergency needs, urgent care, and other requests by July 1, 2000, and within 30 days of any amendment to the timelines. The timelines shall be made available to the public upon request.

(d) If a health care service plan approves a request by an enrollee for a second opinion, the enrollee shall be responsible only for the costs of applicable copayments that the plan requires for similar referrals.

(e) If the enrollee is requesting a second opinion about care from his or her primary care physician, the second opinion shall be provided by an appropriately qualified health care professional of the enrollee's choice within the same physician organization.

(f) If the enrollee is requesting a second opinion about care from a specialist, the second opinion shall be provided by any provider of the enrollee's choice from any independent practice association or medical group within the network of the same or equivalent specialty. If the specialist is not within the same physician organization, the plan shall incur the cost or negotiate the fee arrangements of that second opinion, beyond the applicable copayments which shall be paid by the enrollee. If not authorized by the plan, additional medical opinions not within the original physician organization shall be the responsibility of the enrollee.

(g) If there is no participating plan provider within the network who meets the standard specified in subdivision (b), then the plan shall authorize a second opinion by an appropriately qualified health professional outside of the plan's provider network. In approving a second opinion either inside or outside of the plan's provider network, the plan shall take into account the ability of the enrollee to travel to the provider.

(h) The health care service plan shall require the second opinion health professional to provide the enrollee and the initial health professional with a consultation report, including any recommended procedures or tests that the second opinion health professional believes appropriate. Nothing in this section shall be construed to prevent the plan from authorizing, based on its

independent determination, additional medical opinions concerning the medical condition of an enrollee.

(i) If the health care service plan denies a request by an enrollee for a second opinion, it shall notify the enrollee in writing of the reasons for the denial and shall inform the enrollee of the right to file a grievance with the plan. The notice shall comply with subdivision (b) of Section 1368.02.

(j) Unless authorized by the plan, in order for services to be covered the enrollee shall obtain services only from a provider who is participating in, or under contract with, the plan pursuant to the specific contract under which the enrollee is entitled to health care services. The plan may limit referrals to its network of providers if there is a participating plan provider who meets the standard specified in subdivision (b).

(k) This section shall not apply to health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements if, subject to all other terms and conditions of the contract that apply generally to all other benefits, access to and coverage for second opinions are not limited.

HISTORY:
Added Stats 1999 ch 531 § 1 (AB 12). Amended Stats 2000 ch 857 § 43 (AB 2903); Stats 2001 ch 328 § 3 (SB 455).

§ 1384. Audit reports and financial statements

(a) Within 90 days after receipt of a request from the director, a plan or other person subject to this chapter shall submit to the director an audit report containing audited financial statements covering the 12-calendar months next preceding the month of receipt of the request, or another period as the director may require.

(b) On or before 105 days after the date of a notice of surrender or order of revocation, a plan shall file with the director a closing audit report containing audited financial statements. The reporting period for the closing audit report shall be the 12-month period preceding the date of the notice of surrender or order of revocation, or for another period as the director may specify. This report shall include other relevant information as specified by rule of the director. The director shall not consent to a surrender and an order of revocation shall not be considered final until the closing audit report has been filed with the director and all concerns raised by the director therefrom have been resolved by the plan, as determined by the director. For good cause, the director may waive the requirement of a closing audit report.

(c) Except as otherwise provided in this subdivision, each plan shall submit financial statements prepared as of the close of its fiscal year within 120 days after the close of the fiscal year. The financial statements referred to in this subdivision and in subdivisions (a) and (b) of this section shall be accompanied by a report, certificate, or opinion of an independent certified public accountant or independent public accountant. The audits shall be conducted in accordance with generally accepted auditing standards and the rules and regulations of the director. However, financial statements from public entities or political subdivisions of the state whose audits are conducted by a county grand jury shall be submitted within 180 days after the close of the fiscal year and need not include a report, certificate, or opinion by an independent certified public

accountant or an independent public accountant, and the audit shall be conducted in accordance with governmental auditing standards.

(d) A plan, solicitor, or solicitor firm shall make any special reports to the director as the director may from time to time require.

(e) For good cause and upon written request, the director may extend the time for compliance with subdivisions (a), (b), and (h) of this section.

(f) A plan, solicitor, or solicitor firm shall, when requested by the director, for good cause, submit its unaudited financial statement, prepared in accordance with generally accepted accounting principles and consisting of at least a balance sheet and statement of income as of the date and for the period specified by the director. The director may require the submission of these reports on a monthly or other periodic basis.

(g) If the report, certificate, or opinion of the independent accountant referred to in subdivision (c) is in any way qualified, the director may require the plan to take any action as the director deems appropriate to permit an independent accountant to remove the qualification from the report, certificate, or opinion.

(h) The director may reject any financial statement, report, certificate, or opinion filed pursuant to this section by notifying the plan, solicitor, or solicitor firm required to make this filing of its rejection and the cause thereof. Within 30 days after the receipt of the notice, the person shall correct the deficiency, and the failure so to do shall be deemed a violation of this chapter. The director shall retain a copy of all filings so rejected.

(i) The director may make rules and regulations specifying the form and content of the reports and financial statements referred to in this section, and may require that these reports and financial statements be verified by the plan or other person subject to this chapter in a manner as the director may prescribe.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1976 ch 652 § 7, effective August 28, 1976, operative July 1, 1976; Stats 1979 ch 1083 § 12; Stats 1980 ch 1031 § 4; Stats 1993 ch 735 § 3 (AB 2079); Stats 1996 ch 139 § 1 (AB 2138); Stats 1999 ch 525 § 130 (AB 78), operative July 1, 2000.

§ 1385. Books of account

Each plan, solicitor firm, and solicitor shall keep and maintain current such books of account and other records as the director may by rule require for the purposes of this chapter. Every plan shall require all providers who contract with the plan to report to the plan in writing all surcharge and copayment moneys paid by subscribers and enrollees directly to such providers, unless the director expressly approves otherwise.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1999 ch 525 § 131 (AB 78), operative July 1, 2000.

ARTICLE 6.1

Pharmacy Benefit Management Services [Operative January 1, 2020]

Section
1385.001. "Pharmacy benefit manager" defined [Operative January 1, 2020].
1385.002. Authority of department [Operative January 1, 2020].
1385.003. Required disclosures of heath care service plan [Operative January 1, 2020].
1385.004. Requirements of pharmacy benefit manager [Operative January 1, 2020].
1385.005. Required registration for pharmacy benefit manager [Operative January 1, 2020].
1385.006. Discipline for failure to comply [Operative January 1, 2020].
1385.007. Task Force on Pharmacy Benefit Management Reporting; Reporting requirements [Effective until January 1, 2021; Inoperative February 1, 2020; Repealed effective January 1, 2021].

HISTORY: Added Stats 2018 ch 905 § 4 (AB 315), effective January 1, 2019, operative January 1, 2020.

§ 1385.001. "Pharmacy benefit manager" defined [Operative January 1, 2020]

For the purposes of this article, "pharmacy benefit manager" means a person, business, or other entity that, pursuant to a contract with a health care service plan, manages the prescription drug coverage provided by the health care service plan, including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs. This definition shall not include a health care service plan licensed under this chapter or any individual employee of a health care service plan or its contracted provider, as defined in subdivision (i) of Section 1345, performing the services described in this section.

HISTORY:
Added Stats 2018 ch 905 § 4 (AB 315), effective January 1, 2019, operative January 1, 2020.

§ 1385.002. Authority of department [Operative January 1, 2020]

(a) Except as specified in Section 1385.007, the requirements of this article shall become operative on January 1, 2020.

(b) Notwithstanding subdivision (a), the department has the authority to enforce the provisions of this article, including the authority to adopt, amend, or repeal any rules and regulations, not inconsistent with the laws of this state, as may be necessary for the protection of the public and to implement this article, including, but not limited to, the director's enforcement authority under this chapter.

(c) Notwithstanding subdivision (a) and Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article by means of all-plan letters or similar instructions to plans and pharmacy benefit managers, without taking regulatory action, until such time as regulations are adopted.

(d) The department may contract with a consultant or consultants with expertise in this subject area to assist the department in developing guidance or instructions described in subdivision (c), or the report required pursuant to Section 1385.007. The department's contract with a consultant shall include conflict-of-interest provisions to prohibit a person from participating in any report in which the person knows or has reason to know he or she has a material financial interest, including, but not limited to, a person who has a consulting or other agreement with a person or organization that would be affected by the results of the report.

(e) Contracts entered into pursuant to the authority in this article shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

HISTORY:
Added Stats 2018 ch 905 § 4 (AB 315), effective January 1, 2019, operative January 1, 2020.

§ 1385.003. Required disclosures of heath care service plan [Operative January 1, 2020]

(a) A health care service plan shall disclose to a contracted pharmacy provider or its contracting agent the prescription drug information contained in subdivision (a) of Section 1363.03, including, but not limited to, the telephone number pharmacy providers may call for assistance and information necessary to process a pharmacy claim.

(b) A health care service plan shall not include in a contract with a pharmacy provider or its contracting agent a provision that prohibits the provider from informing a patient of a less costly alternative to a prescribed medication.

HISTORY:
Added Stats 2018 ch 905 § 4 (AB 315), effective January 1, 2019, operative January 1, 2020.

§ 1385.004. Requirements of pharmacy benefit manager [Operative January 1, 2020]

(a) A health care service plan that contracts with a pharmacy benefit manager for management of any or all of its prescription drug coverage shall require the pharmacy benefit manager to do all of the following:

(1) Comply with the provisions of Section 1385.003.

(2) Register with the department pursuant to the requirements of this article.

(3) Exercise good faith and fair dealing in the performance of its contractual duties to a health care service plan.

(4) Comply with the requirements of Chapter 9.5 (commencing with Section 4430) of Division 2 of the Business and Professions Code, as applicable.

(5) Inform all pharmacists under contract with or subject to contracts with the pharmacy benefit manager of the pharmacist's rights to submit

complaints to the department under Section 1371.39 and of the pharmacist's rights as a provider under Section 1375.7.

(b) A pharmacy benefit manager shall notify a health care service plan in writing of any activity, policy, or practice of the pharmacy benefit manager that directly or indirectly presents a conflict of interest that interferes with the discharge of the pharmacy benefit manager's duty to the health care service plan to exercise good faith and fair dealing in the performance of its contractual duties pursuant to subdivision (a).

HISTORY:
Added Stats 2018 ch 905 § 4 (AB 315), effective January 1, 2019, operative January 1, 2020.

§ 1385.005. Required registration for pharmacy benefit manager [Operative January 1, 2020]

(a) A pharmacy benefit manager required to register with the department pursuant to Section 1385.004 shall complete an application for registration with the department that shall include, but not be limited to, all of the information required by subdivision (c).

(b) A pharmacy benefit manager registration obtained pursuant to this section is not transferable.

(c) The department shall develop an application form for pharmacy benefit manager registration. The application form for a pharmacy benefit manager registration shall require the pharmacy benefit manager to submit the following information to the department:

(1) The name of the pharmacy benefit manager.

(2) The address and contact telephone number for the pharmacy benefit manager.

(3) The name and address of the pharmacy benefit manager's agent for service of process in the state.

(4) The name and address of each person beneficially interested in the pharmacy benefit manager.

(5) The name and address of each person with management or control over the pharmacy benefit manager.

(d) If the applicant is a partnership or other unincorporated association, a limited liability company, or a corporation, and the number of partners, members, or stockholders, as the case may be, exceeds five, the application shall so state, and shall further state the name, address, usual occupation, and professional qualifications of each of the five partners, members, or stockholders who own the five largest interests in the applicant entity. Upon request by the department, the applicant shall furnish the department with the name, address, usual occupation, and professional qualifications of partners, members, or stockholders not named in the application, or shall refer the department to an appropriate source for that information.

(e) The application shall contain a statement to the effect that the applicant has not been convicted of a felony and has not violated any of the provisions of this article. If the applicant cannot make this statement, the application shall contain a statement of the violation, if any, or shall describe the reasons that prevent the applicant from being able to comply with the requirements with respect to the statement.

(f) The department may set a fee for a registration required by this article. The application fee shall not exceed the reasonable costs of the department in carrying out its duties under this article.

(g) Within 30 days of a change in any of the information disclosed to the department on an application for a registration, the pharmacy benefit manager shall notify the department of that change in writing.

(h) For purposes of this section, "person beneficially interested" with respect to a pharmacy benefit manager means and includes the following:

(1) If the applicant is a partnership or other unincorporated association, each partner or member.

(2) If the applicant is a corporation, each of its officers, directors, and stockholders, provided that a natural person shall not be deemed to be beneficially interested in a nonprofit corporation.

(3) If the applicant is a limited liability company, each officer, manager, or member.

HISTORY:
Added Stats 2018 ch 905 § 4 (AB 315), effective January 1, 2019, operative January 1, 2020.

§ 1385.006. Discipline for failure to comply [Operative January 1, 2020]

The failure by a health care service plan to comply with the contractual requirements pursuant to this article shall constitute grounds for disciplinary action. The director shall, as appropriate, investigate and take enforcement action against a health care service plan that fails to comply with these requirements and shall periodically evaluate contracts between health care service plans and pharmacy benefit managers to determine if any audit, evaluation, or enforcement actions should be undertaken by the department.

HISTORY:
Added Stats 2018 ch 905 § 4 (AB 315), effective January 1, 2019, operative January 1, 2020.

§ 1385.007. Task Force on Pharmacy Benefit Management Reporting; Reporting requirements [Effective until January 1, 2021; Inoperative February 1, 2020; Repealed effective January 1, 2021]

(a) By July 1, 2019, the department, in collaboration with other agencies, departments, advocates, experts, health care service plan representatives, and other entities and stakeholders that it deems appropriate, shall convene a Task Force on Pharmacy Benefit Management Reporting to determine what information related to pharmaceutical costs, if any, the department should require to be reported by health care service plans or their contracted pharmacy benefit managers, in addition to reporting required by Section 1367.243. The task force shall consider inclusion of information including, but not limited to, the following:

(1) Wholesale acquisition costs of pharmaceuticals.

(2) Rebates obtained by the health care service plan or the pharmacy benefit manager from pharmaceutical manufacturers.

(3) Payments to network pharmacies.

(4) Exclusivity arrangements between health care service plans or contracted pharmacy benefit managers with pharmaceutical manufacturers.

(b) The task force shall consider the results of information reporting pursuant to Section 1367.243 and Chapter 9 (commencing with Section 127675) of Part 2 of Division 107 in determining what information should be reported pursuant to subdivision (a).

(c) The department shall submit a report of the Task Force on Pharmacy Benefit Management Reporting to the President pro Tempore of the Senate, the Speaker of the Assembly, and the Senate and Assembly Committees on Health, with the recommendations of the task force no later than February 1, 2020, on which date the task force shall cease to exist.

(d) This section shall become inoperative on February 1, 2020, and, as of January 1, 2021, is repealed.

HISTORY:
Added Stats 2018 ch 905 § 4 (AB 315), effective January 1, 2019, inoperative February 1, 2020, repealed January 1, 2021.

ARTICLE 6.2

Review of Rate Increases

Section

1385.01. Definitions [Effective until January 1, 2020].
1385.01. Definitions [Effective January 1, 2020].
1385.02. Applicability of article [Effective until January 1, 2020].
1385.02. Applicability of article [Effective January 1, 2020].
1385.03. Filing of rate information for individual and small group health care service plan contracts prior to implementing any rate change; Disclosure of information [Effective until January 1, 2020].
1385.03. Filing of rate information for individual and small group health care service plan contracts prior to implementing any rate change; Disclosure of information [Effective January 1, 2020; Effective until January 1, 2021; Inoperative July 1, 2020; Repealed effective January 1, 2021].
1385.03. Filing of rate information for health care service plan contracts prior to implementing any rate change; Disclosure of information [Effective January 1, 2020; Operative July 1, 2020].
1385.04. Filing of rate information for large group health care service plan contracts prior to implementing any rate change; Disclosure of information and aggregate data.
1385.045. Filing of weighted average rate increase for large group health care service plan contracts; Disclosure of information and aggregate data [Effective until January 1, 2020].
1385.045. Filing of weighted average rate increase for large group health care service plan contracts; Disclosure of information and aggregate data [Effective January 1, 2020].
1385.046. Large group contractholder application to review rate change; Review procedure [Effective January 1, 2020; Operative July 1, 2021].
1385.05. Authority of department; Information that may be requested.
1385.06. Submission of filing; Contents; Contract with independent actuary or actuaries.
1385.07. Publication of information; Confidential information; Information to be included [Effective until January 1, 2020].
1385.07. Publication of information; Confidential information; Information to be included [Effective January 1, 2020].
1385.08. Issuance of guidance to health care service plans regarding compliance with article.
1385.09. Filing by health care service plan contract documenting cost savings and impact on rates [Effective January 1, 2020].
1385.10. Health care service plan annual claims reporting requirements.
1385.11. Review of rate filings by department; Report; Unreasonable rate increase findings.
1385.13. Duties of department; Submission of information.

HISTORY: Added Stats 2010 ch 661 § 4, effective January 1, 2011.

§ 1385.01. Definitions [Effective until January 1, 2020]

For purposes of this article, the following definitions shall apply:

(a) "Large group health care service plan contract" means a group health care service plan contract other than a contract issued to a small employer, as defined in Section 1357, 1357.500, or 1357.600.

(b) "Small group health care service plan contract" means a group health care service plan contract issued to a small employer, as defined in Section 1357, 1357.500, or 1357.600.

(c) "PPACA" means Section 2794 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-94), as amended by the federal Patient Protection and Affordable Care Act (Public Law (111-148)), and any subsequent rules, regulations, or guidance issued under that section.

(d) "Unreasonable rate increase" has the same meaning as that term is defined in PPACA.

HISTORY:
Added Stats 2010 ch 661 § 4 (SB 1163), effective January 1, 2011. Amended Stats 2011 ch 296 § 142 (AB 1023), effective January 1, 2012; Stats 2012 ch 852 § 7 (AB 1083), effective January 1, 2013.

§ 1385.01. Definitions [Effective January 1, 2020]

For purposes of this article, the following definitions shall apply:

(a)(1) "Blended" means a rating method that combines community rating and experience rating methods.

(2) "Community rated" means a rating method in the large group market that bases rates on the expected costs to a health care service plan of providing covered benefits to all enrollees, including both low-risk and high-risk enrollees. Premiums may vary according to the factors in this article.

(3) "Experience rated" means a rating method in the large group market under which a health care service plan calculates the premiums for a large group in whole or blended based on the group's prior experience.

(b)(1) For individual and small group market products, "geographic region" has the same meaning as in Sections 1357.512 and 1399.855.

(2) For large group market products, "geographic region" means one of the following areas composed of the regions defined in Sections 1357.512 and 1399.855:

(A) An area composed of regions 2, 4, 5, 6, 7, and 8, which consist of the Counties of Alameda, Contra Costa, Marin, Napa, San Mateo, Santa Clara, Solano, and Sonoma and the City and County of San Francisco.

(B) An area composed of regions 1 and 3, which consist of the Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba.

(C) An area composed of regions 9 and 12, which consist of the Counties of Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, and Ventura.

(D) An area composed of regions 10, 11, and 14, which consist of the Counties of Fresno, Kern, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.

(E) An area composed of regions 13 and 17, which consist of the Counties of Imperial, Inyo, Mono, Riverside, and San Bernardino.

(F) An area composed of regions 15 and 16, which consist of the County of Los Angeles.

(G) An area composed of regions 18 and 19, which consist of the Counties of Orange and San Diego.

(c) "Large group health care service plan contract" means a group health care service plan contract other than a contract issued to a small employer, as defined in Section 1357, 1357.500, or 1357.600.

(d) "Small group health care service plan contract" means a group health care service plan contract issued to a small employer, as defined in Section 1357, 1357.500, or 1357.600.

(e) "PPACA" means Section 2794 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-94), as amended by the federal Patient Protection and Affordable Care Act (Public Law (111-148)), and any subsequent rules, regulations, or guidance issued under that section.

(f) "Unreasonable rate increase" has the same meaning as that term is defined in PPACA.

HISTORY:
Added Stats 2010 ch 661 § 4 (SB 1163), effective January 1, 2011. Amended Stats 2011 ch 296 § 142 (AB 1023), effective January 1, 2012; Stats 2012 ch 852 § 7 (AB 1083), effective January 1, 2013; Stats 2019 ch 807 § 2 (AB 731), effective January 1, 2020.

§ 1385.02. Applicability of article [Effective until January 1, 2020]

This article shall apply to health care service plan contracts offered in the individual or group market in California. However, this article shall not apply to a specialized health care service plan contract; a Medicare supplement contract subject to Article 3.5 (commencing with Section 1358.1); a health care service plan contract offered in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code); a health care service plan contract offered in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), or the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code); a health care service plan conversion contract offered pursuant to Section 1373.6; or a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35) or Article 10.5 (commencing with Section 1399.801).

HISTORY:
Added Stats 2010 ch 661 § 4 (SB 1163), effective January 1, 2011.

§ 1385.02. Applicability of article [Effective January 1, 2020]

This article shall apply to a health care service plan contract offered in the individual or group market in California. However, this article shall not apply to a specialized health care service plan contract, a Medicare supplement contract subject to Article 3.5 (commencing with Section 1358.1), a health care service plan contract offered in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan contract offered in the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), a health care service plan conversion contract offered pursuant to Section 1373.6, a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35) or Article 10.5 (commencing with Section 1399.801), or a Mexican prepaid health plan subject to Section 1351.2. This article does not limit, impair, or interfere with the authority of the California Public Employees' Retirement System, as set forth in Section 22794 of the Government Code and Article 6 (commencing with Section 22850) of Part 5 of Division 5 of Title 2 of the Government Code.

HISTORY:
Added Stats 2010 ch 661 § 4 (SB 1163), effective January 1, 2011. Amended Stats 2019 ch 807 § 3 (AB 731), effective January 1, 2020.

§ 1385.03. Filing of rate information for individual and small group health care service plan contracts prior to implementing any rate change; Disclosure of information [Effective until January 1, 2020]

(a) All health care service plans shall file with the department all required rate information for grandfathered individual and grandfathered and nongrandfathered small group health care service plan contracts at least 120 days prior to implementing any rate change. All health care service plans shall file with the department all required rate information for nongrandfathered individual health care service plan contracts on the earlier of the following dates:

(1) One hundred days before October 15 of the preceding policy year.

(2) The date specified in the federal guidance issued pursuant to Section 154.220(b) of Title 45 of the Code of Federal Regulations.

(b) A plan shall disclose to the department all of the following for each individual and small group rate filing:

(1) Company name and contact information.

(2) Number of plan contract forms covered by the filing.

(3) Plan contract form numbers covered by the filing.

(4) Product type, such as a preferred provider organization or health maintenance organization.

(5) Segment type.

(6) Type of plan involved, such as for profit or not for profit.

(7) Whether the products are opened or closed.

(8) Enrollment in each plan contract and rating form.

(9) Enrollee months in each plan contract form.

(10) Annual rate.

(11) Total earned premiums in each plan contract form.

(12) Total incurred claims in each plan contract form.

(13) Average rate increase initially requested.

(14) Review category: initial filing for new product, filing for existing product, or resubmission.

(15) Average rate of increase.

(16) Effective date of rate increase.

(17) Number of subscribers or enrollees affected by each plan contract form.

(18) The plan's overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A plan may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories in the geographic regions listed in Sections 1357.512 and 1399.855. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

(19) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

(20) A comparison of claims cost and rate of changes over time.

(21) Any changes in enrollee cost sharing over the prior year associated with the submitted rate filing.

(22) Any changes in enrollee benefits over the prior year associated with the submitted rate filing.

(23) The certification described in subdivision (b) of Section 1385.06.

(24) Any changes in administrative costs.

(25) Any other information required for rate review under PPACA.

(c) A health care service plan subject to subdivision (a) shall also disclose the following aggregate data for all rate filings submitted under this section in the individual and small group health plan markets:

(1) Number and percentage of rate filings reviewed by the following:

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of subscribers.

(E) Number of covered lives affected.

(2) The plan's average rate increase by the following categories:

(A) Plan year.

(B) Segment type.

(C) Product type.

(3) Any cost containment and quality improvement efforts since the plan's last rate filing for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(d) The department may require all health care service plans to submit all rate filings to the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Submission of the required rate filings to SERFF shall be deemed to be filing with the department for purposes of compliance with this section.

(e) A plan shall submit any other information required under PPACA. A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(f)(1) A plan shall respond to the department's request for any additional information necessary for the department to complete its review of the plan's rate filing for individual and small group health care service plan contracts under this article within five business days of the department's request or as otherwise required by the department.

(2) Except as provided in paragraph (3), the department shall determine whether a plan's rate increase for individual and small group health care service plan contracts is unreasonable or not justified no later than 60 days following receipt of all the information the department requires to makes its determination.

(3) For all nongrandfathered individual health care service plan contracts, the department shall issue a determination that the plan's rate increase is unreasonable or not justified no later than 15 days before October 15 of the preceding policy year. If a health care service plan fails to provide all the information the department requires in order for the department to make its determination, the department may determine that a plan's rate increase is unreasonable or not justified.

(g) If the department determines that a plan's rate increase for individual or small group health care service plan contracts is unreasonable or not justified consistent with this article, the health care service plan shall provide notice of that determination to any individual or small group applicant. The notice provided to an individual applicant shall be consistent with the notice described in subdivision (c) of Section 1389.25. The notice provided to a small group applicant shall be consistent with the notice described in subdivision (c) of Section 1374.21.

(h) For purposes of this section, "policy year" has the same meaning as set forth in subdivision (g) of Section 1399.845.

HISTORY:

Added Stats 2010 ch 661 § 4 (SB 1163), effective January 1, 2011. Amended Stats 2014 ch 572 § 10 (SB 959), effective January 1, 2015; Stats 2016 ch 498 § 2 (SB 908), effective January 1, 2017; Stats 2017 ch 468 § 2 (AB 156), effective January 1, 2018.

§ 1385.03. Filing of rate information for individual and small group health care service plan contracts prior to implementing any rate change; Disclosure of information [Effective January 1, 2020; Effective until January 1, 2021; Inoperative July 1, 2020; Repealed effective January 1, 2021]

(a) A health care service plan shall file with the department all required rate information for grandfathered individual and grandfathered and nongrandfathered small group health care service plan contracts at least 120 days prior to implementing a rate change. A health care service plan shall file with the department all required rate information for nongrandfathered individual health care service plan contracts on the earlier of the following dates:

(1) One hundred days before October 15 of the preceding policy year.

(2) The date specified in the federal guidance issued pursuant to Section 154.220(b) of Title 45 of the Code of Federal Regulations.

(b) A plan shall disclose to the department all of the following for each individual and small group rate filing:

(1) Company name and contact information.

(2) Number of plan contract forms covered by the filing.

(3) Plan contract form numbers covered by the filing.

(4) Product type, such as a preferred provider organization or health maintenance organization.

(5) Segment type.

(6) Type of plan involved, such as for profit or not for profit.

(7) Whether the products are opened or closed.

(8) Enrollment in each plan contract and rating form.

(9) Enrollee months in each plan contract form.

(10) Annual rate.

(11) Total earned premiums in each plan contract form.

(12) Total incurred claims in each plan contract form.

(13) Average rate increase initially requested.

(14) Review category: initial filing for new product, filing for existing product, or resubmission.

(15) Average rate of increase.

(16) Effective date of rate increase.

(17) Number of subscribers or enrollees affected by each plan contract form.

(18) The plan's overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A plan may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories in the geographic regions listed in Sections 1357.512 and 1399.855.

(19) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(20) A comparison of claims cost and rate of changes over time.

(21) Any changes in enrollee cost sharing over the prior year associated with the submitted rate filing.

(22) Any changes in enrollee benefits over the prior year associated with the submitted rate filing.

(23) The certification described in subdivision (b) of Section 1385.06.

(24) Any changes in administrative costs.

(25) Any other information required for rate review under the federal Patient Protection and Affordable Care Act (PPACA).

(c) A health care service plan subject to subdivision (a) shall also disclose the following aggregate data for all rate filings submitted under this section in the individual and small group health care service plan markets:

(1) Number and percentage of rate filings reviewed by the following:

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of subscribers.

(E) Number of covered lives affected.

(2) The plan's average rate increase by the following categories:

(A) Plan year.

(B) Segment type.

(C) Product type.

(3) Any cost containment and quality improvement efforts since the plan's last rate filing for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(d) The department may require all health care service plans to submit all rate filings to the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Submission of the required rate filings to SERFF shall be deemed to be filing with the department for purposes of compliance with this section.

(e) A plan shall submit any other information required under PPACA. A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(f)(1) A plan shall respond to the department's request for any additional information necessary for the department to complete its review of the plan's rate filing for individual and small group health care service plan contracts under this article within five business days of the department's request or as otherwise required by the department.

(2) Except as provided in paragraph (3), the department shall determine whether a plan's rate increase for individual and small group health care service plan contracts is unreasonable or not justified no later than 60 days following receipt of all the information the department requires to make its determination.

(3) For all nongrandfathered individual health care service plan contracts, the department shall issue a determination that the plan's rate increase is unreasonable or not justified no later than 15 days before October

15 of the preceding policy year. If a health care service plan fails to provide all the information the department requires in order for the department to make its determination, the department may determine that a plan's rate increase is unreasonable or not justified.

(g) If the department determines that a plan's rate increase for individual or small group health care service plan contracts is unreasonable or not justified consistent with this article, the health care service plan shall provide notice of that determination to any individual or small group applicant. The notice provided to an individual applicant shall be consistent with the notice described in subdivision (c) of Section 1389.25. The notice provided to a small group applicant shall be consistent with the notice described in subdivision (c) of Section 1374.21.

(h) For purposes of this section, "policy year" has the same meaning as set forth in subdivision (g) of Section 1399.845.

(i) This section shall become inoperative on July 1, 2020, and, as of January 1, 2021, is repealed.

HISTORY:

Added Stats 2010 ch 661 § 4 (SB 1163), effective January 1, 2011. Amended Stats 2014 ch 572 § 10 (SB 959), effective January 1, 2015; Stats 2016 ch 498 § 2 (SB 908), effective January 1, 2017; Stats 2017 ch 468 § 2 (AB 156), effective January 1, 2018; Stats 2019 ch 247 § 1 (SB 343), effective January 1, 2020; Stats 2019 ch 807 § 4 (AB 731), effective January 1, 2020, inoperative July 1, 2020, repealed January 1, 2021 (ch 807 prevails).

§ 1385.03. Filing of rate information for health care service plan contracts prior to implementing any rate change; Disclosure of information [Effective January 1, 2020; Operative July 1, 2020]

(a)(1) A health care service plan shall file with the department all required rate information for grandfathered individual and grandfathered and nongrandfathered group health care service plan contracts at least 120 days before implementing any rate change.

(2) A health care service plan shall file with the department all required rate information for nongrandfathered individual health care service plan contracts on the earlier of the following dates:

(A) One hundred days before the commencement of the annual enrollment period of the preceding policy year.

(B) The date specified in the federal guidance issued pursuant to Section 154.220(b) of Title 45 of the Code of Federal Regulations.

(3) For large group products that are either experience rated, in whole or blended, or community rated, a health care service plan shall file the information required by this article at least annually and shall file 120 days before any change in the methodology, factors, or assumptions that would affect the rates paid by a large group.

(b) A plan shall disclose to the department all of the following for each rate filing for products in the individual, small group, community-rated segment of the large group market, and experience-rated segment, in whole or blended, in the large group market:

(1) Company name and contact information.

(2) Number of plan contract forms covered by the filing.

(3) Plan contract form numbers covered by the filing.

(4) Product type, such as a preferred provider organization or health maintenance organization.

(5) Segment type.

(6) Type of plan involved, such as for profit or not for profit.

(7) Whether the products are opened or closed.

(8) Enrollment in each plan contract and rating form.

(9) Enrollee months in each plan contract form.

(10) Annual rate.

(11) Total earned premiums in each plan contract form.

(12) Total incurred claims in each plan contract form.

(13) Average rate increase initially requested.

(14) Review category: initial filing for new product, filing for existing product, or resubmission.

(15) Average rate of increase.

(16) Effective date of rate increase.

(17) Number of subscribers or enrollees affected by each plan contract form.

(18) A comparison of claims cost and rate of changes over time.

(19) Any changes in enrollee cost sharing over the prior year associated with the submitted rate filing.

(20) Any changes in enrollee benefits over the prior year associated with the submitted rate filing.

(21) The certification described in subdivision (b) of Section 1385.06.

(22) Any changes in administrative costs.

(23) Any other information required for rate review under PPACA.

(c) A health care service plan subject to subdivision (a) shall disclose the following by geographic region for individual, grandfathered group, and nongrandfathered group contracts:

(1) The plan's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. The plan shall also disclose integrated care management fees or other similar fees, as well as reclassification of services from one benefit category to another, such as from inpatient to outpatient.

(2) Aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories.

(3) Information by benefit category that demonstrates the price paid compared to the price paid by the Medicare Program for the same services.

(4) Variation in trend, by geographic region, if the plan serves more than one geographic region.

(d) A health care service plan subject to subdivision (a) shall disclose, by geographic region for individual, grandfathered group, and nongrandfathered group contracts, the amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(e) A health care service plan subject to subdivision (a) that fails to file the information required by subdivisions (c), (d), (g), and (h) for each benefit

category shall also disclose the following for individual, grandfathered group, and nongrandfathered group contracts by market and by geographic region:

(1) The amount spent in the prior two years, the amount projected to be spent in the current year, and the amount projected to be spent for the subsequent year for each of the following:

(A) Physician services.

(B) Inpatient hospital services.

(C) Outpatient hospital services, including emergency department services.

(D) Laboratory services.

(E) Imaging and radiology services.

(F) Other ancillary services.

(G) Prescription drugs.

(H) Integrated care management fees or other similar fees.

(I) Reclassification of services from one benefit category to another, such as from inpatient to outpatient.

(2) Utilization of services for the prior two years, current year, and subsequent year, as measured by the plan for the following:

(A) Physician services.

(B) Inpatient hospital services.

(C) Outpatient hospital services, including emergency department services.

(D) Laboratory services.

(E) Imaging and radiology services.

(F) Other ancillary services.

(G) Prescription drugs.

(f) A health care service plan subject to subdivision (a) shall also disclose the following aggregate data for all rate filings submitted under this section in the individual and group health care service plan markets:

(1) Number and percentage of rate filings reviewed by the following:

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of subscribers.

(E) Number of covered lives affected.

(2) The plan's average rate increase by the following categories:

(A) Plan year.

(B) Segment type.

(C) Product type.

(3) Any cost containment and quality improvement efforts since the plan's last rate filing for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period. If rate filings in a prior year or years included a description of cost containment or quality improvement efforts, the plan shall document the effects of those efforts, if any, including the impact on rates and documented improvements in quality, such as reduction of readmissions, reduction of emergency room use, or other recognized measures of quality improvement.

(g) For large group experience-rated, in whole or blended, and community-rated filings, the plan shall also submit the following:

(1) The geographic regions used.

(2) Age, including age rating factors.

(3) Industry or occupation adjustments.

(4) Family composition.

(5) Enrollee cost sharing.

(6) Covered benefits in addition to basic health care services, as defined in subdivision (b) of Section 1345, and other benefits mandated by this article.

(7) The base rate or rates and the factors used to determine the base rate or rates.

(8) Whether benefits, including prescription drugs, dental, and vision, are separately contracted.

(9) Variations in covered benefits, including durable medical equipment, infertility, and other similar benefits.

(10) Cost-sharing variations, described with actuarial value ranges and any expected impact on rates.

(11) Any other factor that affects the community rating.

(h) For large group filings that are experience rated, either in whole or blended, the plan shall submit the methodology for modifying the rate based on experience.

(i)(1) The department may require all health care service plans to submit all rate filings to the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Submission of the required rate filings to SERFF shall be deemed to be filing with the department for purposes of compliance with this section.

(2) If California-specific information is required, the department may require additional schedules or documents.

(j) A plan shall submit any other information required under PPACA. A plan shall also submit any other information required pursuant to a regulation adopted by the department to comply with this article.

(k)(1) A plan shall respond to the department's request for any additional information necessary for the department to complete its review of the plan's rate filing for individual and group health care service plan contracts under this article within five business days of the department's request or as otherwise required by the department.

(2) Except as provided in paragraph (3), the department shall determine whether a plan's rate change for individual and small group health care service plan contracts is unreasonable or not justified no later than 60 days following receipt of all the information the department requires to makes its determination. For both experience-rated, in whole or blended, and community-rated large groups, the department shall determine whether the methodology, factors, and assumptions used to determine rates are unreasonable or not justified no later than 60 days following receipt of all the information the department requires to make its determination.

(3) For all nongrandfathered individual health care service plan contracts, the department shall issue a determination that the plan's rate change is unreasonable or not justified no later than 15 days before the start of the next annual enrollment period. If a health care service plan fails to

provide all the information the department requires in order for the department to make its determination, the department may determine that a plan's rate change is unreasonable or not justified.

(4) The department may contract with a consultant or consultants with expertise to assist the department in its review. Contracts entered into pursuant to the authority in this article shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, and the State Contract Act (Chapter 1 (commencing with Section 10100) of Part 2 of Division 2 of the Public Contract Code).

(*l*) If the department determines that a plan's rate change for individual or group health care service plan contracts is unreasonable or not justified consistent with this article, the health care service plan shall provide notice of that determination to an individual or group applicant. For experience-rated, in whole or blended, and community-rated large groups, the determination by the department shall apply to methodology, factors, and assumptions used to determine rates. The notice provided to an individual applicant shall be consistent with the notice described in subdivision (c) of Section 1389.25. The notice provided to a group applicant shall be consistent with the notice described in Section 1374.21.

(m) Failure to provide the information required by subdivision (b), (c), (d), (e), (g), or (h) shall constitute an unjustified rate.

(n) For purposes of this section, "policy year" has the same meaning as set forth in subdivision (g) of Section 1399.845.

(o)(1) The department may adopt emergency regulations implementing this section. The department may, on a one-time basis, readopt an emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(p) This section shall become operative on July 1, 2020.

HISTORY:
Added Stats 2019 ch 807 § 5 (AB 731), effective January 1, 2020, operative July 1, 2020.

§ 1385.04. Filing of rate information for large group health care service plan contracts prior to implementing any rate change; Disclosure of information and aggregate data

(a) For large group health care service plan contracts, all health plans shall file with the department at least 60 days prior to implementing any rate change all required rate information for unreasonable rate increases. This

filing shall be concurrent with the written notice described in subdivision (a) of Section 1374.21.

(b) For large group rate filings, health plans shall submit all information that is required by PPACA. A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(c) A health care service plan subject to subdivision (a) shall also disclose the following aggregate data for all rate filings submitted under this section in the large group health plan market:

(1) Number and percentage of rate filings reviewed by the following:

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of subscribers.

(E) Number of covered lives affected.

(2) The plan's average rate increase by the following categories:

(A) Plan year.

(B) Segment type.

(C) Product type.

(3) Any cost containment and quality improvement efforts since the plan's last rate filing for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(d) The department may require all health care service plans to submit all rate filings to the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Submission of the required rate filings to SERFF shall be deemed to be filing with the department for purposes of compliance with this section.

HISTORY:
Added Stats 2010 ch 661 § 4 (SB 1163), effective January 1, 2011.

§ 1385.045. Filing of weighted average rate increase for large group health care service plan contracts; Disclosure of information and aggregate data [Effective until January 1, 2020]

(a) For large group health care service plan contracts, each health plan shall file with the department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of enrollees in each large group benefit design in the plan's large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited to, benefits such as basic health care services and prescription drugs. The large group benefit design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

(b)(1) A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) The department shall conduct an annual public meeting regarding large group rates within four months of posting the aggregate information described in this section in order to permit a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market. The meeting shall be held in either the Los Angeles area or the San Francisco Bay area.

(c) A health care service plan subject to subdivision (a) shall also disclose the following for the aggregate rate information for the large group market submitted under this section:

(1) For rates effective during the 12-month period ending January 1 of the following year, number and percentage of rate changes reviewed by the following:

(A) Plan year.

(B) Segment type, including whether the rate is community rated, in whole or in part.

(C) Product type.

(D) Number of enrollees.

(E) The number of products sold that have materially different benefits, cost sharing, or other elements of benefit design.

(2) For rates effective during the 12-month period ending January 1 of the following year, any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.

(D) Industry.

(E) Health status factors, including, but not limited to, experience and utilization.

(F) Employee, and employee and dependents, including a description of the family composition used.

(G) Enrollees' share of premiums.

(H) Enrollees' cost sharing, including cost sharing for prescription drugs.

(I) Covered benefits in addition to basic health care services, as defined in Section 1345, and other benefits mandated under this article.

(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.

(K) Any other factor that affects the rate that is not otherwise specified.

(3)(A) The plan's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology for the applicable 12-month period ending January 1 of the following year. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories, to the maximum extent possible, that are the same as, or similar to, those used by other plans.

(B) The amount of the projected trend separately attributable to the use of services, price inflation, and fees and risk for annual plan contract trends by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

(C) A comparison of the aggregate per enrollee per month costs and rate of changes over the last five years for each of the following:

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

(D) Any changes in enrollee cost sharing over the prior year associated with the submitted rate information, including both of the following:

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the benefit categories determined by the department.

(ii) Any aggregate changes in enrollee cost sharing over the prior years as measured by the weighted average actuarial value, weighted by the number of enrollees.

(E) Any changes in enrollee benefits over the prior year, including a description of benefits added or eliminated, as well as any aggregate changes, as measured as a percentage of the aggregate claims costs, listed by the categories determined by the department.

(F) Any cost containment and quality improvement efforts since the plan's prior year's information pursuant to this section for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(G) The number of products covered by the information that incurred the excise tax paid by the health plan.

(4)(A) For covered prescription generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be disclosed:

(i) The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs as defined in this subparagraph.

(ii) The year-over-year increase, as a percentage, in per-member, per-month total health plan spending for each category of prescription drugs as defined in this subparagraph.

(iii) The year-over-year increase in per-member, per-month costs for drug prices compared to other components of the health care premium.

(iv) The specialty tier formulary list.

(B) The plan shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.

(C)(i) The plan shall include information on its use of a pharmacy benefit manager, if any, including which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The plan shall also include the name or names of the pharmacy benefit manager, or managers if the plan uses more than one.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2018, and on or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 1385.07.

(e) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

HISTORY:
Added Stats 2015 ch 801 § 2 (SB 546), effective January 1, 2016. Amended Stats 2017 ch 603 § 2 (SB 17), effective January 1, 2018.

§ 1385.045. Filing of weighted average rate increase for large group health care service plan contracts; Disclosure of information and aggregate data [Effective January 1, 2020]

(a) For large group health care service plan contracts, a health care service plan shall file with the department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of enrollees in each large group benefit design in the plan's large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited to, benefits such as basic health care services and prescription drugs. The large group benefit design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

(b)(1) A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) The department shall conduct a public meeting in every even-numbered year regarding large group rates within four months of posting the aggregate information described in this section in order to permit a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market. The meeting shall be held in either the Los Angeles area or the San Francisco Bay area.

(c) A health care service plan subject to subdivision (a) shall also disclose the following for the aggregate rate information for the large group market submitted under this section:

(1) For rates effective during the 12-month period ending January 1 of the

following year, number and percentage of rate changes reviewed by the following:

(A) Plan year.

(B) Segment type, including whether the rate is community rated, in whole or in part.

(C) Product type.

(D) Number of enrollees.

(E) The number of products sold that have materially different benefits, cost sharing, or other elements of benefit design.

(2) For rates effective during the 12-month period ending January 1 of the following year, any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.

(D) Industry.

(E) Health status factors, including, but not limited to, experience and utilization.

(F) Employee, and employee and dependents, including a description of the family composition used.

(G) Enrollees' share of premiums.

(H) Enrollees' cost sharing, including cost sharing for prescription drugs.

(I) Covered benefits in addition to basic health care services, as defined in Section 1345, and other benefits mandated under this article.

(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.

(K) Any other factor that affects the rate that is not otherwise specified.

(3)(A) The plan's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology for the applicable 12-month period ending January 1 of the following year.

(B) The amount of the projected trend separately attributable to the use of services, price inflation, and fees and risk for annual plan contract trends by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(C) A comparison of the aggregate per enrollee per month costs and rate of changes over the last five years for each of the following:

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

(D) Any changes in enrollee cost sharing over the prior year associated with the submitted rate information, including both of the following:

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the benefit categories determined by the department.

(ii) Any aggregate changes in enrollee cost sharing over the prior years as measured by the weighted average actuarial value, weighted by the number of enrollees.

(E) Any changes in enrollee benefits over the prior year, including a description of benefits added or eliminated, as well as any aggregate changes, as measured as a percentage of the aggregate claims costs, listed by the categories determined by the department.

(F) Any cost containment and quality improvement efforts since the plan's prior year's information pursuant to this section for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(G) The number of products covered by the information that incurred the excise tax paid by the health care service plan.

(4)(A) For covered prescription generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be disclosed:

(i) The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs as defined in this subparagraph.

(ii) The year-over-year increase, as a percentage, in per-member,per-month total health care service plan spending for each category of prescription drugs as defined in this subparagraph.

(iii) The year-over-year increase in per-member,per-month costs for drug prices compared to other components of the health care premium.

(iv) The specialty tier formulary list.

(B) The plan shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.

(C)(i) The plan shall include information on its use of a pharmacy benefit manager, if any, including which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The plan shall also include the name or names of the pharmacy benefit manager, or managers if the plan uses more than one.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2018, and on or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 1385.07.

(e) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

HISTORY:
Added Stats 2015 ch 801 § 2 (SB 546), effective January 1, 2016. Amended Stats 2017 ch 603 § 2 (SB 17), effective January 1, 2018; Stats 2019 ch 247 § 2 (SB 343), effective January 1, 2020; Stats 2019 ch 807 § 6 (AB 731), effective January 1, 2020 (ch 807 prevails).

§ 1385.046. Large group contractholder application to review rate change; Review procedure [Effective January 1, 2020; Operative July 1, 2021]

(a) Upon receiving notice of a rate change, a large group contractholder that has coverage that is experience rated in whole or blended and that meets the criteria in subdivision (e) may apply within 60 days to have the department review the rate change to determine whether the rate change is unreasonable or not justified, consistent with this article.

(b) Upon receiving an application, the department shall notify the health care service plan of the application, and the plan shall provide the information required by the department to complete the department's review of the proposed rate within five business days of the department's request or as otherwise required by the department.

(c) The department shall use all reasonable efforts to complete its review of the rate change within 60 days of receiving all the information the department requires to make its determination, and shall notify the health care service plan and the large group contractholder of its determination.

(d) A rate change under review by the department shall not be imposed before a determination is made by the department pursuant to subdivision (c) or within 60 days following receipt by the department of all information the department requires to make its determination, whichever occurs earlier.

(e) To apply for a review of a rate change for a particular group, at least one of the following shall apply:

(1) The contractholder has more than 2,000 total enrollees.

(2) The plan failed to provide the information required by this article or Section 1385.10.

(f) To facilitate review, the department may group appeals that apply to the same health care service plan and that raise similar questions about rates, methodology, assumptions, or factors.

(g) The department may contract with a consultant or consultants with expertise to assist the department in its review. Contracts entered into pursuant to the authority in this article shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, and the State Contract Act (Chapter 1 (commencing with Section 10100) of Part 2 of Division 2 of the Public Contract Code).

(h) This section shall become operative on July 1, 2021.

HISTORY:
Added Stats 2019 ch 807 § 7 (AB 731), effective January 1, 2020, operative July 1, 2021.

§ 1385.05. Authority of department; Information that may be requested

Notwithstanding any provision in a contract between a health care service plan and a provider, the department may request from a health care service plan any information required under this article or PPACA.

HISTORY:
Added Stats 2010 ch 661 § 4 (SB 1163), effective January 1, 2011.

§ 1385.06. Submission of filing; Contents; Contract with independent actuary or actuaries

(a) A filing submitted under this article shall be actuarially sound.

(b)(1) The plan shall contract with an independent actuary or actuaries consistent with this section.

(2) A filing submitted under this article shall include a certification by an independent actuary or actuarial firm that the rate increase is reasonable or unreasonable and, if unreasonable, that the justification for the increase is based on accurate and sound actuarial assumptions and methodologies. Unless PPACA requires a certification of actuarial soundness for each large group contract, a filing submitted under Section 1385.04 shall include a certification by an independent actuary, as described in this section, that the aggregate or average rate increase is based on accurate and sound actuarial assumptions and methodologies.

(3) The actuary or actuarial firm acting under paragraph (2) shall not be an affiliate or a subsidiary of, nor in any way owned or controlled by, a health care service plan or a trade association of health care service plans. A board member, director, officer, or employee of the actuary or actuarial firm shall not serve as a board member, director, or employee of a health care service plan. A board member, director, or officer of a health care service plan or a trade association of health care service plans shall not serve as a board member, director, officer, or employee of the actuary or actuarial firm.

(c) Nothing in this article shall be construed to permit the director to establish the rates charged subscribers and enrollees for covered health care services.

HISTORY:
Added Stats 2010 ch 661 § 4 (SB 1163), effective January 1, 2011.

§ 1385.07. Publication of information; Confidential information; Information to be included [Effective until January 1, 2020]

(a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all information submitted under this article shall be made publicly available by the department except as provided in subdivision (b).

(b)(1) The contracted rates between a health care service plan and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250)

of Division 7 of Title 1 of the Government Code). The contracted rates between a health care service plan and a provider shall not be disclosed by a health care service plan to a large group purchaser that receives information pursuant to Section 1385.10.

(2) The contracted rates between a health care service plan and a large group shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Information provided to a large group purchaser pursuant to Section 1385.10 shall be deemed confidential information that shall not be made public by the department and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) In addition, the department and the health care service plan shall, at a minimum, make the following information readily available to the public on their Internet Web sites, in plain language and in a manner and format specified by the department, except as provided in subdivision (b). For individual and small group health care service plan contracts, the information shall be made public for 120 days prior to the implementation of the rate increase. For large group health care service plan contracts, the information shall be made public for 60 days prior to the implementation of the rate increase. The information shall include:

(1) Justifications for any unreasonable rate increases, including all information and supporting documentation as to why the rate increase is justified.

(2) A plan's overall annual medical trend factor assumptions in each rate filing for all benefits.

(3) A health plan's actual costs, by aggregate benefit category to include hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(4) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

HISTORY:

Added Stats 2010 ch 661 § 4 (SB 1163), effective January 1, 2011. Amended Stats 2014 ch 577 § 2 (SB 1182), effective January 1, 2015; Stats 2016 ch 498 § 3 (SB 908), effective January 1, 2017.

§ 1385.07. Publication of information; Confidential information; Information to be included [Effective January 1, 2020]

(a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all information submitted under this article shall be made publicly available by the department except as provided in subdivision (b).

(b)(1) The contracted rates between a health care service plan and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The contracted rates between a health care service plan and a provider shall not be disclosed by a health care service plan to a large group purchaser that receives information pursuant to Section 1385.10.

(2) The contracted rates between a health care service plan, including those submitted to the department pursuant to Section 1385.046, and a large group shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Information provided to a large group purchaser pursuant to Section 1385.10 shall be deemed confidential information that shall not be made public by the department and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) In addition, the department and the health care service plan shall, at a minimum, make the following information readily available to the public on their internet websites in plain language and in a manner and format specified by the department, except as provided in subdivision (b). For individual and small group health care service plan contracts, the information shall be made public for 120 days prior to the implementation of the rate increase. For large group health care service plan contracts, the information shall be made public for 60 days prior to the implementation of the rate increase. The information shall include:

(1) Justifications for any unreasonable rate increases, including all information and supporting documentation as to why the rate increase is justified.

(2) A plan's overall annual medical trend factor assumptions in each rate filing for all benefits.

(3) A health care service plan's actual costs, by aggregate benefit category to include hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(4) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician

services, prescription drugs and other ancillary services, laboratory, and radiology.

HISTORY:
Added Stats 2010 ch 661 § 4 (SB 1163), effective January 1, 2011. Amended Stats 2014 ch 577 § 2 (SB 1182), effective January 1, 2015; Stats 2016 ch 498 § 3 (SB 908), effective January 1, 2017; Stats 2019 ch 247 § 3 (SB 343), effective January 1, 2020; Stats 2019 ch 807 § 8 (AB 731), effective January 1, 2020 (ch 807 prevails).

§ 1385.08. Issuance of guidance to health care service plans regarding compliance with article

(a) On or before July 1, 2012, the director may issue guidance to health care service plans regarding compliance with this article. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(b) The department shall consult with the Department of Insurance in issuing guidance under subdivision (a), in adopting necessary regulations, in posting information on its Internet Web site under this article, and in taking any other action for the purpose of implementing this article.

HISTORY:
Added Stats 2010 ch 661 § 4 (SB 1163), effective January 1, 2011.

§ 1385.09. Filing by health care service plan contract documenting cost savings and impact on rates [Effective January 1, 2020]

A health care service plan contract subject to Section 1385.03 or 1385.04 shall file a separate schedule documenting the cost savings associated with Section 1367.016 and the impact on rates.

HISTORY:
Added Stats 2019 ch 862 § 4 (AB 290), effective January 1, 2020.

§ 1385.10. Health care service plan annual claims reporting requirements

(a)(1) A health care service plan shall annually provide claims data at no charge to a large group purchaser if the large group purchaser requests the information and otherwise meets the requirements of this section.

(2) The health care service plan shall provide claims data that a qualified statistician has determined are deidentified so that the claims data do not identify or do not provide a reasonable basis from which to identify an individual. If the statistician is unable to determine that the data has been deidentified, then the data that cannot be deidentified shall not be provided by the health care service plan to the large group purchaser. A health care service plan may provide the claims data in an aggregated form as necessary to comply with subdivisions (e) and (f).

(b)(1) As an alternative to providing claims data required pursuant to subdivision (a), the plan shall provide, at no charge to a large group purchaser, all of the following:

(A) Deidentified data sufficient for the large group purchaser to calcu-

late the cost of obtaining similar services from other health plans and evaluate cost-effectiveness by service and disease category.

(B) Deidentified aggregated patient-level data on demographics, prescribing, encounters, inpatient services, outpatient services, and any other data that is comparable to what is required of the health plan to comply with risk adjustment, reinsurance, or risk corridors pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(C) Deidentified aggregated patient-level data used to experience rate the large group, including diagnostic and procedure coding and costs assigned to each service that the plan has available.

(2) The health care service plan shall obtain a formal determination from a qualified statistician that the data provided pursuant to this subdivision have been deidentified so that the data do not identify or do not provide a reasonable basis from which to identify an individual. If the statistician is unable to determine that the data has been deidentified, the health care service plan shall not provide the data that cannot be deidentified to the large group purchaser. The statistician shall document the formal determination in writing and shall, upon request, provide the protocol used for deidentification to the department.

(c) Data provided pursuant to this section shall only be provided to a large group purchaser that meets both of the following conditions:

(1) Is able to demonstrate its ability to comply with state and federal privacy laws.

(2) Is a large group purchaser that is either an employer with an enrollment of greater than 1,000 covered lives and at least 500 covered lives enrolled with the health care service plan providing the information or a multiemployer trust with an enrollment of greater than 500 covered lives and at least 250 covered lives enrolled with the health care service plan providing the information.

(d) Nothing in this section shall be construed to prohibit a plan and purchaser from negotiating the release of additional information not described in this section.

(e) All disclosures of data to the large group purchaser made pursuant to this section shall comply with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the federal Health Information Technology for Economic and Clinical Health Act, Title XIII of the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and implementing regulations.

(f) All disclosures of data to the large group purchaser made pursuant to this section shall comply with the Confidentiality of Medical Information Act (Chapter 1 (commencing with Section 56) of Part 2.6 of Division 1 of the Civil Code).

HISTORY:

Added Stats 2014 ch 577 § 3 (SB 1182), effective January 1, 2015.

§ 1385.11. Review of rate filings by department; Report; Unreasonable rate increase findings

(a) Whenever it appears to the department that any person has engaged, or is about to engage, in any act or practice constituting a violation of this article, including the filing of inaccurate or unjustified rates or inaccurate or unjustified rate information, the department may review the rate filing to ensure compliance with the law.

(b) The department may review other filings.

(c) The department shall accept and post to its Internet Web site any public comment on a rate increase submitted to the department during the applicable period described in subdivision (d) of Section 1385.07.

(d) The department shall report to the Legislature at least quarterly on all unreasonable rate filings.

(e) The department shall post on its Internet Web site any changes submitted by the plan to the proposed rate increase, including any documentation submitted by the plan supporting those changes.

(f) If the director makes a decision that an unreasonable rate increase is not justified or that a rate filing contains inaccurate information, the department shall post that decision on its Internet Web site.

(g) Nothing in this article shall be construed to impair or impede the department's authority to administer or enforce any other provision of this chapter.

HISTORY:
Added Stats 2010 ch 661 § 4 (SB 1163), effective January 1, 2011. Amended Stats 2014 ch 572 § 11 (SB 959), effective January 1, 2015; Stats 2016 ch 498 § 4 (SB 908), effective January 1, 2017.

§ 1385.13. Duties of department; Submission of information

The department shall do all of the following in a manner consistent with applicable federal laws, rules, and regulations:

(a) Provide data to the United States Secretary of Health and Human Services on health care service plan rate trends in premium rating areas.

(b) Commencing with the creation of the Exchange, provide to the Exchange such information as may be necessary to allow compliance with federal law, rules, regulations, and guidance.

HISTORY:
Added Stats 2010 ch 661 § 4 (SB 1163), effective January 1, 2011.

ARTICLE 7

Discipline

Section
1386. Suspension or revocation of license; Grounds for disciplinary action; Order to individual.
1387. Civil penalties.
1388. Discipline of person acting as solicitor or solicitor firm.
1389. Petition to reinstate license.

HISTORY: Added Stats 1975 ch 941 § 2, operative July 1, 1976.

§ 1386. Suspension or revocation of license; Grounds for disciplinary action; Order to individual

(a) The director may, after appropriate notice and opportunity for a hearing, by order suspend or revoke any license issued under this chapter to a health care service plan or assess administrative penalties if the director determines that the licensee has committed any of the acts or omissions constituting grounds for disciplinary action.

(b) The following acts or omissions constitute grounds for disciplinary action by the director:

(1) The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director.

(2) The plan has issued, or permits others to use, evidence of coverage or uses a schedule of charges for health care services that do not comply with those published in the latest evidence of coverage found unobjectionable by the director.

(3) The plan does not provide basic health care services to its enrollees and subscribers as set forth in the evidence of coverage. This subdivision shall not apply to specialized health care service plan contracts.

(4) The plan is no longer able to meet the standards set forth in Article 5 (commencing with Section 1367).

(5) The continued operation of the plan will constitute a substantial risk to its subscribers and enrollees.

(6) The plan has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter, any rule or regulation adopted by the director pursuant to this chapter, or any order issued by the director pursuant to this chapter.

(7) The plan has engaged in any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code.

(8) The plan has permitted, or aided or abetted any violation by an employee or contractor who is a holder of any certificate, license, permit, registration, or exemption issued pursuant to the Business and Professions Code or this code that would constitute grounds for discipline against the certificate, license, permit, registration, or exemption.

(9) The plan has aided or abetted or permitted the commission of any illegal act.

(10) The engagement of a person as an officer, director, employee, associate, or provider of the plan contrary to the provisions of an order issued by the director pursuant to subdivision (c) of this section or subdivision (d) of Section 1388.

(11) The engagement of a person as a solicitor or supervisor of solicitation contrary to the provisions of an order issued by the director pursuant to Section 1388.

(12) The plan, its management company, or any other affiliate of the plan, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in the plan, management company, or affiliate, has been convicted of or pleaded nolo contendere to a crime, or committed any act involving dishonesty, fraud, or deceit, which crime or act is substantially related to the qualifications, functions, or duties of a person engaged in business in accordance with this chapter. The director may revoke or deny a license hereunder irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code.

(13) The plan violates Section 510, 2056, or 2056.1 of the Business and Professions Code or Section 1375.7.

(14) The plan has been subject to a final disciplinary action taken by this state, another state, an agency of the federal government, or another country for any act or omission that would constitute a violation of this chapter.

(15) The plan violates the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

(16) The plan violates Section 806 of the Military and Veterans Code.

(17) The plan violates Section 1262.8.

(c)(1) The director may prohibit any person from serving as an officer, director, employee, associate, or provider of any plan or solicitor firm, or of any management company of any plan, or as a solicitor, if either of the following applies:

(A) The prohibition is in the public interest and the person has committed, caused, participated in, or had knowledge of a violation of this chapter by a plan, management company, or solicitor firm.

(B) The person was an officer, director, employee, associate, or provider of a plan or of a management company or solicitor firm of any plan whose license has been suspended or revoked pursuant to this section and the person had knowledge of, or participated in, any of the prohibited acts for which the license was suspended or revoked.

(2) A proceeding for the issuance of an order under this subdivision may be included with a proceeding against a plan under this section or may constitute a separate proceeding, subject in either case to subdivision (d).

(d) A proceeding under this section shall be subject to appropriate notice to, and the opportunity for a hearing with regard to, the person affected in accordance with subdivision (a) of Section 1397.

HISTORY:

Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1977 ch 818 § 15, effective September 16, 1977; Stats 1979 ch 1083 § 13; Stats 1980 ch 974 § 15; Stats 1986 ch 718 § 6; Stats 1996 ch 1094 § 1 (SB 1805); Stats 1998 ch 836 § 1 (SB 955); Stats 1999 ch 525 § 132 (AB 78), ch 526 § 11 (SB 19); Stats 2000 ch 135 § 91 (AB 2539), ch 1067 § 15 (SB 2094) (ch 1067 prevails); Stats 2002 ch 925 § 2 (AB 2907); Stats 2006 ch 622 § 1 (AB 2884), effective January 1, 2007; Stats 2008 ch 603 § 5 (AB 1203), effective January 1, 2009.

§ 1387. Civil penalties

(a) Any person who violates any provision of this chapter, or who violates any rule or order adopted or issued pursuant to this chapter, shall be liable for a civil penalty not to exceed two thousand five hundred dollars ($2,500) for each violation, which shall be assessed and recovered in a civil action brought

in the name of the people of the State of California by the director in any court of competent jurisdiction.

(b) As applied to the civil penalties for acts in violation of this chapter, the remedies provided by this section and by other sections of this chapter are not exclusive, and may be sought and employed in any combination to enforce this chapter.

(c) No action shall be maintained to enforce any liability created under subdivision (a), unless brought before the expiration of four years after the act or transaction constituting the violation.

HISTORY:
Added Stats 1986 ch 718 § 8. Amended Stats 1999 ch 525 § 133 (AB 78), operative July 1, 2000.

§ 1388. Discipline of person acting as solicitor or solicitor firm

(a) The director may, after appropriate notice and opportunity for hearing, by order, censure a person acting as a solicitor or solicitor firm, or suspend for a period not exceeding 24 months or bar a person from operating as a solicitor or solicitor firm, or assess administrative penalties against a person acting as a solicitor or solicitor firm if the director determines that the person has committed any of the acts or omissions constituting grounds for disciplinary action.

(b) The following acts or omissions constitute grounds for disciplinary action by the director:

(1) The continued operation of the solicitor or solicitor firm in a manner that may constitute a substantial risk to a plan or subscribers and enrollees.

(2) The solicitor or solicitor firm has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter, any rule or regulation adopted by the director pursuant to the chapter, or any order issued by the director pursuant to this chapter.

(3) The solicitor or solicitor firm has engaged in any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code.

(4) The engagement of a person as an officer, director, employee, or associate of the solicitor firm contrary to the provisions of an order issued by the director pursuant to subdivision (d) of this section or subdivision (c) of Section 1386.

(5) The solicitor or solicitor firm, or its management company, or any other affiliate of the solicitor firm, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in that solicitor firm, management company, or affiliate, has been convicted or pleaded nolo contendere to a crime, or committed any act involving dishonesty, fraud, or deceit, which crime or act is substantially related to the qualifications, functions, or duties of a person engaged in business in accordance with the provisions of this chapter. The director may issue an order hereunder irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code.

(c) The director shall notify plans of any order issued pursuant to subdivision (a) which suspends or bars a person from engaging in operations as a

solicitor or solicitor firm. It shall be unlawful for any plan, after receipt of notice of the order, to receive any new subscribers or enrollees through that person or to otherwise utilize any solicitation services of that person in violation thereof.

(d)(1) The director may prohibit any person from serving as an officer, director, employee, or associate of any plan or solicitor firm, or as a solicitor, if that person was an officer, director, employee, or associate of a solicitor firm that has been the subject of an order of suspension or bar from engaging in operations as a solicitor firm pursuant to this section and that person had knowledge of, or participated in, any of the prohibited acts for which the order was issued.

(2) A proceeding for the issuance of an order under this subdivision may be included with a proceeding against a solicitor firm under this section or may constitute a separate proceeding, subject in either case to subdivision (e).

(e) A proceeding for the issuance of an order under this section shall be subject to appropriate notice to, and the opportunity for a hearing with regard to, the person affected in accordance with subdivision (a) of Section 1397.

HISTORY:
Added Stats 1979 ch 1083 § 16. Amended Stats 1980 ch 974 § 16; Stats 1998 ch 836 § 2 (SB 955); Stats 1999 ch 525 § 134 (AB 78), operative July 1, 2000.

§ 1389. Petition to reinstate license

(a) A person whose license has been revoked, or suspended for more than one year, may petition the director to reinstate the license as provided by Section 11522 of the Government Code. No petition may be considered if the petitioner is under criminal sentence for a violation of this chapter, or any offense which would constitute grounds for discipline, or denial of licensure under this chapter, including any period of probation or parole.

(b) A person who is barred, or suspended for more than one year, from acting as a solicitor or solicitor firm pursuant to Section 1388, or who is subject to an order, pursuant to subdivision (c) of Section 1386 or subdivision (d) of Section 1388, which by its terms is effective for more than one year, may petition the director to reduce by order such penalty in a manner generally consistent with the provisions of Section 11522 of the Government Code. No petition may be considered if the petitioner is under criminal sentence for a violation of this chapter, or any offense which would constitute grounds for discipline under this chapter, including any period of probation or parole.

(c) The petition for restoration shall be in the form prescribed by the director and the director may condition the granting of such petition upon such additional information and undertakings as the director may require in order to determine whether such person, if restored, would engage in business in full compliance with the objectives and provisions of this chapter and the rules and regulations adopted by the director pursuant to this chapter.

(d) The director may, by rule, prescribe a fee not to exceed five hundred dollars ($500) for the filing of a petition for restoration pursuant to this section. In addition, the director may condition the granting of such a petition to a plan upon payment of the assessment due and unpaid pursuant to subdivision (b) of Section 1356 as of the 15th day of December occurring within the preceding

12-calendar months and, if the plan's suspension or revocation was in effect for more than 12 months, upon the filing of a new plan application and the payment of the fee prescribed by subdivision (a) of Section 1356.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1976 ch 652 § 8, effective August 28, 1976, operative July 1, 1976; Stats 1979 ch 1083 § 17; Stats 1999 ch 525 § 135 (AB 78), operative July 1, 2000.

ARTICLE 7.5

Underwriting Practices

Section
1389.1. Applications for coverage; HIV test prohibition.
1389.2. Written statement of actuarial basis.
1389.21. Proscription against rescission, cancellation, or limitation of policy, or rise in premiums after 24 months following issuance of health care service plan contract.
1389.25. Written notice required for changes in premium rate or coverage for individual plan contract; Information on new coverage options in case of rejection.
1389.3. Postclaims underwriting.
1389.4. Written policies required; Filing; Posting (Inoperative November 1, 2013; Operative date contingent).
1389.4. Written policies required; Filing; Exceptions (Operative term contingent).
1389.5. Right to transfer to another individual plan (Inoperative; Operative date contingent).
1389.6. Compensation of a person or entity employed or contracted; Performance goals or quotas.
1389.7. Issuance of new individual plan contract where contract rescinded; Premium rate; Preexisting condition provision; Notice; Contract effective date (Inoperative; Operative date contingent).
1389.7. Issuance of new individual plan contract where contract rescinded; Premium rate; Preexisting condition provision; Notice; Contract effective date; Applicability (Operative term contingent).
1389.8. Duty with regard to assisting applicant for a health care service plan; Attestation; Civil penalty.

HISTORY: Added Stats 1993 ch 1210 § 3.

§ 1389.1. Applications for coverage; HIV test prohibition

(a) The director shall not approve any plan contract unless the director finds that the application conforms to both of the following requirements:

(1) All applications for coverage which include health-related questions shall contain clear and unambiguous questions designed to ascertain the health condition or history of the applicant.

(2) The application questions related to an applicant's health shall be based on medical information that is reasonable and necessary for medical underwriting purposes. The application shall include a prominently displayed notice that shall read:

"California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage."

(b) Nothing in this section shall authorize the director to establish or require a single or standard application form for application questions.

HISTORY:
Added Stats 1993 ch 1210 § 3 (AB 1100). Amended Stats 1999 ch 525 § 136 (AB 78), operative July 1, 2000.

§ 1389.2. Written statement of actuarial basis

At the request of the director, a health care service plan shall provide a

written statement of the actuarial basis for any medical underwriting decision on any application form, or contract issued or delivered to, or denied a resident of this state.

HISTORY:
Added Stats 1993 ch 1210 § 3 (AB 1100). Amended Stats 1999 ch 525 § 137 (AB 78), operative July 1, 2000.

§ 1389.21. Proscription against rescission, cancellation, or limitation of policy, or rise in premiums after 24 months following issuance of health care service plan contract

(a) A health care service plan shall not rescind a plan contract, or limit any provisions of a plan contract, once an enrollee is covered under the contract unless the plan can demonstrate that the enrollee has performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the contract.

(b) If a plan intends to rescind a plan contract pursuant to subdivision (a), the plan shall send a notice to the enrollee or subscriber via regular certified mail at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and notifying the enrollee or subscriber of his or her right to appeal that decision to the director pursuant to subdivision (b) of Section 1365.

(c) Notwithstanding subdivision (a), Section 1365 or any other provision of law, after 24 months following the issuance of a health care service plan contract, a plan shall not rescind the plan contract for any reason, and shall not cancel the plan contract, limit any of the provisions of the plan contract, or raise premiums on the plan contract due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not. Nothing in this subdivision shall be construed to alter existing law that otherwise applies to a health care service plan within the first 24 months following the issuance of a health care service plan contract.

HISTORY:
Added Stats 2009 ch 406 § 1 (AB 108), effective January 1, 2010. Amended Stats 2010 ch 658 § 8 (AB 2470), effective January 1, 2011.

§ 1389.25. Written notice required for changes in premium rate or coverage for individual plan contract; Information on new coverage options in case of rejection

(a)(1) This section shall apply only to a full service health care service plan offering health coverage in the individual market in California and shall not apply to a specialized health care service plan, a health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan conversion contract offered pursuant to Section 1373.6, a health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), or a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35).

(2) A local initiative, as defined in subdivision (w) of Section 53810 of Title 22 of the California Code of Regulations, that is awarded a contract by the State Department of Health Care Services pursuant to subdivision (b) of

Section 53800 of Title 22 of the California Code of Regulations, shall not be subject to this section unless the plan offers coverage in the individual market to persons not covered by Medi-Cal or the Healthy Families Program.

(b)(1) No change in the premium rate or coverage for an individual plan contract shall become effective unless the plan has provided a written notice of the change at least 10 days prior to the start of the annual enrollment period applicable to the contract or 60 days prior to the effective date of the contract renewal, whichever occurs earlier in the calendar year.

(2) The written notice required pursuant to paragraph (1) shall be provided to the individual contractholder at his or her last address known to the plan. The notice shall state in italics and in 12-point type the actual dollar amount of the premium rate increase and the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the plan design or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change to the plan design or benefits.

(c)(1) If the department determines that a rate is unreasonable or not justified consistent with Article 6.2 (commencing with Section 1385.01), the plan shall notify the contractholder of this determination. This notification may be included in the notice required in subdivision (b). The notification to the contractholder shall be developed by the department. The development of the notification required under this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(2) The notification to the contractholder shall include the following statements in 14-point type:

(A) The Department of Managed Health Care has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the plan.

(B) During the open enrollment period, the contractholder has the option to obtain other coverage from this plan or another plan, or to keep this coverage.

(C) The contractholder may want to contact Covered California at www.coveredca.com for help in understanding available options.

(D) Many Californians are eligible for financial assistance from Covered California to help pay for coverage.

(3) The plan may include in the notification to the contractholder the Internet Web site address at which the plan's final justification for implementing an increase that has been determined to be unreasonable by the director may be found pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations.

(4) The notice shall also be provided to the solicitor for the contractholder, if any, so that the solicitor may assist the purchaser in finding other coverage.

(5) In developing the notification, the department shall take into consideration that this notice is required to be provided to an individual applicant pursuant to subdivision (g) of Section 1385.03.

(d) If a plan rejects a dependent of a subscriber applying to be added to the subscriber's individual grandfathered health plan, rejects an applicant for a Medicare supplement plan contract due to the applicant having end-stage renal disease, or offers an individual grandfathered health plan to an applicant at a rate that is higher than the standard rate, the plan shall inform the applicant about the California Major Risk Medical Insurance Program (MRMIP) (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code) and about the new coverage options, and the potential for subsidized coverage, through Covered California. The plan shall direct persons seeking more information to MRMIP, Covered California, plan or policy representatives, insurance agents, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.

(e) A notice provided pursuant to this section is a private and confidential communication and, at the time of application, the plan shall give the individual applicant the opportunity to designate the address for receipt of the written notice in order to protect the confidentiality of any personal or privileged information.

(f) For purposes of this section, the following definitions shall apply:

(1) "Covered California" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(2) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111–148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), and any rules, regulations, or guidance issued pursuant to that law.

HISTORY:
Added Stats 2005 ch 526 § 3 (AB 356), effective January 1, 2006. Amended Stats 2010 ch 31 § 1 (SB 227), effective June 29, 2010, ch 661 § 25 (SB 1163), effective January 1, 2011; Stats 2014 ch 572 § 12 (SB 959), effective January 1, 2015; Stats 2016 ch 498 § 5 (SB 908), effective January 1, 2017.

§ 1389.3. Postclaims underwriting

No health care service plan shall engage in the practice of postclaims underwriting. For purposes of this section, "postclaims underwriting" means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract. This section shall not limit a plan's remedies described in subdivision (a) of Section 1389.21.

HISTORY:
Added Stats 1993 ch 1210 § 3 (AB 1100). Amended Stats 2010 ch 658 § 9 (AB 2470), effective January 1, 2011.

§ 1389.4. Written policies required; Filing; Posting (Inoperative November 1, 2013; Operative date contingent)

(a) A full service health care service plan that issues, renews, or amends individual health plan contracts shall be subject to this section.

(b) A health care service plan subject to this section shall have written

policies, procedures, or underwriting guidelines establishing the criteria and process whereby the plan makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall ensure that the plan rating and underwriting criteria comply with Sections 1365.5 and 1389.1 and all other applicable provisions of state and federal law.

(c) On or before June 1, 2006, and annually thereafter, every health care service plan shall file with the department a general description of the criteria, policies, procedures, or guidelines the plan uses for rating and underwriting decisions related to individual health plan contracts, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the plan products for which they would be eligible. A plan may comply with this section by submitting to the department underwriting materials or resource guides provided to plan solicitors or solicitor firms, provided that those materials include the information required to be submitted by this section.

(d) Commencing January 1, 2011, the director shall post on the department's Internet Web site, in a manner accessible and understandable to consumers, general, noncompany specific information about rating and underwriting criteria and practices in the individual market and information about the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code) and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code. The director shall develop the information for the Internet Web site in consultation with the Department of Insurance to enhance the consistency of information provided to consumers. Information about individual health coverage shall also include the following notification:

"Please examine your options carefully before declining group coverage or continuation coverage, such as COBRA, that may be available to you. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(e) This section does not authorize public disclosure of company specific rating and underwriting criteria and practices submitted to the director.

(f) This section does not apply to a closed block of business, as defined in Section 1367.15.

(g)(1) This section shall become inoperative on November 1, 2013, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative 12 months after the date of that repeal or amendment.

HISTORY:
Added Stats 2005 ch 526 § 4 (AB 356), effective January 1, 2006, as H & S C § 1389.3. Amended and renumbered by Stats 2006 ch 128 § 1 (1744), effective January 1, 2007; Amended Stats 2007 ch 577 § 13 (AB 1750), effective October 13, 2007; Stats 2010 ch 31 § 2 (SB 227), effective June 29, 2010; Stats 2013-2014 1st Ex Sess ch 2 § 9 (SBX1 2), effective September 30, 2013, inoperative November 1, 2013, operative date contingent; Stats 2015 ch 303 § 261 (AB 731), effective January 1, 2016, inoperative November 1, 2013, operative date contingent.

§ 1389.4. Written policies required; Filing; Exceptions (Operative term contingent)

(a) A full service health care service plan that renews individual grandfathered health benefit plans shall be subject to this section.

(b) A health care service plan subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the plan makes its decision to provide or to deny coverage to dependents applying for an individual grandfathered health plan and sets the rate for that coverage. These guidelines, policies, or procedures shall ensure that the plan rating and underwriting criteria comply with Sections 1365.5 and 1389.1 and all other applicable provisions of state and federal law.

(c) On or before the June 1 next following the operative date of this section, and annually thereafter, every health care service plan shall file with the department a general description of the criteria, policies, procedures, or guidelines the plan uses for rating and underwriting decisions related to individual grandfathered health plans, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the plan products for which they would be eligible. A plan may comply with this section by submitting to the department underwriting materials or resource guides provided to plan solicitors or solicitor firms, provided that those materials include the information required to be submitted by this section.

(d) This section does not authorize public disclosure of company specific rating and underwriting criteria and practices submitted to the director.

(e) For purposes of this section, the following definitions shall apply:

(1) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

(2) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(f)(1) This section shall become operative on November 1, 2013, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become inoperative 12 months after the date of that repeal or amendment.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 2 § 10 (SBX1 2), effective September 30, 2013, operative November 1, 2013, operative term contin-

gent. Amended Stats 2015 ch 303 § 262 (AB 731), effective January 1, 2016, operative November 1, 2013, operative term contingent.

§ 1389.5. Right to transfer to another individual plan (Inoperative; Operative date contingent)

(a) This section applies to a health care service plan that provides coverage under an individual plan contract that is issued, amended, delivered, or renewed on or after January 1, 2007.

(b) At least once each year, the health care service plan shall permit an individual who has been covered for at least 18 months under an individual plan contract to transfer, without medical underwriting, to any other individual plan contract offered by that same health care service plan that provides equal or lesser benefits, as determined by the plan.

"Without medical underwriting" means that the health care service plan shall not decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion on the individual who transfers to another individual plan contract pursuant to this section.

(c) The plan shall establish, for the purposes of subdivision (b), a ranking of the individual plan contracts it offers to individual purchasers and post the ranking on its Internet Web site or make the ranking available upon request. The plan shall update the ranking whenever a new benefit design for individual purchasers is approved.

(d) The plan shall notify in writing all enrollees of the right to transfer to another individual plan contract pursuant to this section, at a minimum, when the plan changes the enrollee's premium rate. Posting this information on the plan's Internet Web site shall not constitute notice for purposes of this subdivision. The notice shall adequately inform enrollees of the transfer rights provided under this section, including information on the process to obtain details about the individual plan contracts available to that enrollee and advising that the enrollee may be unable to return to his or her current individual plan contract if the enrollee transfers to another individual plan contract.

(e) The requirements of this section do not apply to the following:

(1) A federally eligible defined individual, as defined in subdivision (c) of Section 1399.801, who is enrolled in an individual health benefit plan contract offered pursuant to Section 1366.35.

(2) An individual offered conversion coverage pursuant to Section 1373.6.

(3) Individual coverage under a specialized health care service plan contract.

(4) An individual enrolled in the Medi-Cal program pursuant to Chapter 7 (commencing with Section 14000) of Division 9 of Part 3 of the Welfare and Institutions Code.

(5) An individual enrolled in the Access for Infants and Mothers Program pursuant to Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code.

(6) An individual enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(f) It is the intent of the Legislature that individuals shall have more choice in their health coverage when health care service plans guarantee the right of an individual to transfer to another product based on the plan's own ranking system. The Legislature does not intend for the department to review or verify the plan's ranking for actuarial or other purposes.

(g)(1) This section shall become inoperative January 1, 2014, or the 91st calendar day following the adjournment of the 2013-14 First Extraordinary Session, whichever date is later.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative 12 months after the date of that repeal or amendment.

HISTORY:
Added Stats 2006 ch 826 § 1 (AB 2889), effective January 1, 2007. Amended Stats 2013-2014 1st Ex Sess ch 2 § 11 (SBX1 2), effective September 30, 2013, inoperative January 1, 2014, operative date contingent; Stats 2015 ch 303 § 263 (AB 731), effective January 1, 2016, inoperative, operative date contingent.

§ 1389.6. Compensation of a person or entity employed or contracted; Performance goals or quotas

Compensation of a person or entity employed by, or contracted with, a health care service plan shall not be based on, or related in any way to, the number of contracts that the person or entity has caused or recommended to be rescinded, canceled, or limited, or the resulting cost savings to the health plan. A health care service plan shall not set performance goals or quotas, or provide compensation to any person or entity employed by, or contracted with, the health care service plan, based on the number of persons whose coverage is rescinded or any financial savings to the health care service plan associated with rescission of coverage.

HISTORY:
Added Stats 2008 ch 188 § 1 (AB 1150), effective January 1, 2009.

§ 1389.7. Issuance of new individual plan contract where contract rescinded; Premium rate; Preexisting condition provision; Notice; Contract effective date (Inoperative; Operative date contingent)

(a) Every health care service plan that offers, issues, or renews individual plan contracts shall offer to any individual, who was covered under an individual plan contract that was rescinded, a new individual plan contract, without medical underwriting, that provides equal benefits. A health care service plan may also permit an individual, who was covered under an individual plan contract that was rescinded, to remain covered under that individual plan contract, with a revised premium rate that reflects the number of persons remaining on the plan contract.

(b) "Without medical underwriting" means that the health care service plan shall not decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion on the individual who is issued a new individual plan contract or remains covered under an individual plan contract pursuant to this section.

(c) If a new individual plan contract is issued, the plan may revise the premium rate to reflect only the number of persons covered on the new individual plan contract.

(d) Notwithstanding subdivisions (a) and (b), if an individual was subject to a preexisting condition provision or a waiting or an affiliation period under the individual plan contract that was rescinded, the health care service plan may apply the same preexisting condition provision or waiting or affiliation period in the new individual plan contract. The time period in the new individual plan contract for the preexisting condition provision or waiting or affiliation period shall not be longer than the one in the individual plan contract that was rescinded and the health care service plan shall credit any time that the individual was covered under the rescinded individual plan contract.

(e) The plan shall notify in writing all enrollees of the right to coverage under an individual plan contract pursuant to this section, at a minimum, when the plan rescinds the individual plan contract. The notice shall adequately inform enrollees of the right to coverage provided under this section.

(f) The plan shall provide 60 days for enrollees to accept the offered new individual plan contract and this contract shall be effective as of the effective date of the original plan contract and there shall be no lapse in coverage.

(g) This section does not apply to any individual whose information in the application for coverage and related communications led to the rescission.

(h)(1) This section shall become inoperative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative 12 months after the date of that repeal or amendment.

HISTORY:

Added Stats 2008 ch 604 § 1 (AB 2569), effective January 1, 2009. Amended Stats 2013-2014 1st Ex Sess ch 2 § 12 (SBX1 2), effective September 30, 2013, inoperative January 1, 2014, operative date contingent; Stats 2015 ch 303 § 264 (AB 731), effective January 1, 2016, inoperative, operative date contingent.

§ 1389.7. Issuance of new individual plan contract where contract rescinded; Premium rate; Preexisting condition provision; Notice; Contract effective date; Applicability (Operative term contingent)

(a) Every health care service plan that offers, issues, or renews individual plan contracts shall offer to any individual, who was covered by the plan under an individual plan contract that was rescinded, a new individual plan contract that provides the most equivalent benefits.

(b) A health care service plan that offers, issues, or renews individual plan contracts inside or outside the California Health Benefit Exchange may also permit an individual, who was covered by the plan under an individual plan contract that was rescinded, to remain covered under that individual plan contract, with a revised premium rate that reflects the number of persons remaining on the individual plan contract consistent with Section 1399.855.

(c) The plan shall notify in writing all enrollees of the right to coverage under an individual plan contract pursuant to this section, at a minimum,

when the plan rescinds the individual plan contract. The notice shall adequately inform enrollees of the right to coverage provided under this section.

(d) The plan shall provide 60 days for enrollees to accept the offered new individual plan contract under subdivision (a), and this contract shall be effective as of the effective date of the original plan contract and there shall be no lapse in coverage.

(e) This section does not apply to any individual whose information in the application for coverage and related communications led to the rescission.

(f) This section applies notwithstanding subdivision (a) or (d) of Section 1399.849.

(g)(1) This section shall become operative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become inoperative 12 months after the date of that repeal or amendment.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 2 § 13 (SBX1 2), effective September 30, 2013, operative January 1, 2014, operative term contingent. Amended Stats 2015 ch 303 § 265 (AB 731), effective January 1, 2016, operative term contingent.

§ 1389.8. Duty with regard to assisting applicant for a health care service plan; Attestation; Civil penalty

(a) Notwithstanding any other provision of law, an agent, broker, solicitor, solicitor firm, or representative who assists an applicant in submitting an application to a health care service plan has the duty to assist the applicant in providing answers to health questions accurately and completely.

(b) An agent, broker, solicitor, solicitor firm, or representative who assists an applicant in submitting an application to a health care service plan shall attest on the written application to both of the following:

(1) That to the best of his or her knowledge, the information on the application is complete and accurate.

(2) That he or she explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and that the applicant understood the explanation.

(c) If, in an attestation required by subdivision (b), a declarant willfully states as true any material fact he or she knows to be false, that person shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Managed Care Fund.

(d) A health care service plan application shall include a statement advising declarants of the civil penalty authorized under this section.

HISTORY:
Added Stats 2008 ch 604 § 2 (AB 2569), effective January 1, 2009.

ARTICLE 8

Other Enforcement Procedures

Section
1390. Violation of chapter; Penalties.
1391. Cease and desist orders.
1391.5. Immediate order to discontinue unsafe practice.
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HISTORY: Added Stats 1975 ch 941 § 2, operative July 1, 1976.

§ 1390. Violation of chapter; Penalties

Any person who willfully violates any provision of this chapter or of any rule or order thereunder shall upon conviction be fined not more than ten thousand dollars ($10,000) or imprisoned pursuant to subdivision (h) of Section 1170 of the Penal Code, or in a county jail for not more than one year, or be punished by both such fine and imprisonment, but no person may be imprisoned for the violation of any rule or order if it is proven that such person had no knowledge of the rule or order.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1977 ch 165 § 3.5, effective June 29, 1977, operative July 1, 1977; Stats 2011 ch 15 § 138 (AB 109), effective April 4, 2011, operative October 1, 2011.

§ 1391. Cease and desist orders

(a)(1) The director may issue an order directing a plan, solicitor firm, or any representative thereof, a solicitor, or any other person to cease and desist from engaging in any act or practice in violation of the provisions of this chapter, any rule adopted pursuant to this chapter, or any order issued by the director pursuant to this chapter.

(2) If the plan, solicitor firm, or any representative thereof, or solicitor, or any other person fails to file a written request for a hearing within 30 days from the date of service of the order, the order shall be deemed a final order of the director and shall not be subject to review by any court or agency, notwithstanding subdivision (b) of Section 1397.

(b) If a timely request for a hearing is made by a licensed plan, the request shall automatically stay the effect of the order only to the extent that the order requires the cessation of operation of the plan or prohibits acceptance of new members by the plan or both. However, no automatic stay shall be issued if any examination or inspection of the plan performed by the director discloses, or reports or documents submitted to the director by the plan on their face show, that the plan is in violation of any fiscal requirement of this chapter or in violation of any requirement of Section 1384 or 1385. In the event of an

automatic stay, only that portion of the order requiring cessation of operation or prohibiting enrollment shall be stayed and all other portions of the order shall remain effective. If a hearing is held, and a finding is made that the health or safety of the members and potential members of the plan might be adversely affected by its continued operation, the stay shall be terminated. This finding shall be made, if at all, not later than 30 days after the date of the hearing.

(c) If a timely request for a hearing is made by an unlicensed plan, the director may stay the effect of the order to the extent that the order requires the cessation of operation of the plan or prohibits acceptance of new members by the plan, for that period and subject to those conditions that the director may require, upon a determination by the director that the action would be in the public interest.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1977 ch 330 § 4; Stats 1979 ch 109 § 1, effective June 12, 1979; Stats 1983 ch 611 § 5; Stats 1984 ch 619 § 3; Stats 1998 ch 836 § 3 (SB 955); Stats 1999 ch 525 § 138 (AB 78), operative July 1, 2000.

§ 1391.5. Immediate order to discontinue unsafe practice

(a) If, after examination or investigation, the director has reasonable grounds to believe that irreparable loss and injury to the plan's enrollee or enrollees occurred or may occur as a result of any act or practice unless the director acts immediately, the director may, by written order, addressed to that person, order the discontinuance of the unsafe or injurious act or practice. The order shall become effective immediately, but shall not become final except in accordance with this section.

(b) No order issued pursuant to this section shall become final except after notice to the affected person of the director's intention to make the order final and of the reasons for the finding. The director shall also notify that person that upon receiving a request for hearing by the plan, the matter shall be set for hearing to commence with 15 business days after receipt of the request, unless that person consents to have the hearing commence at a later date.

(c) If no hearing is requested within 15 days after the mailing or service of the required notice, and none is ordered by the director, the order shall become final on the 15th day without a hearing and shall not be subject to review by any court or agency notwithstanding subdivision (b) of Section 1397.

(d) If a hearing is requested or ordered, it shall be held in accordance with the provisions of the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and the director shall have all of the powers granted under that act.

(e) If, upon conclusion of the hearing, it appears to the director that the affected person has conducted business in an unsafe or injurious manner, the director shall make the order of discontinuance final.

(f) For purposes of this section, "person" includes any plan, solicitor firm, or any representative thereof, a solicitor, or any other person defined in subdivision (j) of Section 1345.

HISTORY:
Added Stats 1999 ch 525 § 139 (AB 78), operative July 1, 2000. Amended Stats 2000 ch 857 § 44 (AB 2903).

§ 1392. Injunctions and other equitable relief

(a)(1) Whenever it appears to the director that any person has engaged, or is about to engage, in any act or practice constituting a violation of any provision of this chapter, any rule adopted pursuant to this chapter, or any order issued pursuant to this chapter, the director may bring an action in superior court, or the director may request the Attorney General to bring an action to enjoin these acts or practices or to enforce compliance with this chapter, any rule or regulation adopted by the director pursuant to this chapter, or any order issued by the director pursuant to this chapter, or to obtain any other equitable relief.

(2) If the director determines that it is in the public interest, the director may include in any action authorized by paragraph (1) a claim for any ancillary or equitable relief and the court shall have jurisdiction to award this additional relief.

(3) Upon a proper showing, a permanent or preliminary injunction, restraining order, writ of mandate, or other relief shall be granted, and a receiver, monitor, conservator, or other designated fiduciary or officer of the court may be appointed for the defendant or the defendant's assets.

(b) A receiver, monitor, conservator, or other designated fiduciary, or officer of the court appointed by the superior court pursuant to this section may, with the approval of the court, exercise any or all of the powers of the defendant's officers, directors, partners, or trustees, or any other person who exercises similar powers and performs similar duties, including the filing of a petition for bankruptcy. No action at law or in equity may be maintained by any party against the director, or a receiver, monitor, conservator, or other designated fiduciary or officer of the court by reason of their exercising these powers or performing these duties pursuant to the order of, or with the approval of, the superior court.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1977 ch 762 § 19; Stats 1982 ch 517 § 268; Stats 1998 ch 836 § 4 (SB 955); Stats 1999 ch 525 § 140 (AB 78), operative July 1, 2000.

§ 1393. Vesting of title to assets; Taking possession of business

(a) The superior court of the county in which is located the principal office of the plan in this state shall, upon the filing by the director of a verified application showing any of the conditions enumerated in Section 1386 to exist, issue its order vesting title to all of the assets of the plan, wherever situated, in the director or the director's successor in office, in his or her official capacity as such, and direct the director to take possession of all of its books, records, property, real and personal, and assets, and to conduct, as conservator, the business or portion of the business of the person as may seem appropriate to the director, and enjoining the person and its officers, directors, agents, servants, and employees from the transaction of its business or disposition of its property until the further order of the court.

(b) Whenever it appears to the director that irreparable loss and injury to the property and business of the plan or to the plan's enrollees has occurred or may occur unless the director acts immediately, the director, without notice and before applying to the court for any order, may take possession of the

property, business, books, records, and accounts of the plan, and of the offices and premises occupied by it for the transaction of its business, and retain possession until returned to the plan or until further order of the director or subject to an order of the court. Any person having possession of and refusing to deliver any of the books, records, or assets of a plan against which a seizure order has been issued by the director, shall be guilty of a misdemeanor and punishable by a fine not exceeding ten thousand dollars ($10,000) or imprisonment not exceeding one year, or both the fine and imprisonment. Whenever the director has taken possession of any plan pursuant to this subdivision, the owners, officers, and directors of the plan may apply to the superior court in the county in which the principal office of the plan is located, within 10 days after the taking, to enjoin further proceedings. The court, after citing the director to show cause why further proceedings should not be enjoined, and after a hearing and a determination of the facts upon the merits, may do any of the following:

(1) Dismiss the application after confirming the director's authority to take possession of all of the plan's books, records, property, real and personal, and assets, and to conduct, as conservator, the business or portion of the business as the director may deem appropriate, and enjoining the owners, officers, and directors, and their agents and employees, from the transaction of plan business or disposition of plan property until the further order of the court.

(2) Enjoin the director from further proceedings and direct the director to surrender the property and business to the plan.

(3) Make any further order as may be just.

(c) If any facts occur that would entitle the director to take possession of the property, business, and assets of the plan, the director may appoint a conservator over the plan and require any bond of the conservator as the director deems proper. The conservator, under the direction of the director, shall take possession of the property, business, and assets of the plan pending further disposition of its business. The conservator shall retain possession until the property, business, and assets of the plan are returned to the plan, or until further order of the director, except that the conservator shall be able to pay necessary costs of the ongoing operation without formal order of the director. Whenever the director has taken possession of any plan pursuant to subdivision (b), thedirector shall, within 10 days after the taking, apply to the superior court in the county in which the principal office of the plan is located for an order confirming the director's appointment of the conservator. The order may be given after a hearing upon notice that the court prescribes.

(d)(1) Subject to the other provisions of this section, a conservator, while in possession of the property, business, and assets of a plan, has the same powers and rights, and is subject to the same duties and obligations, as the director under the same circumstances, and during this time, the rights of a plan and of all persons with respect to the plan are the same as if the director had taken possession of the property, business, and assets of the plan, for the purpose of carrying out the conservatorship.

(2) Subject to the other provisions of this section, a conservator, while in possession of the property, business, and assets of a plan, shall have all of the rights, powers, and privileges of the plan, and its officers and directors, for

the purpose of carrying out the conservatorship. All expenses of any conservatorship shall be paid from the assets of the plan, and shall be a lien on the plan which shall be prior to any other lien.

(3) No action at law or in equity may be maintained by any party against the director or a conservator by reason of their exercising or performing the privileges, powers, rights, duties, and obligations pursuant to the order, or with the approval, of the superior court.

(e) Upon appointing a conservator, the director shall cause to be made and completed, at the earliest possible date, an examination of the affairs of the plan as shall be necessary to inform the director as to the plan's financial condition.

(f) If the director becomes satisfied that it may be done safely and in the public interest, the director may terminate the conservatorship and permit the plan for which the conservator was appointed to resume its business under the direction of its board of directors, subject to any terms, conditions, restrictions, and limitations the director prescribes.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1998 ch 836 § 5 (SB 955); Stats 1999 ch 525 § 141 (AB 78), operative July 1, 2000.

§ 1393.5. Civil penalties for violation of license provisions

(a) A person who violates Section 1349, or any person who directly or indirectly participates in the direction of the management or policies of the person in violation of Section 1349, including, but not limited to, any officer, director, partner, or other person occupying a principal management or supervisory position, shall be liable for civil penalties as follows:

(1) A sum not more than two thousand five hundred dollars ($2,500), and

(2) a sum not exceeding five hundred dollars ($500) for each subscriber under an individual or group plan contract which was entered into or renewed while such person was in violation of Section 1349.

(b) The penalty specified in paragraph (2) of subdivision (a) shall be imposed only if one or more of the following occurs:

(1) The solicitation of the entry into or renewal of such contract, or of any subscription or enrollment thereunder, included the use by the plan or a representative of the plan of any advertising, evidence of coverage, or disclosure form which was untrue, misleading, or deceptive.

(2) The contract is not in compliance with this chapter, or the rules adopted pursuant to this chapter.

(3) The plan does not have a financially sound operation and adequate provision against the risk of insolvency.

(4) The plan has operated in violation of the provisions of subdivision (a), (b), (c), (d), or (e) of Section 1367.

(5) The plan has not complied with the provisions of Section 1379.

(c) The civil penalty may be assessed and recovered only in a civil action. The cause of action may be brought in the name of the people of the State of California by the Attorney General or the director, as determined by the director.

HISTORY:
Added Stats 1982 ch 99 § 1, effective March 6, 1982. Amended Stats 1985 ch 908 § 4; Stats 1999 ch 525 § 142 (AB 78), operative July 1, 2000.

§ 1393.6. Administrative penalties for violation of provisions relating to small employer group access to contracts for health care services and preexisting condition provisions and late enrollees

For violations of Article 3.1 (commencing with Section 1357), Article 3.15 (commencing with Section 1357.50), Article 3.16 (commencing with Section 1357.500), and Article 3.17 (commencing with Section 1357.600), the director may, after appropriate notice and opportunity for hearing, by order levy administrative penalties as follows:

(a) Any person, solicitor, or solicitor firm, other than a health care service plan, who willfully violates any provision of this chapter, or who willfully violates any rule or order adopted or issued pursuant to this chapter, is liable for administrative penalties of not less than two hundred fifty dollars ($250) for each first violation, and of not less than one thousand dollars ($1,000) and not more than two thousand five hundred dollars ($2,500) for each subsequent violation.

(b) Any health care service plan that willfully violates any provision of this chapter, or that willfully violates any rule or order adopted or issued pursuant to this chapter, is liable for administrative penalties of not less than two thousand five hundred dollars ($2,500) for each first violation, and of not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000) for each second violation, and of not less than fifteen thousand dollars ($15,000) and not more than one hundred thousand dollars ($100,000) for each subsequent violation.

(c) The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(d) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the director to enforce the provisions of this chapter.

HISTORY:
Added Stats 1992 ch 1128 § 8 (AB 1672), operative July 1, 1993. Amended Stats 1999 ch 525 § 143 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 45 (AB 2903); Stats 2008 ch 607 § 9 (SB 1379), effective September 30, 2008; Stats 2012 ch 852 § 8 (AB 1083), effective January 1, 2013.

§ 1394. Penalties not exclusive

The civil, criminal, and administrative remedies available to the director pursuant to this article are not exclusive, and may be sought and employed in any combination deemed advisable by the director to enforce the provisions of this chapter.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1999 ch 525 § 144 (AB 78), operative July 1, 2000.

§ 1394.1. Complaint for involuntary dissolution of plan

Notwithstanding any other provision of law, the director may file a verified complaint for involuntary dissolution of a health care service plan on any one or more of the grounds specified in subdivision (b) of Section 1386. The complaint shall be filed in the superior court of the county where the principal executive office of the health care service plan is located or, if the principal executive office of the health care service plan is not located in this state, or the health care service plan has no such office, the County of Sacramento.

HISTORY:
Added Stats 1985 ch 908 § 5. Amended Stats 1999 ch 525 § 145 (AB 78), operative July 1, 2000.

§ 1394.2. Priority of claims.

Notwithstanding any other provision of law, in any involuntary dissolution of a health care service plan as provided for in Section 1394.1, or other insolvency proceeding involving a health care service plan, the following expenses and claims have priority in the following order:

(a) First, administrative expenses allowed by the superior court and any fees and charges assessed against the estate of the dissolved health care service plan in conjunction with the dissolution of the estate.

(b) Second, taxes due the State of California.

(c) Third, claims having preference by the laws of the United States and by the laws of this state.

(d) Fourth, claims of health care service plan subscribers and enrollees for reimbursement for services rendered by noncontracting providers. Upon proper showing, the superior court may make an order relieving subscribers and enrollees from liability or stay any proceeding to secure payment for any services rendered by a noncontracting provider upon payment, in whole or in part, of the claim or claims of those noncontracting providers.

(e) Fifth, claims of health care service plan group contract holders for reimbursement for services rendered by noncontracting providers to subscribers and enrollees under the group contract.

(f) Sixth, any and all claims, including all officers' and directors' claims for indemnity, arising against the estate of the dissolved health care service plan.

HISTORY:
Added Stats 1985 ch 908 § 6.

§ 1394.3. Applicable law in involuntary dissolution actions

Except as provided for in Section 1394.1, and 1394.2, the involuntary dissolution of a health care service plan shall be in accordance with either of the following:

(a) Chapter 18 (commencing with Section 1800) of Division 1 of Title 1 of the Corporations Code, if the plan is incorporated under the General Corporation Law.

(b) Chapter 15 (commencing with Section 8510) of Part 3 of Division 2 of Title 1 of the Corporations Code if the plan is incorporated under the Nonprofit Corporation Law.

HISTORY:
Added Stats 1985 ch 908 § 7. Amended Stats 1999 ch 525 § 146 (AB 78), operative July 1, 2000.

ARTICLE 8.5

Service of Process

Section
1394.5. Methods of service.
1394.7. Definitions; Insolvency of health care service plan.
1394.8. Definitions; Insolvency of specialized health care service plan.

HISTORY: Added Stats 1989 ch 845 § 4.

§ 1394.5. Methods of service

When any person, including any nonresident of this state, engages in conduct prohibited or made actionable by this chapter or any rule, regulation, or order adopted hereunder, whether or not the person has filed a power of attorney under subdivision (j) of Section 1351, and personal jurisdiction over the person cannot otherwise be obtained in this state, that conduct shall be considered equivalent to the appointment of the director or the director's successor in office to be the attorney in fact to receive any lawful process in any noncriminal suit, action, or proceeding against the person or the person's successor, executor, or administrator which arises out of that conduct and which is brought under this chapter or any rule, regulation, or order adopted hereunder, with the same force and validity as if personally served. Service may be made by leaving a copy of the process in the office of the director, but it is not effective unless the plaintiff or petitioner, who may be the director in a suit, action, or proceeding instituted by him or her, forthwith sends notice of the service and a copy of the process by registered or certified mail to the defendant or respondent at his or her last known address or takes other steps which are reasonably calculated to give actual notice, and in a court action, an affidavit of compliance with this section is filed in the case on or before the return day of the process, if any, or within such further time as the court allows. In the case of administrative orders issued by the director, the affidavit of compliance need not be filed with the administrative tribunal unless the respondent requests a hearing.

HISTORY:
Added Stats 1989 ch 845 § 4. Amended Stats 1999 ch 525 § 147 (AB 78), operative July 1, 2000.

§ 1394.7. Definitions; Insolvency of health care service plan

(a) As used in this section the following definitions shall apply:

(1) "Health care service plan" means any plan as defined in Section 1345, but this section does not apply to specialized health care service contracts.

(2) "Carrier" means a health care service plan, an insurer issuing group disability coverage which covers hospital, medical, or surgical expenses, a nonprofit hospital service plan, or any other entity responsible for either the payment of benefits or the provision of hospital, medical, and surgical benefits under a group contract.

(3) "Insolvency" means that the director has determined that the health

care service plan is not financially able to provide health care services to its enrollees and (A) the director has taken an action pursuant to Section 1386, 1391, or 1399, or (B) an order requested by the director or the Attorney General has been issued by the superior court under Section 1392, 1393, or 1394.1.

(b) In the event of the insolvency of a health care service plan and upon order of the director, any health care service plan which the director determines to have sufficient health care delivery resources and sufficient financial and administrative capacity and that participated in the enrollment process with the insolvent health care service plan at the last regular open enrollment period of a group shall offer enrollees of the group in the insolvent health care service plan a 30-day enrollment period commencing upon the date specified by the director. Each health care service plan shall offer enrollees of the group in the insolvent health care service plan the same coverages and rates that it offered to enrollees of the group at the last regular open enrollment period of the group. Coverage shall be effective upon receipt by the successor plan of an application for enrollment by or on behalf of a subscriber or enrollee of the insolvent plan. The director shall send a notice of the insolvency of a health care service plan to the Insurance Commissioner.

(c) If no other carrier had been offered to groups enrolled in the insolvent health care service plan, or if the director determines that the other carriers do not include a sufficient number of health care service plans that have adequate health care delivery resources or the financial or administrative capacity to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health care service plan, then the director shall allocate equitably the insolvent health care service plan's group contracts for the groups, except for Medi-Cal contracts made pursuant to Section 14200 of the Welfare and Institutions Code, among all health care service plans which operate within at least a portion of the service area of the insolvent health care service plan, taking into consideration the health care delivery resources and the financial and administrative capacity of each health care service plan. The director shall also have the authority to allocate equitably enrollees, except Medi-Cal enrollees, if he or she has been unable to successfully place them through the open enrollment procedure in subdivision (b). The director shall make every reasonable effort to allocate enrollees within 30 days of the insolvency of the plan, but not later than 45 days after insolvency. Each health care service plan to which a group or groups are so allocated shall offer the group or groups the health care service plan's coverage which is most similar to each group's coverage with the insolvent health care service plan, as determined by the director, at rates determined in accordance with the successor health care service plan's existing rating methodology. Coverage shall be effective upon the date specified by thedirector. Further, except to the extent benefits for any condition would have been reduced or excluded under the insolvent health care service plan's contract or policy, no provision in a successor health care service plan's contract of coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted on the effective date of the enrollee's assignment to the succeeding health care service plan shall be applied with respect to those enrollees validly covered under the insolvent health care service plan's contract or policy on the date of the assignment.

The State Department of Health Services shall have the authority to allocate Medi-Cal enrollees to other carriers with valid Medi-Cal contracts, which operate within the same service area of an insolvent Medi-Cal contractor and that have sufficient capacity to absorb the Medi-Cal enrollees allocated to them.

(d) The director shall also allocate equitably the insolvent health care service plan's nongroup enrollees among all health care service plans which operate within at least a portion of the service area of the insolvent health care service plan, taking into consideration the health care delivery resources or the financial and administrative capacity of each health care service plan. Each health care service plan to which nongroup enrollees are allocated shall offer the nongroup enrollees the health care service plan's most similar coverage for individual or conversion coverage, as determined by the director, taking into consideration his or her type of coverage in the insolvent health care service plan, at rates determined in accordance with the successor health care service plan's existing rating methodology. Coverage shall be effective upon the date specified by the director. Further, except to the extent benefits for any condition would have been reduced or excluded under the insolvent health care service plan's contract or policy, no provision in a successor health care service plan's contract of coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted on the effective date of the enrollee's assignment to the succeeding health care service plan shall be applied with respect to those enrollees validly covered under the insolvent health care service plan's contract or policy on the date of the assignment. Successor health care service plans which do not offer direct nongroup enrollment may aggregate all allocated nongroup enrollees into one group for rating and coverage purposes.

(e) Contracting providers shall continue to provide services to enrollees of an insolvent plan until the effective date of an enrollee's coverage in a successor plan selected pursuant to either open enrollment or the allocation process but in no event for the period exceeding that required by their contract or 45 days in the case of allocation, whichever is greater; or for a period exceeding that required by their contract or 30 days in the case of open enrollment, whichever is greater.

(f) The failure to comply with an order under this section shall constitute a violation of this section.

HISTORY:
Added Stats 1990 ch 1043 § 8 (SB 785). Amended Stats 1991 ch 422 § 3 (SB 244); Stats 1999 ch 525 § 148 (AB 78), operative July 1, 2000.

§ 1394.8. Definitions; Insolvency of specialized health care service plan

(a) As used in this section:

(1) "Carrier" means a specialized health care service plan, and any of the following entities which offer coverage comparable to the coverages offered by a specialized health care service plan: an insurer issuing group disability coverage; a nonprofit hospital service plan; or any other entity responsible for either the payment of benefits for or the provisions of services under a group contract.

(2) "Insolvency" means that the director has determined that the specialized health care service plan is not financially able to provide specialized health care services to its enrollees and (A) the director has taken an action pursuant to Section 1386, 1391, 1399, or (B) an order requested by the director or the Attorney General has been issued by the superior court under Sections 1392, 1393, or 1394.1.

(3) "Specialized health care service plan" means any plan authorized to issue only specialized health care service plan contracts as defined in Section 1345.

(b) In the event of the insolvency of a specialized health care service plan and upon order of the director, any specialized health care service plan which the director determines to have sufficient health care delivery resources and sufficient financial and administrative capacity and that participated in the enrollment process with the insolvent specialized health care service plan at the last regular open enrollment period of a group for the same type of specialized health care services shall offer enrollees of the group in the insolvent specialized health care service plan a 30-day enrollment period commencing upon the date specified by the director. Each specialized health care service plan shall offer enrollees of the group in the insolvent specialized health care service plan the same specialized coverage and rates that it offered to the enrollees of the group at its last regular open enrollment period. Coverage shall be effective upon receipt by the successor plan of an application for enrollment by or on behalf of a subscriber or enrollee of the insolvent plan. The director shall send a notice of the insolvency of a specialized health care service plan to the Insurance Commissioner.

(c) If no other carrier for the same type of specialized health care services had been offered to some groups enrolled in the insolvent specialized health care service plan, or if the director determines that the other carriers do not include a sufficient number of specified health care service plans which have adequate health care delivery resources or the financial and administrative capacity to assure that the specialized health care services will be available and accessible to all of the group enrollees of the insolvent specialized health care service plan, then the director shall allocate equitably the insolvent specialized health care service plan's group contracts for the groups among all specialized health care service plans which offer the same type of specialized health care services as the insolvent plan and which operate within at least a portion of the service area of the insolvent specialized health care service plan, taking into consideration the health care delivery resources and the financial and administrative capacity of each specialized health care service plan. The director shall also have the authority to allocate equitable enrollees if he or she has been unable to successfully place them through the open enrollment procedure in subdivision (b). The director shall make every reasonable effort to allocate enrollees within 30 days of the insolvency of the plan, but not later than 45 days after insolvency. Each specialized health care service plan to which a group or groups is so allocated shall offer such group or groups the specialized health care service plan's coverage which is most similar to each group's coverage with the insolvent specialized health care service plan as determined by the director, at rates determined in accordance with the successor specialized health care service plan's existing rating methodology.

Coverage shall be effective on a date specified by the director. Further, except to the extent benefits for any condition would have been reduced or excluded under the insolvent specialized health care service plan's contract or policy, no provision in a successor specialized health care service plan's contract of coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted on the effective date of the enrollee's assignment to the succeeding plan shall be applied with respect to those enrollees validly covered under the insolvent specialized health care service plan's contract or policy on the date of the assignment.

(d) The director shall also allocate equitably the insolvent specialized health care service plan's nongroup enrollees among all specialized health care services which offer the same type of specialized health care services as the insolvent plan and which operate within at least a portion of the insolvent specialized health care service plan's service area, taking into consideration the health care delivery resources and the financial and administrative capacity of each specialized health care service plan. Each specialized health care service plan to which nongroup enrollees are allocated shall offer the nongroup enrollees the health care service plan's most similar coverage for individual or conversion coverage, as determined by the director, taking into consideration his or her type of coverage in the insolvent specialized health care service plan at rates determined in accordance with the successor specialized health care service plan's existing rating methodology. Coverage shall be effective on the date specified by the director. Further, except to the extent benefits for any condition would have been reduced or excluded under the insolvent specialized health care service plan's contract or policy, no provision in a successor specialized health care service plan's contract of coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted on the effective date of the enrollee's assignment to the succeeding plan shall be applied with respect to those enrollees validly covered under the insolvent specialized health care service plan's contract or policy on the date of the assignment. Successor specialized health care service plans which do not offer direct nongroup enrollment may aggregate all allocated nongroup enrollees into one group for rating and coverage purposes.

(e) Contracting providers shall continue to provide services to enrollees of an insolvent plan until the effective date of an enrollee's coverage in a successor plan selected pursuant to either open enrollment or the allocation process but in no event for the period exceeding that required by their contract or 45 days in the case of allocation, whichever is greater; or for a period exceeding that required by their contract or 30 days in the case of open enrollment, whichever is greater.

(f) Failure to comply with an order pursuant to this section shall constitute a violation of this section.

HISTORY:

Added Stats 1990 ch 1043 § 9 (SB 785).

Amended Stats 1999 ch 525 § 149 (AB 78), operative July 1, 2000.

ARTICLE 9

Miscellaneous

Section
1395. Advertising; Contracts with licensed professionals; Offices; Misrepresentations by plan; Compliance by plan.
1395.5. Contract to restrict health care provider's advertising.
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§ 1395. Advertising; Contracts with licensed professionals; Offices; Misrepresentations by plan; Compliance by plan

(a) Notwithstanding Article 6 (commencing with Section 650) of Chapter 1 of Division 2 of the Business and Professions Code, any health care service plan or specialized health care service plan may, except as limited by this subdivision, solicit or advertise with regard to the cost of subscription or enrollment, facilities and services rendered, provided, however, Article 5 (commencing with Section 600) of Chapter 1 of Division 2 of the Business and Professions Code remains in effect. Any price advertisement shall be exact, without the use of such phrases as "as low as," "and up," "lowest prices" or words or phrases of similar import. Any advertisement that refers to services, or costs for the services, and that uses words of comparison must be based on verifiable data substantiating the comparison. Any health care service plan or specialized health care service plan so advertising shall be prepared to provide information sufficient to establish the accuracy of the comparison. Price advertising shall not be fraudulent, deceitful, or misleading, nor contain any offers of discounts, premiums, gifts, or bait of similar nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

(b) Plans licensed under this chapter shall not be deemed to be engaged in the practice of a profession, and may employ, or contract with, any professional licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code to deliver professional services. Employment by or a contract with a plan as a provider of professional services shall not constitute a ground for disciplinary action against a health professional licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code by a licensing agency regulating a particular health care profession.

(c) A health care service plan licensed under this chapter may directly own, and may directly operate through its professional employees or contracted licensed professionals, offices and subsidiary corporations, including pharmacies that satisfy the requirements of subdivision (d) of Section 4080.5 of the Business and Professions Code, as are necessary to provide health care services to the plan's subscribers and enrollees.

(d) A professional licensed pursuant to the provisions of Division 2 (commencing with Section 500) of the Business and Professions Code who is employed by, or under contract to, a plan may not own or control offices or branch offices beyond those expressly permitted by the provisions of the Business and Professions Code.

(e) Nothing in this chapter shall be construed to repeal, abolish, or diminish the effect of Section 129450 of the Health and Safety Code.

(f) Except as specifically provided in this chapter, nothing in this chapter shall be construed to limit the effect of the laws governing professional corporations, as they appear in applicable provisions of the Business and Professions Code, upon specialized health care service plans.

(g) No representative of a participating health, dental, or vision plan or its subcontractor representative shall in any manner use false or misleading claims to misrepresent itself, the plan, the subcontractor, or the Healthy Families or Medi-Cal program while engaging in application assistance activities that are subject to this section. Notwithstanding any other provision of this chapter, any representative of the health, dental, or vision care plan or of the health, dental, or vision care plan's subcontractor who violates any of the provisions of Section 12693.325 of the Insurance Code shall only be subject to a fine of five hundred dollars ($500) for each of those violations.

(h) A health care service plan shall comply with Section 12693.325 of the Insurance Code and Section 14409 of the Welfare and Institutions Code. In addition to any other disciplinary powers provided by this chapter, if a health care service plan violates any of the provisions of Section 12693.325 of the Insurance Code, the department may prohibit the health care service plan from providing application assistance and contacting applicants pursuant to Section 12693.325 of the Insurance Code.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1980 ch 1167 § 1; Stats 1981 ch 798 § 2; Stats 1996 ch 1023 § 162 (SB 1497), effective September 29, 1996; Stats 2000 ch 93 § 9 (AB 2877), effective July 7, 2000; Stats 2001 ch 171 § 2 (AB 430), effective August 10, 2001.

§ 1395.5. Contract to restrict health care provider's advertising

(a) Except as provided in subdivisions (b) and (c), no contract that is issued, amended, renewed, or delivered on or after January 1, 1999, between a health care service plan, including a specialized health care service plan, and a provider shall contain provisions that prohibit, restrict, or limit the health care provider from advertising.

(b) Nothing in this section shall be construed to prohibit plans from establishing reasonable guidelines in connection with the activities regulated pursuant to this chapter, including those to prevent advertising that is, in whole or in part, untrue, misleading, deceptive, or otherwise inconsistent with this chapter or the rules and regulations promulgated thereunder. For adver-

tisements mentioning a provider's participation in a plan, nothing in this section shall be construed to prohibit plans from requiring each advertisement to contain a disclaimer to the effect that the provider's services may be covered for some, but not all, plan contracts, or that plan contracts may cover some, but not all, provider services.

(c) Nothing in this section is intended to prohibit provisions or agreements intended to protect service marks, trademarks, trade secrets, or other confidential information or property. If a health care provider participates on a provider panel or network as a result of a direct contractual arrangement with a health care service plan that, in turn, has entered into a direct contractual arrangement with another person or entity, pursuant to which enrollees, subscribers, insureds, and other beneficiaries of that other person or entity may receive covered services from the health care provider, then nothing in this section is intended to prohibit reasonable provisions or agreements in the direct contractual arrangement between the health care provider and the health care service plan that protect the name or trade name of the other person or entity or require that the health care provider obtain the consent of the health care service plan prior to the use of the name or trade name of the other person or entity in any advertising by the health care provider.

(d) Nothing in this section shall be construed to impair or impede the authority of the director to regulate advertising, disclosure, or solicitation pursuant to this chapter.

HISTORY:
Added Stats 1998 ch 523 § 3 (SB 1951).
Amended Stats 1999 ch 525 § 150 (AB 78), operative July 1, 2000.

§ 1395.6. Disclosure relating to health care provider's participation in network; Disclosures by contracting agent conveying its list of contracted health care providers and reimbursement rates; Election by provider to be excluded from list; Demonstration by payor of entitlement to pay contracted rate

(a) In order to prevent the improper selling, leasing, or transferring of a health care provider's contract, it is the intent of the Legislature that every arrangement that results in a payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel shall be disclosed to the provider in advance and that the payor shall actively encourage beneficiaries to use the network, unless the health care provider agrees to provide discounts without that active encouragement.

(b) Beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor, as defined in subparagraph (A) of paragraph (3) of subdivision (d), or another contracting agent shall, upon entering or renewing a provider contract, do all of the following:

(1) Disclose to the provider whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents, and specify whether those payors or contracting agents include workers' compensation insurers or automobile insurers.

(2) Disclose what specific practices, if any, payors utilize to actively encourage a payor's beneficiaries to use the list of contracted providers when

obtaining medical care that entitles a payor to claim a contracted rate. For purposes of this paragraph, a payor is deemed to have actively encouraged its beneficiaries to use the list of contracted providers if one of the following occurs:

(A) The payor's contract with subscribers or insureds offers beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information to its beneficiaries, who are parties to the contract, or, in the case of workers' compensation insurance, the employer, advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to beneficiaries in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or Internet web site addresses supplied directly to every beneficiary. However, internet web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of a beneficiary.

(3) Disclose whether payors to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the payors' beneficiaries to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.

(4) Disclose, upon the initial signing of a contract, and within 30 calendar days of receipt of a written request from a provider or provider panel, a payor summary of all payors currently eligible to claim a provider's contracted rate due to the provider's and payor's respective written agreement with any contracting agent.

(5) Allow providers, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care as described in paragraph (2). Each provider's election under this paragraph shall be binding on the contracting agent with which the provider has the contract and any contracting agent that buys, leases, or otherwise obtains the list of contracted providers. A provider shall not be excluded from any list of contracted providers that is sold, leased, transferred, or conveyed to payors that actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care, based upon the provider's refusal to be included on any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care.

(6) Nothing in this subdivision shall be construed to impose requirements or regulations upon payors, as defined in subparagraph (A) of paragraph (3) of subdivision (d).

(c) Beginning July 1, 2000, a payor, as defined in subparagraph (B) of paragraph (3) of subdivision (d), shall do all of the following:

(1) Provide an explanation of benefits or explanation of review that identifies the name of the network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered.

(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. The failure of a payor to make the demonstration within 30 business days shall render the payor responsible for the amount that the payor would have been required to pay pursuant to the applicable health care service plan contract, including a specialized health care service plan contract, covering the beneficiary, which amount shall be due and payable within 10 business days of receipt of written notice from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this paragraph. A payor shall be deemed to have demonstrated that it is entitled to pay a contracted rate if it complies with either of the following:

(A) Discloses the name of the network that has a written agreement with the provider whereby the provider agrees to accept discounted rates, and describes the specific practices the payor utilizes to comply with paragraph (2) of subdivision (b).

(B) Identifies the provider's written agreement with a contracting agent whereby the provider agrees to be included on lists of contracted providers sold, leased, transferred, or conveyed to payors that do not actively encourage beneficiaries to use the list of contracted providers pursuant to paragraph (5) of subdivision (b).

(d) For the purposes of this section, the following terms have the following meanings:

(1) "Beneficiary" means:

(A) For workers' compensation insurance, an employee seeking health care services for a work-related injury.

(B) For automobile insurance, those persons covered under the medical payments portion of the insurance contract.

(C) For group or individual health services covered through a health care service plan contract, including a specialized health care service plan contract, or a policy of disability insurance that covers hospital, medical, or surgical benefits, a subscriber, an enrollee, a policyholder, or an insured.

(2) "Contracting agent" means a health care service plan, including a specialized health care service plan, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying, a provider or provider panel to payors to provide health care services to beneficiaries.

(3)(A) For the purposes of subdivision (b), "payor" means a health care service plan, including a specialized health care service plan, an insurer

licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries.

(B) For the purposes of subdivision (c), "payor" means only a health care service plan, including a specialized health care service plan that has purchased, leased, or otherwise obtained the use of a provider or provider panel to provide health care services to beneficiaries pursuant to a contract that authorizes payment at discounted rates.

(4) "Payor summary" means a written summary that includes the payor's name and the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan.

(5) "Provider" means any of the following:

(A) Any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) Any person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) Any person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200).

(E) Any entity exempt from licensure pursuant to Section 1206.

(e) This section shall become operative on July 1, 2000.

HISTORY:
Added Stats 1999 ch 545 § 2 (SB 559), operative July 1, 2000. Amended Stats 2000 ch 1067 § 16 (SB 2094), ch 1069 § 2 (SB 1732).

§ 1395.7. Staff-model dental health care service plan; Compliance with policies and procedures

(a) A staff-model dental health care service plan that arranges for or establishes credit extended by a third party shall establish and comply with policies and procedures that ensure that its dentists, employees, and agents, and employees or agents of its dentists, comply with Section 654.3 of the Business and Professions Code.

(b) A staff-model dental health care service plan that arranges for or establishes credit extended by a third party shall establish and comply with policies and procedures that ensure that, within 15 business days of an enrollee's request, the plan refunds to a lender any payment received through that credit for treatment that has not been rendered or costs that have not been incurred.

(c) A staff-model dental health care service plan that directly extends credit or establishes a payment plan shall, at a minimum, establish and comply with policies and procedures that ensure that, within 15 business days of an enrollee's request, the plan refunds to the enrollee any payment received through that credit or payment plan for treatment that has not been rendered or costs that have not been incurred.

(d) For purposes of this section, the following definitions shall apply:

(1) "Staff-model dental health care service plan" means a specialized health care service plan that contracts to provide coverage for dental care services and that retains dentists as employees to care for its enrollees.

(2) "Enrollee" includes, but is not limited to, an enrollee's parent or other legal representative.

HISTORY:
Added Stats 2009 ch 418 § 2 (AB 171), effective January 1, 2010.

§ 1396. Misstatements or omissions in documents filed

It is unlawful for any person willfully to make any untrue statement of material fact in any application, notice, amendment, report, or other submission filed with the director under this chapter or the regulations adopted thereunder, or willfully to omit to state in any application, notice, or report any material fact which is required to be stated therein.

HISTORY:
Added Stats 1989 ch 845 § 5. Amended Stats 1999 ch 525 § 151 (AB 78), operative July 1, 2000.

§ 1396.5. Privileges of nonprofit hospital corporations which indemnified subscribers

A nonprofit hospital corporation which substantially indemnified subscribers and enrollees and was operating in 1965 under Chapter 11A (commencing with Section 11490) of Part 2 of Division 2 of the Insurance Code and which is regulated under the Knox-Keene Health Care Service Plan Act shall enjoy the privileges under the act which would have been available to it had it been registered under the Knox-Mills Health Plan Act and applied for a license under the Knox-Keene Health Care Service Plan Act in 1976.

HISTORY:
Added Stats 1990 ch 1043 § 10 (SB 785).

§ 1397. Hearings; Judicial review

(a) Whenever reference is made in this chapter to a hearing before or by the director, the hearing shall be held in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and the director shall have all of the powers granted under that act.

(b) Every final order, decision, license, or other official act of the director under this chapter is subject to judicial review in accordance with the law.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1985 ch 106 § 80; Stats 1991 ch 1091 § 70 (AB 1487); Stats 1999 ch 525 § 152 (AB 78), operative July 1, 2000.

§ 1397.5. Summary of complaints against plans

(a) The director shall make and file annually with the Department of Managed Health Care as a public record, an aggregate summary of grievances against plans filed with the director by enrollees or subscribers. This summary shall include at least all of the following information:

(1) The total number of grievances filed.

(2) The types of grievances.

(b) The summary set forth in subdivision (a) shall include the following disclaimer: THIS INFORMATION IS PROVIDED FOR STATISTICAL PURPOSES ONLY. THE DIRECTOR OF THE DEPARTMENT OF MANAGED CARE HAS NEITHER INVESTIGATED NOR DETERMINED WHETHER THE GRIEVANCES COMPILED WITHIN THIS SUMMARY ARE REASONABLE OR VALID.

(c) Nothing in this section shall require or authorize the disclosure of grievances filed with or received by the director and made confidential pursuant to any other provision of law including, but not limited to, the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code). Nothing in this section shall affect any other provision of law including, but not limited to, the California Public Records Act and the Information Practices Act of 1977.

HISTORY:
Added Stats 1994 ch 614 § 8 (SB 1832). Amended Stats 1999 ch 525 § 153 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 46 (AB 2903).

§ 1397.6. Contracts with medical consultants

The director may contract with necessary medical consultants to assist with the health care program. These contracts shall be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

HISTORY:
Added Stats 1995 ch 788 § 3 (SB 454). Amended Stats 1999 ch 525 § 154 (AB 78), operative July 1, 2000.

§ 1398. [Section repealed 2000.]

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1999 ch 525 § 155 (AB 78), operative July 1, 2000. Repealed Stats 2000 ch 857 § 47 (AB 2903). The repealed section related to participation by department employees.

§ 1398.5. References to prior law

All references to the Knox-Mills Health Plan Act (Article 2.5 (commencing with Section 12530) of Chapter 6 of Part 2 of Division 3 of the Government Code), which was repealed by Chapter 941 of the Statutes of 1975, shall be deemed to be references to the Knox-Keene Health Care Service Plan Act of 1975.

HISTORY:
Added Stats 1976 ch 490 § 1.

§ 1399. Surrender of license; Summary suspension or revocation of license

(a) Surrender of a license as a health plan becomes effective 30 days after receipt of an application to surrender the license or within a shorter period of time as the director may determine, unless a revocation or suspension

proceeding is pending when the application is filed or a proceeding to revoke or suspend or to impose conditions upon the surrender is instituted within 30 days after the application is filed. If this proceeding is pending or instituted, surrender becomes effective at the time and upon the conditions as the director by order determines.

(b) If the director finds that any plan is no longer in existence, or has ceased to do business or has failed to initiate business activity as a licensee within six months after licensure, or cannot be located after reasonable search, the director may by order summarily revoke the license of the plan.

(c) The director may summarily suspend or revoke the license of a plan upon (1) failure to pay any fee required by this chapter within 15 days after notice by the director that the fee is due and unpaid, (2) failure to file any amendment or report required under this chapter within 15 days after notice by the director that the report is due, (3) failure to maintain any bond or insurance pursuant to Section 1376, (4) failure to maintain a deposit, insurance, or guaranty arrangement pursuant to Section 1377, or (5) failure to maintain a deposit pursuant to Section 1300.76.1 of Title 28 of the California Code of Regulations.

HISTORY:

Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1977 ch 818 § 19, effective September 16, 1977; Stats 1982 ch 99 § 2, effective March 6, 1982; Stats 1989 ch 845 § 6; Stats 1993 ch 735 § 4 (AB 2079); Stats 1999 ch 525 § 156 (AB 78), operative July 1, 2000; Stats 2009 ch 298 § 9 (AB 1540), effective January 1, 2010; Amended Stats 2009 ch 298 § 9 (AB 1540), effective January 1, 2010.

§ 1399.1. Administrative actions applicable to transitionally licensed plans

(a) All orders and other actions taken by the Commissioner of Corporations pursuant to the authority contained in subdivision (c) of Section 1350 on or before September 30, 1977, and all administrative or judicial decisions or orders relating to the same and all conditions imposed upon the same remain in effect against a plan holding a transitional license.

(b) The Knox-Mills Health Plan Act as in effect prior to its repeal continues to govern all suits, actions, prosecutions or proceedings which are pending or which may be initiated under subdivision (c) of Section 1350 on the basis of facts or circumstances occurring on or before September 30, 1977.

HISTORY:

Added Stats 1977 ch 818 § 19, effective September 16, 1977. Amended Stats 1999 ch 525 § 157 (AB 78), operative July 1, 2000.

§ 1399.3. Material change to contract effective upon delivery of notice by health care service plan to solicitor

(a) A material change made by a health care service plan, as defined in subdivision (f) of Section 1345, to the terms and conditions of a contract between the health care service plan and a solicitor shall not become effective until the health care service plan has delivered to the solicitor, at least 45 days prior to the effective date of the change, written or electronic notice indicating the change or changes to the contract. For purposes of this section, a "material change" is a change made to a provision of the contract affecting any of the following:

(1) Commissions, bonuses, and incentives paid to the solicitor.
(2) Right of survivorship.
(3) Indemnification of the solicitor by the health care service plan.
(4) Errors and omissions coverage requirements for the solicitor.

(b) Subdivision (a) shall not apply under either of the following circumstances:

(1) The change to the contract is mutually agreed upon by the health care service plan and the solicitor.
(2) The change to the contract is required by state or federal law.

HISTORY:
Added Stats 2015 ch 482 (AB 1163), effective January 1, 2016.

§ 1399.5. Legislative intent; Application of chapter

It is the intent of the Legislature that the provisions of this chapter shall be applicable to any private or public entity or political subdivision which, in return for a prepaid or periodic charge paid by or on behalf of a subscriber or enrollee, provides, administers or otherwise arranges for the provision of health care services, as defined in this chapter, unless such entity is exempted from the provisions of this chapter by, or pursuant to, Section 1343.

HISTORY:
Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1980 ch 628 § 4.

ARTICLE 9.5

Claims Reviewers

Section
1399.55. Disclosure of rationale for rejection of claim from health care provider or patient.
1399.56. Compensation of person retained to review claims for health care services.
1399.57. Application of article to Medi-Cal services or benefits.

HISTORY: Added Stats 1992 ch 544 § 1.

§ 1399.55. Disclosure of rationale for rejection of claim from health care provider or patient

Health care service plans shall, upon rejecting a claim from a health care provider or a patient, and upon their demand, disclose the specific rationale used in determining why the claim was rejected. Nothing in this section is intended to expand or restrict the ability of a health care provider or a patient from having health care coverage approved in advance of services.

HISTORY:
Added Stats 1992 ch 544 § 1 (AB 2083).

§ 1399.56. Compensation of person retained to review claims for health care services

Compensation of a person retained by a health care service plan to review claims for health care services shall not be based on either of the following:

(a) A percentage of the amount by which a claim is reduced for payment.

(b) The number of claims or the cost of services for which the person has denied authorization or payment.

HISTORY:
Added Stats 1992 ch 544 § 1 (AB 2083).
Amended Stats 1995 ch 787 § 2 (AB 73).

§ 1399.57. Application of article to Medi-Cal services or benefits

This article does not apply to services or benefits provided pursuant to Medi-Cal, including services or benefits provided under Chapters 7 (commencing with Section 14000) and 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

HISTORY:
Added Stats 1992 ch 544 § 1 (AB 2083).

ARTICLE 10

Discontinuance and Replacement of Group Health Care Service Plan Contracts

Section
1399.60. Application.
1399.61. Definitions.
1399.62. Extension of benefits.
1399.63. Required coverage following discontinuance of prior contract or policy.
1399.64. Compliance requirement.

HISTORY: Added Stats 1977 ch 64 § 2, effective May 18, 1977.

§ 1399.60. Application

The provisions of this article shall apply to all group health care service contracts issued in this state pursuant to this chapter.

HISTORY:
Added Stats 1977 ch 64 § 2, effective May 18, 1977.

§ 1399.61. Definitions

In this article, unless the context otherwise requires:

(a) "Carrier" shall mean the health care service plan or other entity responsible for the payment of benefits or provision of services under a group contract.

(b) "Dependent" shall have the meaning set forth in a contract.

(c) "Discontinuance" shall mean the termination of the contract between the entire employer unit under a contract and the health care service plan, and does not refer to the termination of any agreement between any individual member under a contract and the health care service plan.

(d) "Employee" shall mean all agents, employees, and members of unions or associations to whom benefits are provided under a contract.

(e) "Extension of benefits" shall mean the continuation of coverage under

a particular benefit provided under a contract following discontinuance with respect to an employee or dependent who is totally disabled on the date of discontinuance.

(f) "Contract" shall mean any group health care service plan or contract subject to the provisions of this article.

(g) "Contractholder" shall mean the entity to which a contract is issued.

(h) "Dues" shall mean the consideration payable to the carrier.

(i) "Replacement coverage" shall mean the benefits provided by a succeeding carrier.

(j) "Totally disabled" shall have the meaning set forth in a contract.

HISTORY:
Added Stats 1977 ch 64 § 2, effective May 18, 1977. Amended Stats 1983 ch 126 § 1.

§ 1399.62. Extension of benefits

(a) Every contract containing hospital, medical, or surgical expense benefits or service benefits shall contain a reasonable extension of such benefits upon discontinuance of the contract with respect to employees or dependents who become totally disabled while enrolled under the contract on or after the date this article becomes applicable to such contract and who continue to be totally disabled at the date of discontinuance of the contract.

(b) Every contract providing hospital, medical or surgical expense benefits or service benefits shall be deemed to include a reasonable extension of such benefits upon discontinuance of the contract if it provides benefits for covered services directly relating to the condition causing total disability existing at the time dues payments cease for the employee or dependent and incurred during a period of not less than 12 months thereafter, which period shall not be interrupted by discontinuance of the contract.

That extension of benefits may be terminated at such time as the employee or dependent is no longer totally disabled or at such time as a succeeding carrier may elect to provide replacement coverage to that employee or dependent without limitation as to the disabling condition.

(c) The services provided during any extension of benefits may be subject to all limitations or restrictions contained in the contract.

HISTORY:
Added Stats 1977 ch 64 § 2, effective May 18, 1977. Amended Stats 1983 ch 888 § 1.

§ 1399.63. Required coverage following discontinuance of prior contract or policy

(a) Any carrier providing replacement coverage with respect to hospital, medical or surgical expense or service benefits within a period of 60 days from the date of discontinuance of a prior contract or policy providing such hospital, medical or surgical expense or service benefits shall immediately cover all employees and dependents who were validly covered under the previous contract or policy at the date of discontinuance, including all former employees entitled to continuation coverage under Section 1373.621, who are within the definitions of eligibility under the succeeding carrier's contract and who would

otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active full-time employment or hospital confinement or pregnancy. However, with respect to employees or dependents who are totally disabled on the date of discontinuance of the prior carrier's contract or policy and entitled to an extension of benefits pursuant to subdivision (b) of Section 1399.62, or pursuant to subdivision (d) of Section 10128.2 of the Insurance Code, the succeeding carrier is not required to provide benefits for services or expenses directly related to any conditions which caused the total disability.

(b) Except as otherwise provided in subdivision (a), until an employee or dependent entitled to coverage under a succeeding carrier's contract pursuant to subdivision (a) of this section qualifies for full benefits by meeting all effective date requirements of the succeeding carrier's contract, the level of benefits shall not be lower than the benefits provided under the prior carrier's contract or policy reduced by the amount of benefits paid by the prior carrier. Such employee or dependent shall continue to be covered by the succeeding carrier until the earlier of the following dates:

(1) The date coverage would terminate for an employee or dependent in accordance with the provisions of the succeeding carrier's contract, or

(2) In the case of an employee or dependent who was totally disabled on the date of discontinuance of the prior carrier's contract or policy and entitled to an extension of benefits pursuant to subdivision (d) of Section 10128.2 of the Insurance Code or subdivision (b) of Section 1399. 62, the date the period of extension of benefits terminates or, if the prior carrier's contract or policy is not subject to this article, the date to which benefits would have been extended had the prior carrier's contract or policy been subject to this article.

(c) Except as otherwise provided in this section, and except to the extent that benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those employees, former employees entitled to continuation coverage under Section 1373.621, and dependents validly covered under the prior carrier's contract or policy on the date of discontinuance.

(d) In a situation where a determination of the prior carrier' s benefit is required by the succeeding carrier, at the succeeding carrier's request, the prior carrier shall furnish a statement of benefits available or pertinent information, sufficient to permit verification of the benefit determination by the succeeding carrier.

(e) For purposes of subdivision (a), a succeeding carrier's coverage shall not exclude any dependent child who was covered by the previous carrier solely because the plan member does not provide the primary support for that dependent child.

(f) Except to the extent that benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in the succeeding carrier's contract, where an employee changes carriers due to a change in employment or other circumstances, that would operate to reduce or

exclude benefits for the following congenital craniofacial anomalies: cleft lip and palate (as defined in ICD–9–CM Diagnosis Code 749, International Classification of Diseases, 9th Revision, Clinical Modification, Volume 1, Second Edition, September, 1980), acrocephalosyndactyly (as defined in ICD–9–CM Diagnosis Code 755.55, cranio only), and other congenital musculoskeletal anomalies (as defined in ICD–9–CM Diagnosis Code 756.0), on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract, shall be applied to those employees, former employees entitled to continuation coverage under Section 1373.621, and dependents validly covered under the prior carrier's contract or policy on the date the prior contract or policy terminated when payment or services had been commenced by the previous carrier. That succeeding coverage shall otherwise be subject to all other provisions of the contract between the insured and the succeeding carrier. Nothing in this subdivision shall be construed to limit or otherwise affect any obligation of a succeeding carrier to provide benefits for a condition not specified in this subdivision, where expressly or impliedly required by other provisions of this chapter; this subdivision is not intended to affect the construction of the language of any other provision of this chapter.

HISTORY:
Added Stats 1977 ch 64 § 2, effective May 18, 1977. Amended Stats 1983 ch 888 § 2; Stats 1986 ch 476 § 1; Stats 1991 ch 685 § 1 (SB 761); Stats 1995 ch 489 § 2 (SB 761).

§ 1399.64. Compliance requirement

This article shall apply to all contracts issued, delivered, amended, or renewed in this state after January 1, 1977. A policy subject to the provisions of this article which is issued, delivered, amended as to benefits, or renewed in this state on or after the effective date of amendments to this article made at the 1977-1978 Regular Session of the Legislature shall be construed to be in compliance with the provisions of this article and such amendments to this article.

HISTORY:
Added Stats 1977 ch 64 § 2, effective May 18, 1977.

ARTICLE 10.2

Mergers and Acquisitions of Health Care Service Plans

Section
1399.65. Mergers, consolidation or acquisition of health care service plans; Requirements.
1399.66. Reimbursement of costs from health care provider to director [Effective until January 1, 2020].
1399.66. Material modifications fees; Reimbursement of costs from health care service plan to director [Effective January 1, 2020].

§ 1399.65. Mergers, consolidation or acquisition of health care service plans; Requirements

(a)(1) A health care service plan that intends to merge or consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control

by, any entity, including another health care service plan or a health insurer licensed under the Insurance Code, shall give notice to, and secure prior approval from, the director.

(2) The transactions or agreements described in paragraph (1) may not be completed until the director approves the transaction or agreement.

(3) A health care service plan described in paragraph (1) shall meet all of the requirements of this chapter. The health care service plan shall file all the information necessary for the director to make the determination to approve, conditionally approve, or disapprove the transaction or agreement described in paragraph (1), including, but not limited to, a complete description of the proposed transaction or agreement, any modified exhibits for plan licensure pursuant to Section 1351, any approvals by federal or other state agencies required for the transaction or agreement, and any supporting documentation required by the director.

(4) The director may conditionally approve the transaction or agreement, contingent upon the health care service plan's agreement to fulfill one or more conditions to benefit subscribers and enrollees of the health care service plan, provide for a stable health care delivery system, and impose other conditions specific to the transaction or agreement in furtherance of this chapter. The director shall engage stakeholders in determining the measures for improvement. For a major transaction or agreement, the director shall obtain an independent analysis of the impact of the transaction or agreement on subscribers and enrollees, the stability of the health care delivery system, and other relevant provisions of this chapter. For any other transaction or agreement, the director may obtain an independent analysis consistent with this paragraph.

(5) If an entity involved in the transaction or agreement is a nonprofit corporation described in Section 5046 of the Corporations Code, the health care service plan shall file all the information required by Article 11 (commencing with Section 1399.70).

(b) In addition to any grounds for disapproval as a result of information provided by a health care service plan pursuant to paragraph (3) of subdivision (a), the director may disapprove the transaction or agreement if the director finds the transaction or agreement would substantially lessen competition in health care service plan products or create a monopoly in this state, including, but not limited to, health coverage products for a specific line of business. In making this finding, the director may obtain an opinion from a consultant or consultants with the expertise to assess the competitive impact of the transaction or agreement.

(c) Prior to approving, conditionally approving, or disapproving a major transaction or agreement, the department shall hold a public meeting on the proposed transaction or agreement. For any other transaction or agreement, the department may hold a public meeting on the proposed transaction or agreement. The public meeting shall be conducted pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code). The meeting shall permit the parties to the proposed transaction and members of the public to provide written and verbal comments regarding the proposed transaction. If a substantive change in the proposed transaction or agreement

is submitted to the director after the initial public meeting, the director may conduct an additional public meeting to hear comments from interested parties with respect to that change. The director shall consider the testimony and comments received at the public meeting in making the determination to approve, conditionally approve, or disapprove the transaction or agreement.

(d) If the director determines a material amount of assets of a health care service plan is subject to purchase, acquisition, or control, the director shall prepare a statement describing the proposed transaction or agreement subject to subdivision (a) and make it available to the public. The statement shall be made available before the public meeting.

(e) This section does not limit the authority of the director to enforce any other provision of this chapter.

(f) For purposes of this section, "entity" means a health care service plan, an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a business trust, an unincorporated organization, any similar entity, or any combination thereof acting in concert.

(g)(1) For purposes of this section, "major transaction or agreement" means a transaction or agreement that meets any of the following criteria:

(A) Affects a significant number of enrollees.

(B) Involves a material amount of assets.

(C) Adversely affects either the subscribers or enrollees or the stability of the health care delivery system because of the entity's market position, including, but not limited to, the entity's market exit from a market segment or the entity's dominance of a market segment.

(2) The director shall, upon request, make available to the public his or her determination of whether a transaction or agreement meets the criteria set forth in this subdivision.

HISTORY:
Added Stats 2018 ch 292 § 1 (AB 595), effective January 1, 2019.

§ 1399.66. Reimbursement of costs from health care provider to director [Effective until January 1, 2020]

(a) Notwithstanding subdivision (d) of Section 1352, a health care service plan that files a material modification that is a transaction or agreement described in subdivision (a) of Section 1399.65 shall be subject to the same fees required by subdivision (a) of Section 1356.

(b)(1) In addition to paying the fees described in subdivision (a), the health care service plan shall reimburse the director for the reasonable costs of all of the following:

(A) The independent analysis described in paragraph (4) of subdivision (a) of Section 1399.65.

(B) The opinion described in subdivision (b) of Section 1399.65.

(C) The public meeting described in subdivision (c)

(D) The statement described in subdivision (d) of Section 1399.65.

(2) The reimbursement required by this subdivision shall be irrespective of the director's approval, conditional approval, or disapproval of the transaction or agreement described in subdivision (a) of Section 1399.65.

(3) If a transaction described in subdivision (a) of Section 1399.65 involves

two health care service plans, the director shall determine whether the reimbursement requirements of this subdivision apply to one or both of the plans.

HISTORY:
Added Stats 2018 ch 292 § 1 (AB 595), effective January 1, 2019.

§ 1399.66. Material modifications fees; Reimbursement of costs from health care service plan to director [Effective January 1, 2020]

(a) Notwithstanding subdivision (d) of Section 1352, a health care service plan that files a material modification that is a transaction or agreement described in subdivision (a) of Section 1399.65 shall be subject to the same fees required by subdivision (a) of Section 1356.

(b)(1) In addition to paying the fees described in subdivision (a), the health care service plan shall reimburse the director for the reasonable costs of all of the following:

(A) The independent analysis described in paragraph (4) of subdivision (a) of Section 1399.65.

(B) The opinion described in subdivision (b) of Section 1399.65.

(C) The public meeting described in subdivision (c) of Section 1399.65.

(D) The statement described in subdivision (d) of Section 1399.65.

(2) The reimbursement required by this subdivision shall be irrespective of the director's approval, conditional approval, or disapproval of the transaction or agreement described in subdivision (a) of Section 1399.65.

(3) If a transaction described in subdivision (a) of Section 1399.65 involves two health care service plans, the director shall determine whether the reimbursement requirements of this subdivision apply to one or both of the plans.

HISTORY:
Added Stats 2018 ch 292 § 1 (AB 595), effective January 1, 2019. Amended Stats 2019 ch 497 § 152 (AB 991), effective January 1, 2020.

ARTICLE 10.5

Individual Access to Contracts for Health Care Services [Renumbered.]

HISTORY: Article 10.5, consisting of §§ 1399.801–1399.818, was added Stats 2000 ch 810 § 2. Renumbered Article 11.5 by Stats 2001 ch 159 § 126.

ARTICLE 11

Nonprofit Plans

Section
1399.70. Submission of copy of articles of incorporation; Report.
1399.71. Submission of public benefit program.
1399.72. Approval for conversion from nonprofit to for-profit status.
1399.73. Contents of application; Fee; Contracts for review.
1399.74. Adoption of regulations; Notice; Public records; Public hearing.
1399.75. Application of article.
1399.76. Exceptions.

HISTORY: Added Stats 1995 ch 792 § 1.

§ 1399.70. Submission of copy of articles of incorporation; Report

(a) In addition to the information required by subdivision (a) of Section 1399.73, a nonprofit health care service plan submitting an application to the director to restructure or convert its activities pursuant to this article shall submit to the director a copy of all of its original and amended articles of incorporation and bylaws, as well as a report summarizing the activities undertaken by the plan to meet its nonprofit obligations as directed by the director.

(b) The report required by this section shall include a summary of the following:

(1) The nature of public benefit or charitable activities undertaken by the plan.

(2) The expenditures incurred by the plan on these public benefit or charitable activities.

(3) The plan's procedure for avoiding conflicts of interest involving public benefit or charitable activities and a summary of any conflicts that have occurred and the manner in which they were resolved.

(c) The report required by this section shall also include a written plan that specifies on a projected basis the information required by subdivision (b) for the immediately following fiscal year.

(d) When requested by the director, the plan shall promptly supplement the report to include any additional information as the director deems necessary to ascertain whether the plan's assets are appropriately being used by the plan to meet its nonprofit obligations.

(e) For purposes of this article, a "nonprofit health care service plan" includes a plan formed under or subject to Part 2 (commencing with Section 5110) or Part 3 (commencing with Section 7110) of Division 2 of the Corporations Code.

HISTORY:
Added Stats 1995 ch 792 § 1 (SB 445).
Amended Stats 1999 ch 525 § 158 (AB 78), operative July 1, 2000.

§ 1399.71. Submission of public benefit program

(a) Any nonprofit health care service plan that intends to restructure its activities as defined in subdivision (d) shall, prior to restructuring, secure approval from the director.

(b) Every nonprofit health care service plan that applies to the department to restructure its activities shall submit for approval by the department a public benefit program that identifies activities to be undertaken by the nonprofit health care service plan following restructuring to continue to meet its nonprofit public benefit obligations. The program shall include all information required pursuant to subdivisions (b) and (c) of Section 1399.70.

(c) The director shall apply the requirements of Section 1399.72 to the public benefit program submitted for approval as part of a restructuring proposal submitted pursuant to subdivision (b) of this section. The set-aside requirement in paragraph (1) of subdivision (c) of Section 1399.72 shall apply only to

the fair value of the portion of the nonprofit health care service plan involved in the restructuring, as determined by the director.

(d)(1) For the purposes of this section, a "restructuring" or "restructure" by a nonprofit health care service plan means the sale, lease, conveyance, exchange, transfer, or other similar disposition of a substantial amount of a nonprofit health care service plan's assets, as determined by the director, to a business or entity carried on for profit. Nothing in this section shall be construed to prohibit the director from consolidating actions taken by a plan for the purpose of treating the consolidated actions as a restructuring or restructure of the plan.

(2) For the purposes of this section, a "restructuring" or "restructure" by a nonprofit health care service plan shall not include any sales or purchases undertaken in the normal and ordinary course of plan business. The director may request information from the plan to verify that transactions qualify as occurring in the normal and ordinary course of plan business, and are not subject to the requirements of subdivision (e).

(e) Notwithstanding that a transaction or consolidated transactions involve a substantial amount of a nonprofit health care service plan's assets and are not in the normal and ordinary course of plan business, a "restructuring" or "restructure" by a nonprofit health care service plan shall not include any of the following transactions:

(1) Investments in a wholly owned subsidiary of the nonprofit health care service plan in which all of the following occur:

(A) Any profit from the investment will not inure to the benefit of any individual.

(B) The investment is fundamentally consistent with and advances the public benefit, charitable, or mutual benefit purpose of the plan.

(C) The investment does not adversely impact the plan's ability to fulfill its public benefit, charitable, or mutual benefit purposes.

(D) No officer or director of the plan has any financial interest constituting a conflict of interest in the investments.

(E) The investment results in the provision of services, goods, or insurance to or for the benefit of the plan or its members, enrollees, or groups.

(2) Sales or purchases of plan assets, including interests in wholly owned subsidiaries and in joint ventures, partnerships, and other investments in for-profit entities, in which all of the following occur:

(A) Any profit from the sale will not inure to the benefit of any individual.

(B) The sale or purchase is fundamentally consistent with and advances the public benefit, charitable, or mutual benefit purposes of the plan.

(C) The plan receives all proceeds from the sale.

(D) No officer or director of the plan has any financial interest constituting a conflict of interest in the sale or purchase.

(E) The transaction is conducted at arm's length and for fair market value.

(F) The sale or purchase does not adversely impact the plan's ability to fulfill its public benefit, charitable, or mutual benefit purposes.

(3) Investments in or joint ventures and partnerships with a for-profit entity in which all of the following occur:

(A) Any profit will not inure to the benefit of any individual.

(B) The mission or purpose of the investment, joint venture, or partnership is fundamentally consistent with the public benefit, charitable, or mutual benefit purposes of the plan.

(C) No officer or director of the plan has any financial interest constituting a conflict of interest in the investment, joint venture, or partnership.

(D) The transaction is conducted at arm's length and for fair market value.

(E) The investment, joint venture, or partnership furthers the plan's ability to fulfill its public benefit, charitable, or mutual benefit purposes.

(F) The investment, joint venture, or partnership results in the provision of services, goods, or insurance to or for the benefit of the plan or its members, enrollees, or groups.

The sharing of profits or earnings upon a reasonable and equitable basis reflecting the contribution of other participants to the investment, joint venture, or partnership or the success thereof shall not constitute private inurement.

(f) All transactions subject to the exemptions listed in subdivision (e) may not be executed by the plan without the written prior approval of the director. In the application for material modification seeking approval, the plan shall demonstrate that the proposed transaction meets all of the relevant conditions for exemption required by subdivision (e).

(g) Prior to issuing a decision to approve an application for a material modification involving a transaction that is exempt pursuant to subdivision (e), the director shall issue a public notice of the filing of the application and may seek public review and comment on the director's determination that the transaction is exempt under subdivision (e).

(h) The director may approve or deny the material modification request, or approve the request with conditions necessary to satisfy the requirements of this section, taking into consideration any public comments submitted to the director.

HISTORY:
Added Stats 1995 ch 792 § 1 (SB 445). Amended Stats 1999 ch 525 § 159 (AB 78), operative July 1, 2000.

§ 1399.72. Approval for conversion from nonprofit to for-profit status

(a) Any health care service plan that intends to convert from nonprofit to for-profit status, as defined in subdivision (b), shall, prior to the conversion, secure approval from the director.

(b) For the purposes of this section, a "conversion" or "convert" by a nonprofit health care service plan means the transformation of the plan from nonprofit to for-profit status, as determined by the director.

(c) Prior to approving a conversion, the director shall find that the conversion proposal meets all of the following charitable trust requirements:

(1) The fair market value of the nonprofit plan is set aside for appropriate charitable purposes. In determining fair market value, the director shall consider, but not be bound by, any market-based information available concerning the plan.

(2) The set-aside shall be dedicated and transferred to one or more

existing or new tax-exempt charitable organizations operating pursuant to Section 501(c)(3)(26 U.S.C.A. Sec. 501(c)(3)) of the federal Internal Revenue Code. The director shall consider requiring that a portion of the set-aside include equity ownership in the plan. Further, the director may authorize the use of a federal Internal Revenue Code Section501(c)(4) organization (26 U.S.C.A. Sec. 501(c)(4)) if, in the director's view, it is necessary to ensure effective management and monetization of equity ownership in the plan and if the plan agrees that the Section 501(c)(4) organization will be limited exclusively to these functions, that funds generated by the monetization shall be transferred to the Section 501(c)(3) organization except to the extent necessary to fund the level of activity of the Section 501(c)(4) organization as may be necessary to preserve the organization's tax status, that no funds or other resources controlled by the Section 501(c)(4) organization shall be expended for campaign contributions, lobbying, or other political activities, and that the Section 501(c)(4) organization shall comply with reporting requirements that are applicable to Section 501(c)(3) organizations, and that the 501(c)(4) organization shall be subject to any other requirements imposed upon 501(c)(3) organizations that the director determines to be appropriate.

(3) Each 501(c)(3) or 501(c)(4) organization receiving a set-aside, its directors and officers, and its assets including any plan stock, shall be independent of any influence or control by the health care service plan and its directors, officers, subsidiaries, or affiliates.

(4) The charitable mission and grant-making functions of the charitable organization receiving any set-aside shall be dedicated to serving the health care needs of the people of California.

(5) Every 501(c)(3) or 501(c)(4) organization that receives a set-aside under this section shall have in place procedures and policies to prohibit conflicts of interest, including those associated with grant-making activities that may benefit the plan, including the directors, officers, subsidiaries, or affiliates of the plan.

(6) Every 501(c)(3) or 501(c)(4) organization that receives a set-aside under this section shall demonstrate that its directors and officers have sufficient experience and judgment to administer grant-making and other charitable activities to serve the state's health care needs.

(7) Every 501(c)(3) or 501(c)(4) organization that receives a set-aside under this section shall provide the director and the Attorney General with an annual report that includes a detailed description of its grant-making and other charitable activities related to its use of the set-aside received from the health care service plan. The annual report shall be made available by the director and the Attorney General for public inspection, notwithstanding the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Each organization shall submit the annual report for its immediately preceding fiscal year within 120 days after the close of that fiscal year. When requested by the director or the Attorney General, the organization shall promptly supplement the report to include any additional information that the director or the Attorney General deems necessary to ascertain compliance with this article.

(8) The plan has satisfied the requirements of this chapter, and a

disciplinary action pursuant to Section 1386 is not warranted against the plan.

(d) The plan shall not file any forms or documents required by the Secretary of State in connection with any conversion or restructuring until the plan has received an order of the director approving the conversion or restructuring, or unless authorized to do so by the director.

HISTORY:
Added Stats 1995 ch 792 § 1 (SB 445). Amended Stats 1999 ch 525 § 160 (AB 78), operative July 1, 2000.

§ 1399.73. Contents of application; Fee; Contracts for review

(a) An application for a conversion or restructuring shall contain the information the director may require, by rule or order.

(b) The director shall charge a health care service plan an application filing fee. The fee for filing an application shall be the actual cost of processing the application, including the overhead costs. The filing fee shall include the costs of undertaking the activities described in subdivisions (c), (d), and (e) of Section 1399.74.

(c) The director may contract with experts or consultants to assist the director in reviewing the application. Contract costs shall not exceed an amount that is reasonable and necessary to review the application. Any contract entered into under this subdivision shall be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. The applicant shall promptly pay the director, upon request, for all contract costs.

HISTORY:
Added Stats 1995 ch 792 § 1 (SB 445). Amended Stats 1999 ch 525 § 161 (AB 78), operative July 1, 2000.

§ 1399.74. Adoption of regulations; Notice; Public records; Public hearing

(a) By July 1, 1996, the director shall adopt regulations, on an emergency basis, that specify the application procedures and requirements for the restructuring or conversion of nonprofit health care service plans. This subdivision shall not be construed to limit or otherwise restrict the director's authority to adopt regulations under Section 1344, including, but not limited to, any additional regulations to implement this article.

(b) Upon receiving an application to restructure or convert, the director shall publish a notice in one or more newspapers of general circulation in the plan's service area describing the name of the applicant, the nature of the application, and the date of receipt of the application. The notice shall indicate that the director will be soliciting public comments and will hold a public hearing on the application. The director shall require the plan to publish a written notice concerning the application pursuant to conditions imposed by rule or order.

(c) Any applications, reports, plans, or other documents under this article shall be public records, subject to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and regulations adopted by the director thereunder. The director shall provide the public with prompt and reasonable access to public records relating

to the restructuring and conversion of health care service plans. Access to public records covered by this section shall be made available no later than one month prior to any solicitation for public comments or public hearing scheduled pursuant to this article.

(d) Prior to approving any conversion or restructuring, the director shall solicit public comments in written form and shall hold at least one public hearing concerning the plan's proposal to comply with the set-aside and other conditions required under this article.

(e) The director may disapprove any application to restructure or convert if the application does not meet the requirements of this chapter or of the Nonprofit Corporation Law (Div. 2 (commencing with Sec. 5000), Title 1, Corp. C.), including any requirements imposed by rule or order of the director.

HISTORY:
Added Stats 1995 ch 792 § 1 (SB 445). Amended Stats 1999 ch 525 § 162 (AB 78), operative July 1, 2000.

§ 1399.75. Application of article

(a) This article shall apply to the restructuring or conversion of nonprofit mutual benefit health care service plans to the extent these plans have held or currently hold assets subject to a charitable trust obligation, as determined by the director.

(b) Nonprofit mutual benefit health care service plans that do not have, or have only a partial, charitable trust obligation, and that intend to convert or restructure their activities shall, prior to the conversion or restructuring, secure approval from the director.

(c) Prior to approving a mutual benefit health care service plan restructuring or conversion under subdivision (b), the director shall find that the plan has complied with its noncharitable obligations including, but not limited to, any obligations set forth in its articles of incorporation regarding the dedication and distribution of assets.

(d) The director, in carrying out the department's responsibilities under subdivision (c), may apply, to the extent appropriate in each case as determined by the director, the beneficiary protections authorized in this act, including, but not limited to, protections concerning the fair market value of assets, the avoidance of conflicts of interest, and the avoidance of undue influence or control, with respect to a mutual benefit plan's proposed disposition of assets.

(e) Nothing in this section shall be construed to limit the director's, Attorney General's, or a court's authority under existing law to impose charitable trust obligations upon any or all of the assets of a mutual benefit corporation or otherwise treat a mutual benefit corporation in the same manner as a public benefit corporation.

HISTORY:
Added Stats 1995 ch 792 § 1 (SB 445). Amended Stats 1999 ch 525 § 163 (AB 78), operative July 1, 2000.

§ 1399.76. Exceptions

This article shall not apply to a nonprofit health care service plan restruc-

ture or conversion that has been submitted as a material modification to the department for review and approval prior to May 16, 1995.

HISTORY:
Added Stats 1995 ch 792 § 1 (SB 445).

ARTICLE 11.1

Consumer Operated and Oriented Plans

Section
1399.80. Definitions.
1399.81. Issuance of license.
1399.83. Licensees subject to specified provisions of law.
1399.84. Loan documentation.
1399.86. Prohibitions in PPACA apply; Additional requirements.
1399.88. Full compliance with requirements of PPACA governing CO-OPs.

HISTORY: Added Stats 2012 ch 859 § 2 (AB 1846), effective January 1, 2013.

§ 1399.80. Definitions

For purposes of this article, the following definitions shall apply:

(a) "Consumer operated and oriented plan" means a nonprofit member organization or nonprofit member corporation that has been established consistent with the requirements of Section 1322 of PPACA and Subpart F (commencing with Section 156.500) of Part 156 of Subchapter B of Subtitle A of Title 45 of the Code of Federal Regulations and remains in full compliance with those requirements. A consumer operated and oriented plan shall also be known as a "CO-OP."

(b) "Formation board" means the initial board of directors of a CO-OP before it has begun accepting enrollment and had an election by the members of the CO-OP to the board of directors.

(c) "Member" includes all individuals, including dependents, 18 years of age or older covered under health care service plan contracts issued by the CO-OP health care service plan.

(d) "Operational board" means the board of directors elected by the members of the CO-OP after it has begun accepting enrollment under its health care service plan contracts.

(e) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules or regulations issued thereunder.

(f) "Nonprofit member organization" or "nonprofit member corporation" means a nonprofit public benefit corporation organized under Part 2 (commencing with Section 5110) of Division 2 of Title 1 of the Corporations Code, a nonprofit mutual benefit corporation organized under Part 3 (commencing with Section 7110) of Division 2 of Title 1 of the Corporations Code, or a similar entity organized under applicable provisions of the Corporations Code, or in the case of a foreign corporation, a nonprofit public benefit corporation, a mutual benefit corporation, or a similar entity organized under nonprofit laws in a state other than California.

(g) "Solvency loan" means a loan provided by the federal Centers for

Medicare and Medicaid Services to a nonprofit member organization or nonprofit member corporation seeking to become licensed as a CO-OP health care service plan, to be used to assist in meeting the state's fiscal soundness and solvency requirements.

(h) "Start-up loan" means a loan provided by the federal Centers for Medicare and Medicaid Services to a nonprofit member organization or nonprofit member corporation seeking to become licensed as a CO-OP health care service plan, to be used for allowed expenses associated with establishing a CO-OP, as further specified by PPACA.

HISTORY:
Added Stats 2012 ch 859 § 2 (AB 1846), effective January 1, 2013.

§ 1399.81. Issuance of license

The director shall have the authority to issue a license to act as a health care service plan to a CO-OP that has been organized as a nonprofit member organization or nonprofit member corporation under the laws of this state. The director may also issue a license to act as a health care service plan to a foreign CO-OP that has been organized as a nonprofit member organization or nonprofit member corporation under the laws of another state, provided that the entity meets the requirements governing CO-OPs under PPACA and this article. A CO-OP seeking or maintaining a license pursuant to this article shall be subject to the same fees that are imposed on other health care service plans pursuant to Article 3 (commencing with Section 1349).

HISTORY:
Added Stats 2012 ch 859 § 2 (AB 1846), effective January 1, 2013.

§ 1399.83. Licensees subject to specified provisions of law

(a) A domestic or foreign CO-OP licensed as a health care service plan pursuant to this article shall be subject to all of the provisions of this chapter and all applicable rules and regulations of the director, including, but not limited to, the general provisions governing the issuance of a license in Article 3 (commencing with Section 1349), the operation and renewal provisions in Article 6 (commencing with Section 1375), and the financial responsibility requirements in Article 9 (commencing with Section 1300.75) of Chapter 2 of Division 1 of Title 28 of the California Code of Regulations.

(b) In compliance with Section 1322(c)(5) of PPACA (42 U.S.C. Sec. 18042(c)(5)), and any rules or regulations issued under that section, a domestic or foreign CO-OP licensed as a health care service plan shall be subject to any state laws that do not prevent the application of requirements under PPACA.

HISTORY:
Added Stats 2012 ch 859 § 2 (AB 1846), effective January 1, 2013.

§ 1399.84. Loan documentation

The director may request any documentation relating to a CO-OP's start-up loan or solvency loan.

HISTORY:
Added Stats 2012 ch 859 § 2 (AB 1846), effective January 1, 2013.

§ 1399.86. Prohibitions in PPACA apply; Additional requirements

(a) A CO-OP shall be subject at all times to the prohibitions in PPACA against converting or selling to a for-profit or nonconsumer-operated entity at any time after receiving a solvency loan.

(b) A CO-OP shall do all of the following, in addition to any other requirements imposed under Section 156.515 of Title 45 of the Code of Federal Regulations:

(1) Implement policies and procedures to foster and ensure member control of the organization. For purposes of this paragraph, a CO-OP shall meet the following requirements:

(A) The CO-OP shall have governing documents that incorporate governing rules that ensure that the directors of the operational board are elected by a majority vote of a quorum of the CO-OP members.

(B) All members of the CO-OP shall be eligible to vote for each director on the CO-OP's operational board.

(C) Each member of the CO-OP shall have one vote in the election of each director of the CO-OP's operational board.

(D) The first elected directors of the CO-OP's operational board shall be elected no later than one year after the effective date on which the CO-OP provides coverage to its first member; the entire operational board shall be elected no later than two years after the same date.

(E) Elections of the directors on the CO-OP's operational board shall be contested so that the total number of candidates for vacant positions on the operational board exceeds the number of vacant positions, except in cases where a seat is vacated midterm due to death, resignation, or removal.

(F) A majority of the voting directors on the operational board shall be members of the CO-OP.

(2) Have an operational board of directors that meets the following requirements:

(A) Each director shall have one vote unless he or she is a nonvoting director.

(B) Positions on the board of directors may be designated for individuals with specialized expertise, experience, or affiliation (for example, providers, employers, including small business consortia, and unions); however, those positions shall not constitute a majority of the operational board even if the individuals in those positions are also members of the CO-OP.

(C)(i) No representative of any federal, state, or local government, or of any political subdivision or instrumentality thereof, and no representative of any organization described in Section 156.510(b)(1)(i) of Title 45 of the Code of Federal Regulations may serve as staff of the CO-OP or on the CO-OP's formation board or operational board.

(ii) No board member or staff of the CO-OP shall enter into an agreement or transaction that would jeopardize member control as required by Section 156.515 of Title 45 of the Code of Federal Regula-

tions. A board member or staff of the CO-OP shall only enter into arm's length transactions as described in Section 156.510(b)(2) (ii) of Title 45 of the Code of Federal Regulations.

(3) Have governing documents that incorporate ethics, conflict of interest, and disclosure standards. These standards shall protect against health care coverage industry involvement and interference. In addition, these standards shall ensure that each director acts in the sole interest of the CO-OP, its members, and its local geographic community, as appropriate, and acts consistently with the terms of the CO-OP's governance documents and applicable state and federal law. At a minimum, these standards shall include the following:

(A) A mechanism to identify potential ethical or other conflicts of interest.

(B) A duty on the CO-OP's executive officers and directors to publicly disclose all potential conflicts of interest pursuant to the same standards required for state boards or commissions.

(C) A process to determine the extent to which a conflict exists.

(D) A process to address any conflict of interest.

(E) A process to be followed in the event a director or executive officer of the CO-OP violates the standards described in this paragraph.

HISTORY:
Added Stats 2012 ch 859 § 2 (AB 1846), effective January 1, 2013.

§ 1399.88. Full compliance with requirements of PPACA governing CO-OPs

In addition to any applicable requirements in this chapter for maintaining a license, a CO-OP is required at all times to be in full compliance with the requirements of PPACA governing CO-OPs. The department may request the federal government's certification that a CO-OP is in compliance with the requirements of PPACA governing CO-OPs, as well as the status of the CO-OP's compliance with its obligations under any loan or loan modification agreement.

HISTORY:
Added Stats 2012 ch 859 § 2 (AB 1846), effective January 1, 2013.

ARTICLE 11.5

Individual Access to Contracts for Health Care Services

Section
1399.801. Definitions.
1399.802. Compliance with chapter and article.
1399.803. Application of article.
1399.804. Availability of contracts to federally eligible defined individuals.
1399.805. Notification of premium charges; Commencement of coverage; Changes.
1399.806. Prohibited exclusions.
1399.809. Discontinuation of plan.
1399.810. Renewal of contracts.
1399.811. Premium requirements.
1399.812. Consistent application of premiums.

Section
1399.813. Disclosure.
1399.814. Exemption from requirement to offer to individuals.
1399.815. Notice of amendments.
1399.816. [Section repealed 2013.]
1399.817. Regulations.
1399.818. Date of applicability of article.
1399.900–1399.904. [See Note] [Reserved.]

HISTORY: Added Stats 2000 ch 810 § 2, as Article 10.5. Renumbered by Stats 2001 ch 159 § 126.

§ 1399.801. Definitions

As used in this article:

(a) "Creditable coverage" means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071)(CHAMPUS).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901)(FEHBP).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(*l*) of the Public Health Service Act, as amended by Public Law 104–191, the Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under 22 U.S.C.A. 2504(e) of the Peace Corps Act.

(b) "Dependent" means the spouse or child of an eligible individual or other individual applying for coverage, subject to applicable terms of the health care plan contract covering the eligible person.

(c) "Federally eligible defined individual" means an individual who as of the date on which the individual seeks coverage under this part, (1) has 18

or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002), (2) is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and has no other health insurance coverage, (3) was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud, and (4) if offered continuation coverage under COBRA or Cal-COBRA, had elected and exhausted this coverage.

(d) "In force business" means an existing health benefit plan contract issued by the plan to a federally eligible defined individual.

(e) "New business" means a health care service plan contract issued to an eligible individual that is not the plan's in force business.

(f) "Preexisting condition provision" means a contract provision that excludes coverage for charges and expenses incurred during a specified period following the eligible individual's effective date, as to a condition for which medical advice, diagnosis, and care of treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265).

§ 1399.802. Compliance with chapter and article

(a) Every health care service plan offering plan contracts to individuals shall, in addition to complying with the provisions of this chapter and the rules adopted thereunder, comply with the provisions of this article.

(b) For the purposes of determining eligibility for small employer coverage, a sole proprietor and the sole proprietor's spouse are not employees with respect to a sole proprietorship that consists only of the sole proprietor and the sole proprietor's spouse. A partner and a partner's spouse are not employees of a partnership that consists solely of partners and their spouses. Employer group health care service plans shall not be issued, marketed, or sold to a sole proprietorship or partnership without employees directly or indirectly through any arrangement. Only individual health care service plans shall be sold to any entity without employees.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265). Amended Stats 2018 ch 700 § 5 (SB 1375), effective January 1, 2019.

§ 1399.803. Application of article

Nothing in this article shall be construed to preclude the application of this chapter to either of the following: (a) an association, trust, or other organization acting as a health care service plan as defined under Section 1345, or (b) an association, trust, multiple employer welfare arrangement, or other organization or person presenting information regarding a health care service plan to persons who may be interested in subscribing or enrolling in the plan.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265).

§ 1399.804. Availability of contracts to federally eligible defined individuals

(a) Commencing January 1, 2001, a plan shall fairly and affirmatively offer, market, and sell the health care service plan contracts described in subdivision (d) of Section 1366.35 that are sold to individuals or to associations that include individuals to all federally eligible defined individuals in each service area in which the plan provides or arranges for the provision of health care services. Each plan shall make available to each federally eligible defined individual the identified health care service plan contracts which the plan offers and sells to individuals or to associations that include individuals.

(b) The plan may not reject an application from a federally eligible defined individual for a health care service plan contract under the following circumstances:

(1) The federally eligible defined individual as defined by subdivision (c) of Section 1399.801 agrees to make the required premium payments.

(2) The federally eligible defined individual, and his or her dependents who are to be covered by the plan contract, work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.

(c) No plan or solicitor shall, directly or indirectly, encourage or direct federally eligible defined individuals to refrain from filing an application for coverage with a plan because of health status, claims experience, industry, occupation, receipt of health care, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, disability, or geographic location provided that it is within the plan's approved service area.

(d) No plan shall, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract to be varied because of health status, claims experience, industry, occupation, receipt of health care, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, disability, or geographic location of the individual.

(e) Each plan shall comply with the requirements of Section 1374.3.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265).

§ 1399.805. Notification of premium charges; Commencement of coverage; Changes

(a)(1) After the federally eligible defined individual submits a completed application form for a plan contract, the plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan contract, unless the plan has provided notice of the premium charge prior to the application being filed. In no case shall the premium charged for any health care service plan contract identified in subdivision (d) of Section 1366.35 exceed the following amounts:

(A) For health care service plan contracts that offer services through a

preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for a federally eligible defined individual who is between the ages of 60 and 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(B) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for a federally eligible defined individual who is between the ages of 60 and 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium rates.

(2) A plan may adjust the premium based on family size, not to exceed the following amounts:

(A) For health care service plans that offer services through a preferred provider arrangement, the average of the Major Risk Medical Insurance Program rate for families of the same size that reside in the same geographic area as the federally eligible defined individual.

(B) For health care service plans identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to a family that is of the same size and resides in the same geographic area as the federally eligible defined individual.

(3) This subdivision shall become inoperative on January 1, 2014. This subdivision shall become operative on January 1, 2020.

(b)(1) After the federally eligible defined individual submits a completed application form for a plan contract, the plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan contract, unless the plan has provided notice of the premium charge prior to the application being filed. In no case shall the premium charged for any health care service plan contract identified in subdivision (d) of Section 1366.35 exceed the following amounts:

(A) With respect to the rate charged for coverage provided in 2014, the rate charged in 2013 for that coverage multiplied by 1.09.

(B) With respect to the rate charged for coverage provided in 2015 and each subsequent year, the rate charged in the prior year multiplied by a factor of one plus the percentage change in the statewide average premium for the second lowest cost silver plan offered on the Exchange. The Exchange shall determine the percentage change in the statewide average premium for the second lowest cost silver plan by subtracting clause (i) from clause (ii) and dividing the result by clause (i).

(i) The average of the premiums charged in the year prior to the applicable year for the second lowest cost silver plan in all 19 rating

regions, with the premium for each region weighted based on the region's relative share of the Exchange's total individual enrollment according to the latest data available to the Exchange.

(ii) The average of the premiums to be charged in the applicable year for the second lowest cost silver plan in all 19 rating regions, with the premium for each region weighted based on the region's relative share of the Exchange's total individual enrollment according to the latest data available to the Exchange.

(C) The Exchange shall determine the percentage change in the statewide average premium no later than 30 days after the Exchange's rates for individual coverage for the applicable year have been finalized.

(2) For purposes of this subdivision, "Exchange" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(3) This subdivision shall become operative on January 1, 2014. This subdivision shall become inoperative on January 1, 2020.

(c) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered or postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(d) During the first 30 days after the effective date of the plan contract, the individual shall have the option of changing coverage to a different plan contract offered by the same health care service plan. If the individual notified the plan of the change within the first 15 days of a month, coverage under the new plan contract shall become effective no later than the first day of the following month. If an enrolled individual notified the plan of the change after the 15th day of a month, coverage under the new plan contract shall become effective no later than the first day of the second month following notification.

(e)(1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plan contracts previously issued pursuant to this section to federally eligible defined individuals.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to health care service plan contracts issued, amended, or renewed on or after that date.

(3) For purposes of this subdivision, the following definitions apply:

(A) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(B) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care Education and Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265). Amended Stats 2013 ch 441 § 9 (AB 1180), effective October 1, 2013.

§ 1399.806. Prohibited exclusions

A plan may not exclude any federally eligible defined individual, or his or her dependents, who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that individual or dependent. No plan contract may limit or exclude coverage for a specific federally eligible defined individual, or his or her dependents, by type of illness, treatment, medical condition, or accident.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265).

§ 1399.809. Discontinuation of plan

The director may require a plan to discontinue the offering of contracts or the acceptance of applications from any individual upon a determination by the director that the plan does not have sufficient financial viability, organization, and administrative capacity to assure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265).

§ 1399.810. Renewal of contracts

All health care service plan contracts offered to a federally eligible defined individual shall be renewable with respect to the individual and dependents at the option of the contractholder except in cases of:

(a) Nonpayment of the required premiums.

(b) Fraud or misrepresentation by the contractholder.

(c) The plan ceases to provide or arrange for the provision of health care services for individual health care service plan contracts in this state, provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefit plans in this state is provided to the director and to the contractholder.

(2) Individual health care service plan contracts subject to this chapter shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan that remains in force, any plan that ceases to offer for sale new individual health care service plan contracts shall continue to be governed by this article with respect to business conducted under this article.

(3) A plan that ceases to write new individual business in this state after January 1, 2001, shall be prohibited from offering for sale new individual health care service plan contracts in this state for a period of three years from the date of the notice to the director.

(d) When the plan withdraws a health care service plan contract from the

individual market, provided that the plan makes available to eligible individuals all plan contracts that it makes available to new individual business, and provided that the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1399.811.

(e)(1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plan contracts previously issued pursuant to this section to federally eligible defined individuals.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to health care service plan contracts issued, amended, or renewed on or after that date.

(3) For purposes of this subdivision, the following definitions apply:

(A) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(B) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care Education and Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265).
Amended Stats 2013 ch 441 § 10 (AB 1180), effective October 1, 2013.

§ 1399.811. Premium requirements

(a)(1) Premiums for contracts offered, delivered, amended, or renewed by plans on or after January 1, 2001, shall be subject to the following requirements:

(A) The premium for new business for a federally eligible defined individual shall not exceed the following amounts:

(i) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally eligible defined individuals who are between the ages of 60 to 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(ii) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally eligible defined individuals who are between the ages of 60 to 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium

charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(B) The premium for in force business for a federally eligible defined individual shall not exceed the following amounts:

(i) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally eligible defined individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(ii) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally eligible defined individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The premium effective on January 1, 2001, shall apply to in force business at the earlier of either the time of renewal or July 1, 2001.

(2) This subdivision shall become inoperative on January 1, 2014. This subdivision shall become operative on January 1, 2020.

(b)(1) Premiums for contracts offered, delivered, amended, or renewed by plans on or after January 1, 2014, shall be subject to the following requirements:

(A) With respect to the rate charged for coverage provided in 2014, the rate charged in 2013 for that coverage multiplied by 1.09.

(B) With respect to the rate charged for coverage provided in 2015 and each subsequent year, the rate charged in the prior year multiplied by a factor of one plus the percentage change in the statewide average premium for the second lowest cost silver plan offered on the Exchange. The Exchange shall determine the percentage change in the statewide average premium for the second lowest cost silver plan by subtracting clause (i) from clause (ii) and dividing the result by clause (i).

(i) The average of the premiums charged in the year prior to the applicable year for the second lowest cost silver plan in all 19 rating regions, with the premium for each region weighted based on the region's relative share of the Exchange's total individual enrollment according to the latest data available to the Exchange.

(ii) The average of the premiums to be charged in the applicable year for the second lowest cost silver plan in all 19 rating regions, with the premium for each region weighted based on the region's relative share of the Exchange's total individual enrollment according to the latest data available to the Exchange.

(C) The Exchange shall determine the percentage change in the statewide average premium no later than 30 days after the Exchange's rates for individual coverage for the applicable year have been finalized.

(2) For purposes of this subdivision, "Exchange" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(3) This subdivision shall become operative on January 1, 2014. This subdivision shall become inoperative on January 1, 2020.

(c) The premium applied to a federally eligible defined individual may not increase by more than the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, the increase in premiums charged to a nonfederally eligible defined individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

(3) For a contract that a plan has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

(d)(1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plan contracts previously issued pursuant to this section to federally eligible defined individuals.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to health care service plan contracts issued, amended, or renewed on or after that date.

(3) For purposes of this subdivision, the following definitions apply:

(A) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(B) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care Education and Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265). Amended Stats 2006 ch 538 § 354 (SB 1852), effective January 1, 2007; Stats 2013 ch 441 § 11 (AB 1180), effective October 1, 2013.

§ 1399.812. Consistent application of premiums

Plans shall apply premiums consistently with respect to all federally eligible defined individuals who apply for coverage.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265).

§ 1399.813. Disclosure

In connection with the offering for sale of any plan contract to an individual, each plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of all individual contracts.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265).

§ 1399.814. Exemption from requirement to offer to individuals

Nothing in this article shall be construed to require a health benefit plan to offer a contract to an individual if the plan does not otherwise offer contracts to individuals.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265).

§ 1399.815. Notice of amendments

(a) At least 20 business days prior to renewing or amending a plan contract subject to this article, or at least 20 business days prior to the initial offering of a plan contract subject to this article, a plan shall file a notice of an amendment with the director in accordance with the provisions of Section 1352. The notice of an amendment shall include a statement certifying that the plan is in compliance with subdivision (a) of Section 1399.805 and with Section 1399.811. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons the plan contract does not comply with the requirements of this chapter.

(b) Prior to making any changes in the premium, the plan shall file an amendment in accordance with the provisions of Section 1352, and shall include a statement certifying the plan is in compliance with subdivision (a) of Section 1399.805 and with Section 1399.811. All other changes to a plan contract previously filed with the director pursuant to subdivision (a) shall be filed as an amendment in accordance with the provisions of Section 1352, unless the change otherwise would require the filing of a material modification.

(c)(1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plan contracts previously issued pursuant to this section to federally eligible defined individuals.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to plan contracts issued, amended, or renewed on or after that date.

(3) For purposes of this subdivision, the following definitions apply:

(A) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(B) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care Education and Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265). Amended Stats 2013 ch 441 § 12 (AB 1180), effective October 1, 2013.

§ 1399.816. [Section repealed 2013.]

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265). Repealed Stats 2013-2014 1st Ex Sess ch 2 § 14 (SBX1 2), effective September 30, 2013. The repealed section related to sharing financing of high-risk individuals.

§ 1399.817. Regulations

The director may issue regulations that are necessary to carry out the purposes of this article. Any rules and regulations adopted pursuant to this article may be adopted as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Until December 31, 2001, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The regulations shall be enforced by the director.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265).

§ 1399.818. Date of applicability of article

This article shall apply to health care service plan contracts offered, delivered, amended, or renewed on or after January 1, 2001.

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265).

§§ 1399.900–1399.904. [See Note] [Reserved.]

HISTORY:

ARTICLE 11.7

Child Access to Health Care Coverage (Inoperative; Operative date contingent)

Section

1399.825. Definitions (Inoperative; Operative date contingent).
1399.826. Child coverage; Preexisting condition; Issuance or offering of individual coverage may not be conditioned; When coverage becomes effective; Establishment of rules for eligibility; Construction (Inoperative; Operative date contingent).
1399.827. Applicability of article (Inoperative; Operative date contingent).
1399.828. Availability of plan's health care service plan contracts to late enrollees; Prohibited activities; Compensation to solicitor prohibited (Inoperative; Operative date contingent).

Section
1399.829. Characteristics to be considered in establishing rates; Limitations (Inoperative; Operative date contingent).
1399.832. When plan not required to offer contract or accept applications (Inoperative; Operative date contingent).
1399.833. Requirement that plan discontinue offering contracts or accepting applications (Inoperative; Operative date contingent).
1399.834. Renewal of contracts; Plan ceasing to offer individual coverage (Inoperative; Operative date contingent).
1399.835. Issuance of guidance to health plans regarding compliance with article (Inoperative; Operative date contingent).
1399.836. Operation of article (Inoperative; Operative date contingent).

HISTORY: Added Stats 2010 ch 656 § 3, effective January 1, 2011. The heading of Article 11.7 which formerly read "Individual Access to Health Care Coverage, amended to read as above by Stats 2013-2014 1st Ex Sess ch 2 § 15 (SBX1 2), effective September 30, 2013, inoperative January 1, 2014, operative date contingent.

§ 1399.825. Definitions (Inoperative; Operative date contingent)

As used in this article:

(a) "Child" means any individual under 19 years of age.

(b) "Individual grandfathered plan coverage" means health care coverage in which an individual was enrolled on March 23, 2010, consistent with Section 1251 of PPACA and any rules or regulations adopted pursuant to that law.

(c) "Initial open enrollment period" means the open enrollment period beginning on January 1, 2011, and ending 60 days thereafter.

(d) "Late enrollee" means a child without coverage who did not enroll in a health care service plan contract during an open enrollment period because of any of the following:

(1) The child lost dependent coverage due to termination or change in employment status of the child or the person through whom the child was covered; cessation of an employer's contribution toward an employee or dependent's coverage; death of the person through whom the child was covered as a dependent; legal separation; divorce; loss of coverage under the Healthy Families Program, the Access for Infants and Mothers Program, or the Medi-Cal program; or adoption of the child.

(2) The child became a resident of California during a month that was not the child's birth month.

(3) The child is born as a resident of California and did not enroll in the month of birth.

(4) The child is mandated to be covered pursuant to a valid state or federal court order.

(e) "Open enrollment period" means the annual open enrollment period, subsequent to the initial open enrollment period, applicable to each individual child that is the month of the child's birth date.

(f) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any subsequent rules or regulations issued pursuant to that law.

(g) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact

that the condition was present before the date of enrollment of the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

(h) "Responsible party for a child" means an adult having custody of the child or with responsibility for the financial needs of the child, including the responsibility to provide health care coverage.

(i) "Standard risk rate" means the lowest rate that can be offered for a child with the same benefit plan, effective date, age, geographic region, and family status.

HISTORY:
Added Stats 2010 ch 656 § 3 (AB 2244), effective January 1, 2011. Amended Stats 2013-2014 1st Ex Sess ch 2 § 17 (SBX1 2), effective September 30, 2013, inoperative January 1, 2014, operative date contingent.

§ 1399.826. Child coverage; Preexisting condition; Issuance or offering of individual coverage may not be conditioned; When coverage becomes effective; Establishment of rules for eligibility; Construction (Inoperative; Operative date contingent)

(a)(1) During each open enrollment period, every health care service plan offering plan contracts in the individual market, other than individual grandfathered plan coverage, shall offer to the responsible party for a child coverage for the child that does not exclude or limit coverage due to any preexisting condition of the child.

(b) A health care service plan offering coverage in the individual market shall not reject an application for a health care service plan contract from a child or filed on behalf of a child by the responsible party during an open enrollment period or from a late enrollee during a period no longer than 63 days from the qualifying event listed in subdivision (d) of Section 1399.825.

(c) Except to the extent permitted by federal law, rules, regulations, or guidance issued by the relevant federal agency, a health care service plan shall not condition the issuance or offering of individual coverage on any of the following factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(9) Any other health status-related factor as determined by department.

This subdivision shall not apply to a contract providing individual grandfathered plan coverage.

(d) When a responsible party for a child submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan contract shall become effective no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later

than the first day of the second month following delivery or postmark of the payment.

(e) A health care service plan offering coverage in the individual market shall not reject the request of a responsible party for a child to include that child as a dependent on an existing health care service plan contract that includes dependent coverage during an open enrollment period.

(f) Nothing in this article shall be construed to prohibit a health care service plan offering coverage in the individual market from establishing rules for eligibility for coverage and offering coverage pursuant to those rules for children and individuals based on factors otherwise authorized under federal and state law for health plan contracts in addition to those offered on a guaranteed issue basis during an open enrollment period to children or late enrollees pursuant to this article. However, a health care service plan, other than a plan providing individual grandfathered plan coverage, shall not impose a preexisting condition provision on coverage, including dependent coverage, offered to a child.

(g) Nothing in this article shall be construed to require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan's existing service area.

(h) Nothing in this article shall be construed to prevent a health care service plan from offering coverage to a family member of an enrollee in grandfathered health plan coverage consistent with Section 1251 of PPACA.

HISTORY:
Added Stats 2010 ch 656 § 3 (AB 2244), effective January 1, 2011. Amended Stats 2013-2014 1st Ex Sess ch 2 § 17 (SBX1 2), effective September 30, 2013, inoperative January 1, 2014, operative date contingent.

§ 1399.827. Applicability of article (Inoperative; Operative date contingent)

This article shall not apply to health care service plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement contracts, Medi-Cal contracts with the State Department of Health Care Services, plan contracts offered under the Healthy Families Program, long-term care coverage, or specialized health care service plan contracts.

HISTORY:
Added Stats 2010 ch 656 § 3 (AB 2244), effective January 1, 2011. Amended Stats 2013-2014 1st Ex Sess ch 2 § 17 (SBX1 2), effective September 30, 2013, inoperative January 1, 2014, operative date contingent.

§ 1399.828. Availability of plan's health care service plan contracts to late enrollees; Prohibited activities; Compensation to solicitor prohibited (Inoperative; Operative date contingent)

(a) Upon the effective date of this article, a health care service plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are offered and sold to a child or the responsible party for a child in each service area in which the plan provides or arranges for the provision of health care services during any open enrollment period, to late enrollees, and during any other period in which state or federal law, rules,

regulations, or guidance expressly provide that a health care service plan shall not condition offer or acceptance of coverage on any preexisting condition.

(b) No health care service plan or solicitor shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct a child or responsible party for a child to refrain from filing an application for coverage with a plan because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the plan's approved service area, of the child.

(2) Encourage or direct a child or responsible party for a child to seek coverage from another plan because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the plan's approved service area, of the child.

(c) A health care service plan shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the child. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the child.

HISTORY:
Added Stats 2010 ch 656 § 3 (AB 2244), effective January 1, 2011. Amended Stats 2013-2014 1st Ex Sess ch 2 § 17 (SBX1 2), effective September 30, 2013, inoperative January 1, 2014, operative date contingent.

§ 1399.829. Characteristics to be considered in establishing rates; Limitations (Inoperative; Operative date contingent)

(a) A health care service plan may use the following characteristics of an eligible child for purposes of establishing the rate of the plan contract for that child, where consistent with federal regulations under PPACA: age, geographic region, and family composition, plus the health care service plan contract selected by the child or the responsible party for the child.

(b) From the effective date of this article to December 31, 2013, inclusive, rates for a child applying for coverage shall be subject to the following limitations:

(1) During any open enrollment period or for late enrollees, the rate for any child due to health status shall not be more than two times the standard risk rate for a child.

(2) The rate for a child shall be subject to a 20-percent surcharge above the highest allowable rate on a child applying for coverage who is not a late enrollee and who failed to maintain coverage with any health care service plan or health insurer for the 90-day period prior to the date of the child's application. The surcharge shall apply for the 12-month period following the effective date of the child's coverage.

(3) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a health care service plan may rate a child based on health status during any period other than an open enrollment period if the child is not a late enrollee.

(4) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a health care service plan may condition an offer or acceptance of coverage on any preexisting condition or other health status-related factor for a period other than an open enrollment period and for a child who is not a late enrollee.

(c) For any individual health care service plan contract issued, sold, or renewed prior to December 31, 2013, the health plan shall provide to a child or responsible party for a child a notice that states the following:

"Please consider your options carefully before failing to maintain or renewing coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for that child, the premium for the same coverage may be higher than the premium you pay now."

(d) A child who applied for coverage between September 23, 2010, and the end of the initial open enrollment period shall be deemed to have maintained coverage during that period.

(e) Effective January 1, 2014, except for individual grandfathered health plan coverage, the rate for any child shall be identical to the standard risk rate.

(f) Health care service plans shall not require documentation from applicants relating to their coverage history.

(g)(1) On and after the operative date of the act adding this subdivision, and until January 1, 2014, a health care service plan shall provide the model notice, as provided in paragraph (3), to all applicants for coverage under this article and to all enrollees, or the responsible party for an enrollee, renewing coverage under this article that contains the following information:

(A) Information about the open enrollment period provided under Section 1399.849.

(B) An explanation that obtaining coverage during the open enrollment period described in Section 1399.849 will not affect the effective dates of coverage for coverage purchased pursuant to this article unless the applicant cancels that coverage.

(C) An explanation that coverage purchased pursuant to this article shall be effective as required under subdivision (d) of Section 1399.826 and that such coverage shall not prevent an applicant from obtaining new coverage during the open enrollment period described in Section 1399.849.

(D) Information about the Medi-Cal program, information about the Healthy Families Program if the Healthy Families Program is accepting enrollment, and information about subsidies available through the California Health Benefit Exchange.

(2) The notice described in paragraph (1) shall be in plain language and 14-point type.

(3) The department shall adopt a uniform model notice to be used by health care service plans in order to comply with this subdivision, and shall consult with the Department of Insurance in adopting that uniform model notice. Use of the model notice shall not require prior approval of the department. The model notice adopted by the department for purposes of this section shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

HISTORY:
Added Stats 2010 ch 656 § 3 (AB 2244), effective January 1, 2011. Amended Stats 2013-2014 1st Ex Sess ch 2 §§ 16, 17 (SBX1 2), effective September 30, 2013, inoperative January 1, 2014, operative date contingent.

§ 1399.832. When plan not required to offer contract or accept applications (Inoperative; Operative date contingent)

No health care service plan shall be required to offer a health care service plan contract or accept applications for the contract pursuant to this article in the case of any of the following:

(a) To a child, if the child who is to be covered by the plan contract does not work or reside within the plan's approved service areas.

(b)(1) Within a specific service area or portion of a service area, if the plan reasonably anticipates and demonstrates to the satisfaction of the director that it will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the child because of its obligations to existing enrollees.

(2) A health care service plan that cannot offer a health care service plan contract to individuals or children because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a contract in the area in which the plan is not offering coverage to individuals to new employer groups until the plan notifies the director that it has the ability to deliver services to individuals, and certifies to the director that from the date of the notice it will enroll all individuals requesting coverage in that area from the plan.

(3) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity has become impaired.

HISTORY:
Added Stats 2010 ch 656 § 3 (AB 2244), effective January 1, 2011. Amended Stats 2013-2014 1st Ex Sess ch 2 § 17 (SBX1 2), effective September 30, 2013, inoperative January 1, 2014, operative date contingent.

§ 1399.833. Requirement that plan discontinue offering contracts or accepting applications (Inoperative; Operative date contingent)

The director may require a health care service plan to discontinue the offering of contracts or acceptance of applications from any individual or child or responsible party for a child upon a determination by the director that the plan does not have sufficient financial viability or organizational and administrative capacity to ensure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375.1), and the rules adopted under those provisions.

HISTORY:
Added Stats 2010 ch 656 § 3 (AB 2244), effective January 1, 2011. Amended Stats 2013-2014 1st Ex Sess ch 2 § 17 (SBX1 2), effective September 30, 2013, inoperative January 1, 2014, operative date contingent.

§ 1399.834. Renewal of contracts; Plan ceasing to offer individual coverage (Inoperative; Operative date contingent)

(a) All health care service plan contracts offered to a child or on behalf of a child to a responsible party for a child shall conform to the requirements of Sections 1365, 1366.3, and 1373.6, and shall be renewable at the option of the enrollee or responsible party for a child on behalf of the enrollee except as permitted to be canceled, rescinded, or not renewed pursuant to Section 1365.

(b) Any plan that ceases to offer for sale new individual health care service plan contracts pursuant to Section 1365 shall continue to be governed by this article with respect to business conducted under this article.

(c) Except as authorized under Section 1399.833, a plan that, as of the effective date of this article, does not write new health care service plan contracts for children in this state or that, after the effective date of this article, ceases to write new health care service plan contracts for children in this state shall be prohibited from offering for sale new individual health care service plan contracts in this state for a period of five years from the date of notice to the director.

HISTORY:
Added Stats 2010 ch 656 § 3 (AB 2244), effective January 1, 2011. Amended Stats 2011 ch 296 § 143 (AB 1023), effective January 1, 2012; Stats 2013-2014 1st Ex Sess ch 2 § 17 (SBX1 2), effective September 30, 2013, inoperative January 1, 2014, operative date contingent.

§ 1399.835. Issuance of guidance to health plans regarding compliance with article (Inoperative; Operative date contingent)

On or before July 1, 2011, the director may issue guidance to health plans regarding compliance with this article and that guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The guidance shall only be effective until the director and the Insurance Commissioner adopt joint regulations pursuant to the Administrative Procedure Act.

HISTORY:
Added Stats 2010 ch 656 § 3 (AB 2244), effective January 1, 2011. Amended Stats 2011 ch 296 § 144 (AB 1023), effective January 1, 2012; Stats 2013-2014 1st Ex Sess ch 2 § 18 (SBX1 2), effective September 30, 2013, inoperative January 1, 2014, operative date contingent.

§ 1399.836. Operation of article (Inoperative; Operative date contingent)

(a) This article shall become inoperative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

(b) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this article shall become operative 12 months after the date of that repeal or amendment.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 2 § 17 (SBX1 2), effective September 30, 2013, inoperative January 1, 2014, operative date contin-

gent. Amended Stats 2015 ch 303 § 266 (AB 731), effective January 1, 2016, inoperative, operative date contingent.

ARTICLE 11.8

Individual Access to Health Care Coverage

Section
1399.845. Defintions.
1399.846. Sole proprietorships and partnerships; Individual health care service plans .
1399.847. Applicability of article.
1399.848. Individual health benefit plans; Annual enrollment period; Special enrollment period; Effective date [Effective January 1, 2020].
1399.849. Individual health benefit plans; Preexisting condition provisions prohibited; Enrollment periods; Triggering events; Coverage effective date; Plans offered outside Exchange; Limitations on eligibility rules; Single risk pool; Applicability.
1399.851. Prohibited activities for insurer, agent, or broker; Applicability; Enforcement.
1399.853. Renewability; When insurer ceases offering plans.
1399.855. Determination of premium rates (Operative term contingent).
1399.857. Requirements not placed on carriers.
1399.858. Discontinuing of offering contracts or acceptance of applications.
1399.859. Notice to applicant or subscriber of eligibility for lower cost coverage through Exchange; Applicability.
1399.861. Notice to subscriber of individual grandfathered health plan of health insurance options; Inclusion of notice in renewal material and application for dependent coverage.
1399.862. Implementation of article.
1399.863. Adoption of emergency regulations.
1399.864. Requirements of health care service plan that contracts with California Health Benefit Exchange to offer a qualified bridge plan; Medical loss ratio; Marketing and sales; Initial open enrollment (For inoperative date and repeal see subd (g)).

HISTORY: Added Stats 2013-2014 1st Ex Sess ch 2 § 18 (SBX1 2), effective September 30, 2013.

§ 1399.845. Defintions

For purposes of this article, the following definitions shall apply:

(a) "Child" means a child described in Section 22775 of the Government Code and subdivisions (n) to (p), inclusive, of Section 599.500 of Title 2 of the California Code of Regulations.

(b) "Dependent" means the spouse or registered domestic partner, or child, of an individual, subject to applicable terms of the health benefit plan.

(c) "Exchange" means the California Health Benefit Exchange created by Section 100500 of the Government Code.

(d) "Family" means the subscriber and his or her dependent or dependents.

(e) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(f) "Health benefit plan" means any individual or group health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include a specialized health care service plan contract, a health care service plan contract provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for

Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), or the program under Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, or Medicare supplement coverage, to the extent consistent with PPACA.

(g) "Policy year" means the period from January 1 to December 31, inclusive.

(h) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

(i) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(j) "Rating period" means the calendar year for which premium rates are in effect pursuant to subdivision (d) of Section 1399.855.

(k) "Registered domestic partner" means a person who has established a domestic partnership as described in Section 297 of the Family Code.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 2 § 18 (SBX1 2), effective September 30, 2013.

§ 1399.846. Sole proprietorships and partnerships; Individual health care service plans

For the purposes of determining eligibility for small employer coverage, a sole proprietor and the sole proprietor's spouse are not employees with respect to a sole proprietorship that consists only of the sole proprietor and the sole proprietor's spouse. A partner and a partner's spouse are not employees of a partnership that consists solely of partners and their spouses. Employer group health care service plans shall not be issued, marketed, or sold to a sole proprietorship or partnership without employees directly or indirectly through any arrangement. Only individual health care service plans shall be sold to any entity without employees.

HISTORY:
Added Stats 2018 ch 700 § 6 (SB 1375), effective January 1, 2019.

§ 1399.847. Applicability of article

Except as provided in Sections 1399.858 and 1399.861, the provisions of this article shall only apply with respect to nongrandfathered individual health benefit plans offered by a health care service plan, and shall apply in addition to the other provisions of this chapter and the rules adopted thereunder.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 2 § 18 (SBX1 2), effective September 30, 2013.

§ 1399.848. Individual health benefit plans; Annual enrollment period; Special enrollment period; Effective date [Effective January 1, 2020]

(a) Notwithstanding paragraph (1) of subdivision (c) of Section 1399.849, with respect to individual health benefit plans offered outside of the Exchange, a plan shall provide an annual enrollment period for policy years beginning on or after January 1, 2020, from November 1 of the preceding calendar year, to January 31 of the benefit year, inclusive.

(b) Notwithstanding paragraph (3) of subdivision (c) of Section 1399.849, with respect to individual health benefit plans offered through the Exchange, for policy years beginning on or after January 1, 2020, a plan shall provide a special enrollment period for all individuals selecting an individual health benefit plan through the Exchange from December 16 of the preceding calendar year, to January 31 of the benefit year, inclusive. An application for a health benefit plan submitted during this special enrollment period shall be treated the same as an application submitted during the annual open enrollment period.

(c) The effective date of coverage for plan selection made from December 16 to January 31, inclusive, shall be February 1 of the benefit year for individual health benefit plans offered outside and through the Exchange.

HISTORY:
Added Stats 2019 ch 828 § 1 (AB 1309), effective January 1, 2020.

§ 1399.849. Individual health benefit plans; Preexisting condition provisions prohibited; Enrollment periods; Triggering events; Coverage effective date; Plans offered outside Exchange; Limitations on eligibility rules; Single risk pool; Applicability

(a)(1) On and after October 1, 2013, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan provides or arranges for the provision of health care services. A plan shall limit enrollment in individual health benefit plans to open enrollment periods, annual enrollment periods, and special enrollment periods as provided in subdivisions (c) and (d).

(2) A plan shall allow the subscriber of an individual health benefit plan to add a dependent to the subscriber's plan at the option of the subscriber, consistent with the open enrollment, annual enrollment, and special enrollment period requirements in this section.

(b) An individual health benefit plan issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.

(c)(1) With respect to individual health benefit plans offered outside of the Exchange, a plan shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, an annual enrollment period for the policy year beginning on January 1, 2015, from November 15, 2014, to February 15, 2015, inclusive, annual enrollment periods for policy years beginning on or after January 1, 2016, to December 31, 2018, inclusive, from

November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive, and annual enrollment periods for policy years beginning on or after January 1, 2019, from October 15, of the preceding calendar year, to January 15 of the benefit year, inclusive.

(2) With respect to individual health benefit plans offered through the Exchange, a plan shall provide an annual enrollment period for the policy years beginning on January 1, 2016, to December 31, 2018, inclusive, from November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive, and annual enrollment periods for policy years beginning on or after January 1, 2019, from November 1 to December 15 of the preceding calendar year, inclusive.

(3) With respect to individual health benefit plans offered through the Exchange, for policy years beginning on or after January 1, 2019, a plan shall provide a special enrollment period for all individuals selecting an individual health benefit plan through the Exchange from October 15 to October 31 of the preceding calendar year, inclusive, and from December 16, of the preceding calendar year, to January 15 of the benefit year, inclusive. An application for a health benefit plan submitted during these two special enrollment periods shall be treated the same as an application submitted during the annual open enrollment period. The effective date of coverage for plan selections made between October 15 and October 31, inclusive, shall be January 1 of the benefit year, and for plan selections made from December 16 to January 15, inclusive, shall be no later than February 1 of the benefit year.

(4) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar year individual health plan contracts, a plan shall also provide a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

(d)(1) Subject to paragraph (2), commencing January 1, 2014, a plan shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

(A) The individual or the individual's dependent loses minimum essential coverage. For purposes of this paragraph, the following definitions shall apply:

(i) "Minimum essential coverage" has the same meaning as that term is defined in Section 1345.5 or subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

(ii) "Loss of minimum essential coverage" includes, but is not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code. "Loss of minimum essential coverage" also includes loss of that coverage for a reason that is not due to the fault of the individual.

(iii) "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to clause (ii) and Sections 1389.7 and 1389.21.

(B) The individual gains a dependent or becomes a dependent.

(C) The individual is mandated to be covered as a dependent pursuant to a valid state or federal court order.

(D) The individual has been released from incarceration.

(E) The individual's health coverage issuer substantially violated a material provision of the health coverage contract.

(F) The individual gains access to new health benefit plans as a result of a permanent move.

(G) The individual was receiving services from a contracting provider under another health benefit plan, as defined in Section 1399.845 of this code or Section 10965 of the Insurance Code, for one of the conditions described in subdivision (c) of Section 1373.96 of this code and that provider is no longer participating in the health benefit plan.

(H) The individual demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the department, with respect to health benefit plans offered outside the Exchange, that the individual did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because the individual was misinformed that the individual was covered under minimum essential coverage.

(I) The individual is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

(J) With respect to individual health benefit plans offered through the Exchange, in addition to the triggering events listed in this paragraph, any other events listed in Section 155.420(d) of Title 45 of the Code of Federal Regulations.

(2) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to apply for coverage from a health care service plan subject to this section. With respect to individual health benefit plans offered through the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to select a plan offered through the Exchange, unless a longer period is provided in Part 155 (commencing with Section 155.10) of Subchapter B of Subtitle A of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage required pursuant to this section shall be consistent with the dates specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations, as applicable. A dependent who is a registered domestic partner pursuant to Section 297 of the Family Code shall have the same effective date of coverage as a spouse.

(f) With respect to individual health benefit plans offered outside the Exchange, the following provisions shall apply:

(1) After an individual submits a completed application form for a plan contract, the health care service plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 1399.855. The individual shall have 30

days in which to exercise the right to buy coverage at the quoted premium charges.

(2) With respect to an individual health benefit plan for which an individual applies during the initial open enrollment period described in paragraph (1) of subdivision (c), when the subscriber submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, to December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan for which an individual applies during the annual open enrollment period described in paragraph (1) of subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15 of the preceding calendar year, coverage shall become effective on January 1 of the benefit year. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 to December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(4) With respect to an individual health benefit plan for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month. When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(B) Notwithstanding subparagraph (A), in the case of a birth, adoption, or placement for adoption, the coverage shall be effective on the date of birth, adoption, or placement for adoption.

(C) Notwithstanding subparagraph (A), in the case of marriage or becoming a registered domestic partner or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the month following the date the plan receives the request for special enrollment.

(g)(1) A health care service plan shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:

(A) Health status.

(B) Medical condition, including physical and mental illnesses.

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability, including conditions arising out of acts of domestic violence.

(H) Disability.

(I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act (Public Law 78-410).

(2) Notwithstanding Section 1389.1, a health care service plan shall not require an individual applicant or the applicant's dependent to fill out a health assessment or medical questionnaire prior to enrollment under an individual health benefit plan. A health care service plan shall not acquire or request information that relates to a health status-related factor from the applicant or the applicant's dependent or any other source prior to enrollment of the individual.

(h)(1) A health care service plan shall consider as a single risk pool for rating purposes in the individual market the claims experience of all insureds and all enrollees in all nongrandfathered individual health benefit plans offered by that health care service plan in this state, whether offered as health care service plan contracts or individual health insurance policies, including those insureds and enrollees who enroll in individual coverage through the Exchange and insureds and enrollees who enroll in individual coverage outside of the Exchange. Student health insurance coverage, as that coverage is defined in Section 147.145(a) of Title 45 of the Code of Federal Regulations, shall not be included in a health care service plan's single risk pool for individual coverage.

(2) Each calendar year, a health care service plan shall establish an index rate for the individual market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment program established for the state pursuant to Section 1343 of PPACA and Exchange user fees, as described in subdivision (d) of Section 156.80 of Title 45 of the Code of Federal Regulations. The premium rate for all of the health benefit plans in the individual market within the single risk pool required under paragraph (1) shall use the applicable marketwide adjusted index rate, subject only to the adjustments permitted under paragraph (3).

(3) A health care service plan may vary premium rates for a particular health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 1367.005. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(E) Administrative costs, excluding user fees required by the Exchange.

(i) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

(j) This section shall not apply to a grandfathered health plan.

(k) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), subdivisions (a), (b), and (g) shall become inoperative 12 months after that repeal or amendment.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 2 § 18 (SBX1 2), effective September 30, 2013. Amended Stats 2014 ch 24 § 1 (SB 20), effective June 16, 2014, ch 572 § 13 (SB 959), effective January 1, 2015; Stats 2015 ch 9 § 2 (SB 125), effective June 17, 2015; Stats 2017 ch 468 § 3 (AB 156), effective January 1, 2018; Stats 2019 ch 38 § 17 (SB 78), effective June 27, 2019.

§ 1399.851. Prohibited activities for insurer, agent, or broker; Applicability; Enforcement

(a) Commencing October 1, 2013, a health care service plan or solicitor shall not, directly or indirectly, engage in the following activities:

(1) Encourage or direct an individual to refrain from filing an application for individual coverage with a plan because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the plan's approved service area, of the individual.

(2) Encourage or direct an individual to seek individual coverage from another plan or health insurer or the California Health Benefit Exchange because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the plan's approved service area, of the individual.

(3) Employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

(b) Commencing October 1, 2013, a health care service plan shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of an individual health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the

individual. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the individual.

(c) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 2 § 18 (SBX1 2), effective September 30, 2013.

§ 1399.853. Renewability; When insurer ceases offering plans

(a) An individual health benefit plan shall be renewable at the option of the enrollee except as permitted to be canceled, rescinded, or not renewed pursuant to Section 1365 and Section 155.430(b) of Title 45 of the Code of Federal Regulations.

(b) Any plan that ceases to offer for sale new individual health benefit plans pursuant to Section 1365 shall continue to be governed by this article with respect to business conducted under this article.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 2 § 18 (SBX1 2), effective September 30, 2013.

§ 1399.855. Determination of premium rates (Operative term contingent)

(a) With respect to individual health benefit plans for policy years on or after January 1, 2014, a health care service plan may use only the following characteristics of an individual, and any dependent thereof, for purposes of establishing the rate of the individual health benefit plan covering the individual and the eligible dependents thereof, along with the health benefit plan selected by the individual:

(1) Age, pursuant to the age bands established by the United States Secretary of Health and Human Services and the age rating curve established by the federal Centers for Medicare and Medicaid Services pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall be determined using the individual's age as of the date of the health benefit plan contract issuance or renewal, as applicable, and shall not vary by more than three to one for like individuals of different age who are 21 years of age or older as described in federal regulations adopted pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)).

(2)(A) Geographic region. The geographic regions for purposes of rating shall be the following:

(i) Region 1 shall consist of the Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

(ii) Region 2 shall consist of the Counties of Marin, Napa, Solano, and Sonoma.

(iii) Region 3 shall consist of the Counties of El Dorado, Placer, Sacramento, and Yolo.

(iv) Region 4 shall consist of the City and County of San Francisco.

(v) Region 5 shall consist of the County of Contra Costa.

(vi) Region 6 shall consist of the County of Alameda.

(vii) Region 7 shall consist of the County of Santa Clara.

(viii) Region 8 shall consist of the County of San Mateo.

(ix) Region 9 shall consist of the Counties of Monterey, San Benito, and Santa Cruz.

(x) Region 10 shall consist of the Counties of Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.

(xi) Region 11 shall consist of the Counties of Fresno, Kings, and Madera.

(xii) Region 12 shall consist of the Counties of San Luis Obispo, Santa Barbara, and Ventura.

(xiii) Region 13 shall consist of the Counties of Imperial, Inyo, and Mono.

(xiv) Region 14 shall consist of the County of Kern.

(xv) Region 15 shall consist of the ZIP Codes in the County of Los Angeles starting with 906 to 912, inclusive, 915, 917, 918, and 935.

(xvi) Region 16 shall consist of the ZIP Codes in the County of Los Angeles other than those identified in clause (xv).

(xvii) Region 17 shall consist of the Counties of Riverside and San Bernardino.

(xviii) Region 18 shall consist of the County of Orange.

(xix) Region 19 shall consist of the County of San Diego.

(B) No later than June 1, 2017, the department, in collaboration with the Exchange and the Department of Insurance, shall review the geographic rating regions specified in this paragraph and the impacts of those regions on the health care coverage market in California, and make a report to the appropriate policy committees of the Legislature.

(3) Whether the plan covers an individual or family, as described in PPACA.

(b) The rate for a health benefit plan subject to this section shall not vary by any factor not described in this section.

(c) With respect to family coverage under an individual health benefit plan, the rating variation permitted under paragraph (1) of subdivision (a) shall be applied based on the portion of the premium attributable to each family member covered under the plan. The total premium for family coverage shall be determined by summing the premiums for each individual family member. In determining the total premium for family members, premiums for no more than the three oldest family members who are under 21 years of age shall be taken into account.

(d) The rating period for rates subject to this section shall be from January 1 to December 31, inclusive.

(e) This section does not apply to an individual health benefit plan that is a grandfathered health plan.

(f) The requirement for submitting a report imposed under subparagraph (B) of paragraph (2) of subdivision (a) is inoperative on June 1, 2021, pursuant to Section 10231.5 of the Government Code.

(g) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become inoperative 12 months after the date of that repeal or amendment.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 2 § 18 (SBX1 2), effective September 30, 2013.
Amended Stats 2015 ch 303 § 267 (AB 731), effective January 1, 2016, operative term contingent.

§ 1399.857. Requirements not placed on carriers

(a) A health care service plan shall not be required to offer an individual health benefit plan or accept applications for the plan pursuant to Section 1399.849 in the case of any of the following:

(1) To an individual who does not live or reside within the plan's approved service areas.

(2)(A) Within a specific service area or portion of a service area, if the plan reasonably anticipates and demonstrates to the satisfaction of the director both of the following:

(i) It will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the individual because of its obligations to existing enrollees.

(ii) It is applying this subparagraph uniformly to all individuals without regard to the claims experience of those individuals or any health status-related factor relating to those individuals.

(B) A health care service plan that cannot offer an individual health benefit plan to individuals because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area pursuant to subparagraph (A) shall not offer a health benefit plan in that area to individuals until the later of the following dates:

(i) The 181st day after the date coverage is denied pursuant to this paragraph.

(ii) The date the plan notifies the director that it has the ability to deliver services to individuals, and certifies to the director that from the date of the notice it will enroll all individuals requesting coverage in that area from the plan.

(C) Subparagraph (B) shall not limit the plan's ability to renew coverage already in force or relieve the plan of the responsibility to renew that coverage as described in Section 1365.

(D) Coverage offered within a service area after the period specified in subparagraph (B) shall be subject to this section.

(b)(1) A health care service plan may decline to offer an individual health benefit plan to an individual if the plan demonstrates to the satisfaction of the director both of the following:

(A) It does not have the financial reserves necessary to underwrite additional coverage. In determining whether this subparagraph has been satisfied, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

(B) It is applying this subdivision uniformly to all individuals without regard to the claims experience of those individuals or any health status-related factor relating to those individuals.

(2) A plan that denies coverage to an individual under paragraph (1) shall not offer coverage before the later of the following dates:

(A) The 181st day after the date that coverage is denied pursuant to this subdivision.

(B) The date the plan demonstrates to the satisfaction of the director that the plan has sufficient financial reserves necessary to underwrite additional coverage.

(3) Paragraph (2) shall not limit the plan's ability to renew coverage already in force or relieve the plan of the responsibility to renew that coverage as described in Section 1365.

(4) Coverage offered within a service area after the period specified in paragraph (2) shall be subject to this section.

(c) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity has become impaired, to the extent permitted by PPACA.

(d) This section shall not apply to an individual health benefit plan that is a grandfathered health plan.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 2 § 18 (SBX1 2), effective September 30, 2013.

§ 1399.858. Discontinuing of offering contracts or acceptance of applications

The director may require a plan to discontinue the offering of contracts or acceptance of applications from any individual, or responsible party for an individual, upon a determination by the director that the plan does not have sufficient financial viability, or organizational and administrative capacity to ensure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 2 § 18 (SBX1 2), effective September 30, 2013.

§ 1399.859. Notice to applicant or subscriber of eligibility for lower cost coverage through Exchange; Applicability

(a) A health care service plan that receives an application for an individual health benefit plan outside the Exchange during the initial open enrollment period, an annual enrollment period, or a special enrollment period described in Section 1399.849 shall inform the applicant that he or she may be eligible for lower cost coverage through the Exchange and shall inform the applicant of the

applicable enrollment period provided through the Exchange described in Section 1399.849.

(b) On or before October 1, 2013, and annually every October 1 thereafter, a health care service plan shall issue a notice to a subscriber enrolled in an individual health benefit plan offered outside the Exchange. The notice shall inform the subscriber that he or she may be eligible for lower cost coverage through the Exchange and shall inform the subscriber of the applicable open enrollment period and special enrollment periods provided through the Exchange described in Section 1399.849.

(c) This section shall not apply where the individual health benefit plan described in subdivision (a) or (b) is a grandfathered health plan.

HISTORY:

Added Stats 2013-2014 1st Ex Sess ch 2 § 18 (SBX1 2), effective September 30, 2013.

Amended Stats 2017 ch 468 § 4 (AB 156), effective January 1, 2018.

§ 1399.861. Notice to subscriber of individual grandfathered health plan of health insurance options; Inclusion of notice in renewal material and application for dependent coverage

(a) On or before October 1, 2013, and annually every October 1 thereafter, a health care service plan shall issue the following notice to all subscribers enrolled in an individual health benefit plan that is a grandfathered health plan:

New improved health insurance options are available in California. You currently have health insurance that is not required to follow many of the new laws. For example, your plan may not provide preventive health services without you having to pay any cost sharing (copayments or coinsurance). Also, your current plan may be allowed to increase your rates based on your health status while new plans and policies cannot. You have the option to remain in your current plan or switch to a new plan. Under the new rules, a health plan cannot deny your application based on any health conditions you may have. For more information about your options, please contact Covered California at ____, your plan representative or insurance agent, or an entity paid by Covered California to assist with health coverage enrollment such as a navigator or an assister.

(b) Commencing October 1, 2013, a health care service plan shall include the notice described in subdivision (a) in any renewal material of the individual grandfathered health plan and in any application for dependent coverage under the individual grandfathered health plan.

(c) A health care service plan shall not advertise or market an individual health benefit plan that is a grandfathered health plan for purposes of enrolling a dependent of a subscriber into the plan for policy years on or after January 1, 2014. Nothing in this subdivision shall be construed to prohibit an individual enrolled in an individual grandfathered health plan from adding a dependent to that plan to the extent permitted by PPACA.

HISTORY:

Added Stats 2013-2014 1st Ex Sess ch 2 § 18 (SBX1 2), effective September 30, 2013.

Amended Stats 2014 ch 31 § 9 (SB 857), effective June 20, 2014.

§ 1399.862. Implementation of article

Except as otherwise provided in this article, this article shall only be implemented to the extent that it meets or exceeds the requirements set forth in PPACA.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 2 § 18 (SBX1 2), effective September 30, 2013.

§ 1399.863. Adoption of emergency regulations

(a) The department may adopt emergency regulations implementing this article no later than December 31, 2014. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(b) The initial adoption of emergency regulations implementing this article and the one readoption of emergency regulations authorized by this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than one year, by which time final regulations may be adopted. The department shall consult with the Insurance Commissioner prior to adopting any regulations pursuant to this section for the specific purpose of ensuring, to the extent practical, that there is consistency of regulations applicable to entities regulated by the department and those regulated by the Insurance Commissioner.

HISTORY:
Added Stats 2013-2014 1st Ex Sess ch 2 § 18 (SBX1 2), effective September 30, 2013.

§ 1399.864. Requirements of health care service plan that contracts with California Health Benefit Exchange to offer a qualified bridge plan; Medical loss ratio; Marketing and sales; Initial open enrollment (For inoperative date and repeal see subd (g))

(a) For purposes of this article, a bridge plan product shall mean an individual health benefit plan, as defined in subdivision (f) of Section 1399.845, that is offered by a health care service plan licensed under this chapter that contracts with the Exchange pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(b) Until December 31, 2014, a health care service plan that contracts with the California Health Benefit Exchange to offer a qualified bridge plan product pursuant to Section 100504 of the Government Code shall do all of the following:

(1) As of the effective date of this section, if the health care service plan has not been approved by the director to offer individual health benefit plans

pursuant to this chapter, the plan shall file a material modification pursuant to Section 1352 to expand its license to include individual health benefit plans.

(2) As of the effective date of this section, if the health care service plan has been approved by the director to offer individual health benefit plans pursuant to this chapter, the plan shall, pursuant to Section 1352, file an amendment to expand its license to include a bridge plan product as an individual health benefit plan.

(c) During the time the health care service plan's material modification or amendment is pending approval by the director, the health care service plan shall be deemed to comply with subdivision (b) of Section 100507 of the Government Code.

(d) A health care service plan shall maintain a medical loss ratio of 85 percent for the bridge plan product. A health care service plan shall utilize, to the extent possible, the same methodology for calculating the medical loss ratio for the bridge plan product that is used for calculating the health care service plan medical loss ratio pursuant to Section 1367.003 and shall report its medical loss ratio for the bridge plan product to the department as provided in Section 1367.003.

(e) Notwithstanding subdivision (a) of Section 1399.849, a health care service plan selling a bridge plan product shall not be required to fairly and affirmatively offer, market, and sell the health care service plan's bridge plan product except to individuals eligible for the bridge plan product pursuant to the State Department of Health Care Services and the Medi-Cal managed care plan's contract entered into pursuant to Section 14005.70 of the Welfare and Institutions Code, provided the health care service plan meets the requirements of subdivision (b) of Section 14005.70 of the Welfare and Institutions Code.

(f) Notwithstanding subdivision (c) of Section 1399.849, a health care service plan selling a bridge plan product shall provide an initial open enrollment period of six months, and an annual enrollment period and a special enrollment period consistent with the annual enrollment and special enrollment periods of the Exchange.

(g) This section shall become inoperative on the October 1 that is five years after the date that federal approval of the bridge plan option occurs, and, as of the second January 1 thereafter, is repealed, unless a later enacted statute that is enacted before that date deletes or extends the dates on which it becomes inoperative and is repealed.

HISTORY:

Added Stats 2013–2014 1st Ex Sess ch 5 § 10 (SBX1 3), effective September 30, 2013.

CALIFORNIA CODE OF REGULATIONS

TITLE 28
Managed Health Care

DIVISION 1
The Department of Managed Health Care

CHAPTER 1
Department Administration

Article
1. Conflict of Interest
2. Administration
3. Electronic Filing

ARTICLE 1
Conflict of Interest

Section
1000. Conflict of Interest for the Department of Managed Health Care.

§ 1000. Conflict of Interest Code for the Department of Managed Health Care.

The Political Reform Act, Government Code Section 81000, et seq., requires state and local government agencies to adopt and promulgate conflict of interest codes. The Fair Political Practices Commission has adopted a regulation (Title 2, California Code of Regulations (CCR), section 18730), which contains the terms of a standard conflict of interest code, which can be incorporated by reference in an agency's code. After public notice and hearing it may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act. Therefore, the terms of 2 CCR, section 18730, and any amendments to it, duly adopted by the Fair Political Practices Commission are hereby incorporated by reference. This section 1000, the attached Appendix, along with 2 CCR section 18730, designating officials and employees and establishing disclosure categories, shall constitute the conflict of interest code of the Department of Managed Health Care (Department).

Designated employees shall file statements of economic interests with the Office of Legal Services of the Department, which will make the statements available for public inspection and reproduction (Government Code, section 81008). Upon receipt of the statement of the Director of the Department, the Office of Legal Services shall make and retain a copy and forward the original to the Fair Political Practices Commission. Statements for all other designated employees will be retained by the Office of Legal Services of the Department.

NOTE: Authority cited: Section 1344, Health and Safety Code; Section 87300, Government Code. Reference: Sections 87300-87302 and 87306, Government Code (the Political Reform Act).

History:

1. New chapter 1, article 1 (section 1000), section and appendix filed 12-12-2001, including editorial renumbering of former chapter 1 to chapter 2; operative 1-11-2002. Approved by Fair Political Practices Commission 10-3-2001 (Register 2001, No. 50).
2. Amendment of division heading filed 8-12-2002; operative 9-11-2002 (Register 2002, No. 33).

3. Change without regulatory effect amending chapter 1 heading, section and appendix disclosure category C(1)-(2) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).
4. Amendment of Appendix filed 7-21-2003; operative 8-20-2003. Approved by Fair Political Practices Commission 5-12-2003 (Register 2003, No. 30).
5. Change without regulatory effect amending first paragraph filed 2-24-2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 9).
6. Amendment of Appendix filed 2-3-2005; operative 3-5-2005. Approved by Fair Political Practices Commission 12-3-2004 (Register 2005, No. 5).
7. Repealer of section and Appendix and new section and appendices A and B filed 11-18-2015; operative 12-18-2015 pursuant to Cal. Code Regs., tit. 2, section 18750(*l*). Approved by Fair Political Practices Commission 10-28-2015 and submitted to OAL for filing and printing only pursuant to Cal. Code Regs., tit. 2, section 18750(k) (Register 2015, No. 47).

Appendix A

DEPARTMENT OF MANAGED HEALTH CARE

DESIGNATED POSITIONS	ASSIGNED DISCLOSURE CATEGORY (IES)
OFFICE OF THE DIRECTOR	
Director, Department of Managed Health Care	1, 5
Chief Deputy Director, all levels, wherever assigned	1, 5
Deputy Directors, all levels, wherever assigned	1, 5
Division Chiefs, all levels, wherever assigned	1, 5
CEAs, all levels, wherever assigned	1, 5
Staff Services Managers, all levels	2, 3
Associate Governmental Program Analysts, all levels	3, 4
Attorneys, supervisory and non-supervisory, all levels	1
Information Officers, all levels, wherever assigned	2, 3
Health Program Specialists/Advisors, all levels	2, 3
Medical Advisors to the Director's Office	2, 3
Health Policy Advisor, all levels	2, 3
Research Program Specialist	2, 3
OFFICE OF ADMINSTRATIVE SERVICES	
Accounting Administrator II	4
Staff Services Managers, all levels	4
OFFICE OF ENFORCEMENT	
Attorneys, supervisory and non-supervisory, all levels	1
Legal Analysts, all levels	2, 3
Associate Governmental Program Analysts, all levels	3, 4
Staff Services Managers, all levels	2, 3
Corporations Investigators, all levels	2, 3

DESIGNATED POSITIONS	ASSIGNED DISCLOSURE CATEGORY (IES)
HELP CENTER	
Health Program Manager, all levels	2, 3
Health Program Specialists, all levels	2, 3
Staff Services Managers, all levels	2, 3
Associate Governmental Program Analyst. all levels	3
Legal Analysts, all levels	2, 3
Nurses, all levels	2, 3
Attorneys, supervisory and non-supervisory, all levels	1
Staff Services Analysts, all levels	2, 3
Associate Health Program Analysts, all levels	2, 3
Health Care Service Plan Analysts, all levels	2, 3
OFFICE OF FINANCIAL REVIEW	
Examiners, supervisory and non-supervisory, all levels	2, 3
Actuaries, supervisory and non-supervisory, all levels	2, 3
Auditors, supervisory and non-supervisory, all levels	2, 3
Staff Services Managers, all levels	2, 3
Associate Governmental Program Analyst. all levels	3
Health Program Specialists, all levels	2, 3
Associate Health Program Advisors, all levels	2, 3
OFFICE OF LEGAL SERVICES	
Attorneys, supervisory and non-supervisory, all levels	1
Staff Services Managers, all levels	2, 3
Legal Analysts, all levels	2, 3
OFFICE OF PLAN LICENSING	
Attorneys, supervisory and non-supervisory, all levels	1
Staff Services Managers, all levels	2, 3
Associate Health Program Advisors, all levels	2, 3
Health Program Specialists, all levels	2, 3
Health Program Managers, all levels	2, 3
Associate Governmental Program Analysts, all levels	3

DESIGNATED POSITIONS	ASSIGNED DISCLOSURE CATEGORY (IES)
OFFICE OF TECHNOLOGY AND INNOVATION	
Data Processing Managers, all levels	4
Information Systems Analysts, all levels	4
System Software Specialists, all levels	4
Programmer Analysts, all levels	4

Consultants/New Positions[1]

[1] Consultants/New Positions shall disclose pursuant to the broadest disclosure category in the code (Category 1) subject to the following limitations:

The Director of the Department may determine in writing that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such wr itten determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. The Director's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict of interest code. Nothing herein excuses any such consultant from any other provisions of this Conflict of Interest Code.

Appendix B

Disclosure Categories

Category 1

Each designated position in this category shall report:

Investments and business positions in business entities, and income (including the receipt of loans, gifts, and travel payments), from any source that are subject to the regulatory, permit or licensing authority of, or have an application for a license or permit pending before, the Department.

* has been the subject of or participated in any legislation or rulemaking activity, any decision, order, or rule issued or enforced by the Department;
* is exempted from the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended by rule of the Director;
* provides medical and health care services and supplies such as hospitals, medical groups, risk-bearing organizations (RBOs), independent practice associations (IPAs), pharmaceutical companies, retail pharmacies, surgical centers, and ambulance companies;
* filed or has pending, a grievance, complaint, or enforcement matter with the Department for whom you made or participated in making the decision, or influenced the outcome of the decision, regarding the grievance or complaint within the past 24 months;
* provided, serviced or installed goods, services, supplies, materials, machinery, equipment, telecommunications, information technology or consulting services utilized by the Department;

Category 2

Each "designated position" in this category shall report:

Investments and business positions in business entities, and income (including the receipt of loans, gifts, and travel payments), from any source that provides medical and health care services and supplies such as hospitals,

medical groups, risk-bearing organizations (RBOs), independent practice associations (IPAs), pharmaceutical companies, retail pharmacies, surgical centers, and ambulance companies.

Category 3

Each designated position in this category shall report:

Investments and business positions in business entities, and income (including the receipt of loans, gifts, and travel payments), from any source that filed or has pending, a grievance, complaint, or enforcement matter with the employee's division for whom you made or participated in making the decision, or influenced the outcome of the decision, regarding the grievance or complaint within the past 24 months.

Category 4

Each designated position in this category shall report:

Investments and business positions in business entities, and income (including the receipt of loans, gifts, and travel payments), from any source that has provided goods, services, supplies, materials, machinery, equipment, telecommunications, or consulting services utilized by the employee's division.

Category 5

Each designated positions in this category shall report:

Investments and business positions in business entities, and income (including the receipt of loans, gifts, and travel payments), from sources that has interests in commercial real property, used in the delivery of healthcare services administrated by the Department

* has sources of income from commercial real property in which the Department has an office
* from any source that engages in land development, construction or the acquisition or sale of real property used in any way in the delivery or regulation of health care services administrated by the Department.

NOTE: Authority cited: Section 1344, Health and Safety Code; Section 87300, Government Code. Reference: Sections 87300-87302 and 87306, Government Code (the Political Reform Act).

History:

1. New chapter 1, article 1 (section 1000), section and appendix filed 12-12-2001, including editorial renumbering of former chapter 1 to chapter 2; operative 1-11-2002. Approved by Fair Political Practices Commission 10-3-2001 (Register 2001, No. 50).
2. Amendment of division heading filed 8-12-2002; operative 9-11-2002 (Register 2002, No. 33).
3. Change without regulatory effect amending chapter 1 heading, section and appendix disclosure category C(1)-(2) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).
4. Amendment of Appendix filed 7-21-2003; operative 8-20-2003. Approved by Fair Political Practices Commission 5-12-2003 (Register 2003, No. 30).
5. Change without regulatory effect amending first paragraph filed 2-24-2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 9).
6. Amendment of Appendix filed 2-3-2005; operative 3-5-2005. Approved by Fair Political Practices Commission 12-3-2004 (Register 2005, No. 5).
7. Repealer of section and Appendix and new section and appendices A and B filed 11-18-2015; operative 12-18-2015 pursuant to Cal. Code Regs., tit. 2, section 18750(*l*). Approved by Fair Political Practices Commission 10-28-2015 and submitted to OAL for filing and printing only pursuant to Cal. Code Regs., tit. 2, section 18750(k) (Register 2015, No. 47).

ARTICLE 2
Administration

Section
1001. Department Internet Web Page and Web Addresses.
1002. Appearance and Practice Before the Department.
1002.4. Public Meetings and Hearings.
1003. Public Comment During Department Meetings.
1004. Verification.
1005. Interpretive Opinions.
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1008. Availability of Department Forms, Publications and Notices; Fees.
1009. Retention of Department Records.
1010. Consumer Participation Program.
1011. Assessment for University of California Analysis of Proposed Mandate Legislation.

§ 1001. Department Internet Web Page and Web Addresses.

The Department shall maintain an internet web page containing information about the Department, its functions and activities. The internet web page may be accessed to obtain departmental forms, notices, and other publications. The internet web page shall be accessible by either of two web addresses: http://www.dmhc.ca.gov, or http://www.hmohelp.ca.gov.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1344, Health and Safety Code.

History:
1. New article 2 (sections 1001-1008) and section filed 8-12-2002; operative 9-11-2002 (Register 2002, No. 33).

§ 1002. Appearance and Practice Before the Department.

A person may be represented by an attorney at law in any proceeding before the Director or Department, provided the attorney is admitted to practice before the highest court of any state or territory of the United States, or the Court of Appeals or the District Court of the United States for the District of Columbia. Alternatively, a person may appear before the Director or Department on his or her own behalf; a member of a partnership may represent the partnership; and an authorized officer of a corporation, trust or association may represent that corporation, trust or association.

NOTE: Authority cited: Sections 1344 and 1346, Health and Safety Code. Reference: Sections 1341, 1342, 1348-1349, 1370, 1386-1388 and 1390-1393, Health and Safety Code.

History:
1. New section filed 8-12-2002; operative 9-11-2002 (Register 2002, No. 33).

§ 1002.4. Public Meetings and Hearings.

(a) A public meeting or hearing may be held pursuant to Health and Safety Code section 1346(a)(5) at the discretion of the Director for the following types of proceedings:

(1) Investigation or analysis of matters affecting the interests of plans, subscribers, enrollees, or the public.

(2) Educational programs for the public, subscribers, enrollees, and licensees.

(3) An amendment, material modification or other plan filing that proposes:

(A) Any change that may have a significant impact, as determined by the Director, on the ability of enrollees to access health care services; or

(B) Any change that may have a material effect, as determined by the Director, on the health care service plan (plan) or on its operations.

(b) Factors that may be considered by the Director in determining whether to hold a public meeting or hearing include:

(1) Whether the proposal has a significant impact on plans, providers, subscribers, enrollees, or Californians generally, including the nature, scope, and significance of any such impact;

(2) Whether a public meeting or hearing would help to assure identification of all relevant issues raised in the proposal, and/or ongoing monitoring of the plan, and inform their resolution;

(3) Whether a public meeting or hearing would provide additional facts or opinions relevant to a decision whether to approve the filing, including any conditions or undertakings to impose on the approval;

(4) Whether a public meeting or hearing would provide a greater depth or scope of understanding of the potential short-term and long-term results or ramifications of an approval, with or without conditions;

(5) Whether the likely costs to the Department outweigh the potential benefit; and

(6) Whether there is sufficient time to hold a meeting or hearing.

(c) Requests for Public Meeting or Hearing.

(1) Any person may request a public meeting or hearing by filing a written request with the Department.

(2) A request for public meeting or hearing shall:

(A) Be in writing addressed to the Director, in care of the Office of Legal Services, Department of Managed Health Care, 980 Ninth Street, Suite 500, Sacramento, CA 95814, or by e-mail addressed to publichearing@dmhc.ca.gov; and

(B) Clearly state that it is a request for a public meeting or hearing and state the matter upon which the public meeting or hearing is requested, including the relevant facts and/or circumstances upon which the request is made; and

(C) Identify the persons or entities on whose behalf the request is made and specify the address to which the Director's determination pursuant to subsection (c)(3) may be mailed or e-mailed.

(3) The Director will determine whether the request for a meeting or hearing warrants a public meeting or hearing.

(4) The Director will notify the person requesting a meeting or hearing of the determination within ten business days of the date the request is submitted.

NOTE: Authority cited: Sections 1342, 1344 and 1346, Health and Safety Code. Reference: Section 1346(a)(5), Health and Safety Code.

History:

1. New section filed 9-11-2006; operative 10-11-2006 (Register 2006, No. 37).

§ 1003. Public Comment During Department Meetings.

At all Department committee, panel or board meetings that are subject to the Bagley-Keene Open Meeting Act (Government Code § 11120 et seq.), members of the public will be permitted to address the committee, panel or board prior to the committee, panel or board making any decision. Public comments will be heard in the order in which speakers sign up; limited to only agenda items; and may be no longer than five minutes in length unless otherwise permitted.

NOTE: Authority cited: Sections 1344 and 1346, Health and Safety Code; and Section 11125.7, Government Code. Reference: Sections 1347, 1347.1 and 1347.15, Health and Safety Code.

History:

1. New section filed 8-12-2002; operative 9-11-2002 (Register 2002, No. 33).

§ 1004. Verification.

(a) Whenever a statute, regulation or the Director requires that a document filed with the Department be verified, the verification shall be by declaration under penalty of perjury pursuant to Code of Civil Procedure section 2015.5.

(b) "Declaration" means a certification in substantially the following form:

(1) I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at _____ on _____
(Location) (Date)

_____ _____
(Signature) (Typed or printed name)

NOTE: Authority cited: Sections 1344 and 1346, Health and Safety Code. Reference: Sections 2012-2015.5, Code of Civil Procedure.

History:

1. New section filed 8-12-2002; operative 9-11-2002 (Register 2002, No. 33).

§ 1005. Interpretive Opinions.

(a) The Director in his or her discretion may honor requests from interested person(s) for written interpretive opinions regarding any provision of, or regulation promulgated pursuant to, the Act.

(b) An interpretive opinion request shall satisfy each of the following conditions:

(1) The request shall be in writing addressed to the Director in care of the Office of Legal Services at the Sacramento Office of the Department or by e-mail at interpretiveopinion@dmhc.ca.gov. The request shall clearly state that it is a request for an interpretive opinion and set forth the question(s) presented, including the relevant facts and/or circumstances upon which the request is made.

(2) The persons or entities on whose behalf the request is made shall be identified and all documents relevant to the request shall be appended to the request.

(c) Each interpretive opinion is applicable only to the matter identified in the specific written request for which the interpretive opinion was prepared. The interpretive opinion may not be relied upon in connection with any other matter.

(d) Attorneys seeking interpretive opinions on behalf of clients shall include with the opinion requests their own analyses of the issues presented by the request, their views with respect to the issues presented and citations of legal authority in support of those views.

(e) The Department shall maintain an index of the person(s) on whose behalf an interpretive opinion was prepared, and the nature of the request.

(f) The Director may select interpretive opinions for publication. Published opinions will be available on the Department's web page. The decision to publish an interpretive opinion will be made solely by the Director with regard to the public interest and the legal question(s) considered. The Director may rescind any published opinion and shall notify the party for whom the opinion was prepared of the rescission. Rescission of a published opinion shall be indicated on the Department's website.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1344, Health and Safety Code.

History:

1. New section filed 8-12-2002; operative 9-11-2002 (Register 2002, No. 33).
2. Amendment of subsection (a), new subsections (b)-(d), subsection relettering and amendment of newly designated subsection (f) filed 10-27-2003; operative 11-26-2003 (Register 2003, No. 44).
3. Change without regulatory effect amending subsection (b)(1) filed 5-5-2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 19).
4. Change without regulatory effect amending subsection (b)(1) filed 9-9-2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 37).

§ 1006. Inspection of Public Records.

(a) Public access to records maintained by the Department is governed by the California Public Records Act (Government Code § 6250 et. seq.). The term "public record," as used in this section, is defined in Government Code section 6252(e). Public records are available for inspection and/or copying pursuant to the following procedures:

(1) Requests for the inspection and/or copying of public records must be sufficiently descriptive to enable Department personnel to identify, locate, and retrieve the records.

(2) Requests must be in writing and sent to the Department's mailing address at Department of Managed Health Care, 980 9th Street, Suite 500, Sacramento, CA 95814, Attention: Office of Legal Services. A properly addressed request will ensure prompt response by the Department.

(3) Retrieval and inspection of any record shall not interfere with the ordinary business operations of the Department. Operational functions of the Department will not be suspended to permit inspection of records where the records are reasonably required by Department personnel in the performance of their duties. If the request requires reviewing numerous records, a mutually agreeable time will be established for the inspection of the records. All inspections will occur during regular business hours of the Department.

(4) Physical inspection of records is permitted in Department offices. Upon completion of the inspection, the person conducting the inspection shall relinquish possession of the records. Persons inspecting Department records shall not destroy, mutilate, deface, alter, or remove any such records from the Department. The Department reserves the right to have Departmental personnel present during the inspection of records in order to prevent the loss or destruction of records.

(b) The Department may refuse to disclose records that are exempt from disclosure under the Public Records Act. (See e.g, Gov. Code, §6254.)

(c) Requests for copies of public records will be conducted pursuant to the following procedures:

(1) The Department shall charge the person requesting copies of public records made by Department personnel at the rate of thirty cents ($0.30) per page. Payment of the total estimated copy charge shall be required before Department personnel copy any records. The Department may waive copying costs when the total copying cost for records requested is less than ten dollars ($10.00) per year.

(2) If the number of records requiring copying is determined to be voluminous by Department personnel, then the Department may require the person requesting the records to supply or hire his/her own copy service to photocopy the records. The cost associated with providing the copy service shall be borne entirely by the requesting person.

(3) Persons requesting copies of transcripts from Department committees, panels or boards shall be charged a flat fee of $30.00 per transcript regardless of page length. Tape-recorded cassette transcripts of Department committees, panels or board meetings shall be charged a flat fee of $5.00 per proceeding.

NOTE: Authority cited: Section 6253.4, Government Code; and Section 1344, Health and Safety Code. References: Section 6250, 6253, 6254 and 6255, Government Code.

History:

1. New section filed 8-12-2002; operative 9-11-2002 (Register 2002, No. 33).

§ 1007. Request for Confidentiality.

(a) The Director will withhold from public inspection, pursuant to the applicable state and/or federal law, information received in connection with

an application (including applications for interpretive opinions) or report, if in the opinion of the Director, the public inspection of such information is not necessary for the purposes of the law under which the information was filed, and the information is reasonably shown to meet either of the following:

(1) The information is proprietary or of a confidential business nature, including but not limited to trade secrets, and has been confidentially maintained by the business entity and the release of which would be damaging or prejudicial to the business concern.

(2) The information is such that the private and/or public interest is served in withholding the information.

(b) Requests for Confidential treatment. A request for confidential treatment of any information received in connection with an application or report submitted to the Department must be filed with the information submitted. The information intended to remain confidential must be filed separately from the remaining parts of the application or report and marked "Confidential Treatment Requested." The person filing the application or report and requesting confidential treatment must sign the request. The signed request must contain the following:

(1) A statement identifying the information that is the subject of the request and the application or report relating thereto.

(2) A statement specifying the provisions of subsection (a) pursuant to which the request is made.

(3) A statement of the grounds upon which the request is made, including (if applicable) a statement as to the information's confidentiality and the measures taken to protect its confidentiality, and a statement of the adverse consequences that are expected to result if the information is disclosed through the public records of the Department.

(4) A statement of the specific time for which confidential treatment of the information is necessary, and the basis for such conclusion.

(5) If appropriate, a statement of the extent to which such information has been, or will be, disclosed to present or proposed investors, or other persons appropriate under the statute pursuant to which the information is filed.

(c) Request for Confidentiality Available for Public Inspection. Requests for confidentiality will be available for public inspection. Therefore, the request for confidentiality should not contain information that is itself confidential.

(d) Granting of Request. If a request for confidential treatment is granted, the person making such request will be notified in writing, the information will be marked "confidential" and kept separate from the public file, and the application or report will be noted with the following legend: "Additional portions of this filing have been granted confidential treatment pursuant to Section 1007 of Title 28, Chapter 1, of the California Code of Regulations. They are contained in a separate confidential file."

(e) Denial of Request. Material for which confidential treatment is requested shall not be deemed filed unless the request is granted, and may be withdrawn by the applicant if the request is denied, unless (1) the Director has already taken an official action in reliance on such information prior to receiving the request for confidential treatment; or (2) the Director determines that the withdrawal of such information is otherwise contrary to the public interest. If withdrawn, such information will not be considered by the Director in connection with the application or report.

(f) Permissible Disclosure of Information Held Confidential. Information held confidential pursuant to this section may be disclosed by the Director, at any time and in the Director's sole discretion, whether on the Director's own motion or upon the request of any person, under the following circumstances:

(1) To other local, state, or federal regulatory or law-enforcement agencies, in accordance with the law;

(2) When necessary or appropriate in any proceeding or investigation pursuant to the law under which the information was filed;

(3) Upon a determination by the Director that the private and/or public interest in disclosing such information outweighs the public interest in non-disclosure; or

(4) Upon a determination by the Director that the justifications for the confidential treatment no longer exist.

(5) If the Director determines to disclose confidentially held information pursuant to subsections (f)(1) through (f)(4), and concludes that the disclosure of such information is necessary and urgent, or that it is impractical under the circumstances to give notice to the person who requested confidential treatment of the information, the information may be disclosed without notice. Otherwise, the person who requested confidential treatment of such information shall be given written and actual notice through certified mail that the release of such information is under consideration and the reasons therefor. Thereafter, the person will be given five business days to explain why the need and justification for continued confidentiality exists.

(g) Requests to Inspect Confidential Information. A request to inspect confidential information pursuant to subsections (f)(1) through (f)(4) shall be in writing, state the justification for the request, and be signed by the person making the request. A copy of the request for inspection shall be forwarded to the person who requested confidential treatment of the information in accordance with subsection (f)(5). If a request for inspection should be held confidential and not disclosed to the owner of the confidential information, the reasons therefor must be stated in such request, in accordance with subsection (b).

(h) Nothing contained herein shall be interpreted as affording any person a right to withdraw information once it has been received by the Director, except as provided in subsection (e).

NOTE: Authority cited: Sections 1344 and 1346, Health and Safety Code. References: Sections 6253, 6254 and 6255, Government Code; Section 1040, Evidence Code; and Sections 1344 and 1351, Health and Safety Code.

History:

1. New section filed 8-12-2002; operative 9-11-2002 (Register 2002, No. 33).

§ 1008. Availability of Department Forms, Publications and Notices; Fees.

(a) Department forms required by the Act or regulations, releases, notice of regulatory changes, and other publications are available free of charge on the Department's web page.

(b) Department forms required by the Act or regulations, releases, notice of regulatory changes, and other publications are available at either the Department's Sacramento or Los Angeles office, or via the mail. The Department will charge thirty cents ($0.30) per page for any document picked up at the Department's offices. Documents requested by mail should be directed to the Department of Managed Health Care, 980 9th Street, Suite 500, Sacramento, CA 95814-2724. The fee for any document mailed will be thirty cents ($0.30) per page, plus postage. The minimum charge for any single order by mail will be $5.00. No charges will be incurred for providing a single copy of the Department's consumer complaint form.

NOTE: Authority cited: Sections 1344 and 1346.4, Health and Safety Code. Reference: Sections 1344 and 1346, Health and Safety Code.

History:
1. New section filed 8-12-2002; operative 9-11-2002 (Register 2002, No. 33).

§ 1009. Retention of Department Records.

(a) The Department shall maintain records and files necessary to accomplish the Department's regulatory function according to subdivision (b) and the approved Record Retention Schedule by the Department of General Services. Records and files may be maintained by the Department using either paper, electronic or other alternative storage technologies, including but not limited to, photography, microphotography, electronically recorded video images on magnetic surfaces, electronic data processing systems, optical disk storage, or any other trusted medium that does not permit additions, deletions, or changes to the original document. Unless specifically superseded by another legal obligation, Department records and files shall be destroyed pursuant to the schedule in subsection (b).

(b) Department records and files shall be destroyed as follows:

(1) Plan license applications, amendments, and material modifications:

(A) A plan's license, original application and execution pages A through D, as described in section 1300.51, shall be retained by the Department until a plan's license is surrendered or revoked. Records and files pertaining to the plan's license will be maintained by the Department for a minimum of two years following the plan's surrender or revocation of the license. Thereafter, the records and files shall be destroyed.

(B) Exhibits to a plan's license application, as described in section 1300.51 subsections E through FF, amendments, and material modifications shall be retained by the Department for a minimum of five years from the date of filing. Thereafter, the records and files shall be destroyed.

(C) Records and files regarding a plan's financial status and fiscal arrangements, as described in section 1300.51, shall be retained for a minimum of five years from the date of filing. Thereafter, the records and files shall be destroyed.

(2) Correspondence between a plan and Department counsel or staff may be retained by the Department if it is determined that the correspondence is of material value in the continued regulation of the plan. Such correspondence shall be maintained for a minimum of five years. Thereafter, the correspondence shall be destroyed.

(3) Final financial and medical survey plan reports shall be maintained by the Department for a minimum of five years from the date of the final report's release or until release of the next final report, whichever is later. Examiner and surveyor working documents used in preparing the report shall also be maintained for a minimum of five years from the date of the final report's release. Thereafter, the report and all working documents shall be destroyed.

(4) Records and files pertaining to Department enforcement investigations and actions, and Department litigation shall be retained for a minimum of five years from the date the matter is closed. Thereafter, the records and files shall be destroyed.

(5) Records and files pertaining to enrollee and consumer complaints, and the Independent Medical Review process, shall be retained for a minimum of two years from the date the Department closes the matter except any medical x-rays may be destroyed immediately following the closure of the matter. Thereafter, the records and files shall be destroyed. Records and files that are determined to be outside of the Department's jurisdiction pertaining to enroll-

ee and consumer complaints, and the Independent Medical Review process may be destroyed immediately following the closure of the matter.

(c) Notwithstanding this section the Department may retain a record, file, or document at the Director's discretion.

(d) The record retention schedule outlined in subsection (b) shall apply to all records and files maintained by the Department after January 1, 1998. Documents filed with the Department, or its predecessor Department of Corporations before January 1, 1998, may be destroyed at the Director's discretion.

NOTE: Authority cited: Section 14750, Government Code; and Section 1344, Health and Safety Code. Reference: Sections 14741, 14745, 14750, 14755 and 14756, Government Code; and Section 1344, Health and Safety Code.

History:

1. New section filed 10-29-2003; operative 11-28-2003 (Register 2003, No. 44).

§ 1010. Consumer Participation Program.

(a) Intent and Regulatory Purpose.

This regulation, in accordance with section 1348.9 of the Health & Safety Code, establishes the Department's procedure and criteria, for determining discretionary awards of reasonable Advocacy and Witness Fees on the basis that a Participant Represent the Interests of Consumers in a Proceeding and has made a Substantial Contribution to the Department in its deliberations. Nothing in this article shall be construed to require any person or organization to seek compensation pursuant to this article.

(b) Definitions.

For purposes of this section, the following definitions shall apply:

(1) "Advocacy and Witness Fees" means the amount of compensation a Participant requests for expenses incurred through representing the interests of consumers in any proceeding relating to legislatively authorized guidance, the adoption of any regulation, or the issuance of an order or decision by the Director, including a decision not to adopt a regulation or take an action. The rate used to determine Advocacy and Witness Fees shall not exceed the Market Rate as defined in this section.

(2) "Advocacy Award" means the amount awarded to a Participant, which may be all or part of the Advocacy and Witness Fees requested. The Advocacy Award shall be the amount the Designated Hearing Officer determines to be reasonably incurred by the Participant while representing the interests of consumers during a Proceeding. An approved Participant may request an Interim Advocacy Award and/or final payment of the Advocacy Award consistent with the provisions below.

(3) "Application for an Advocacy Award" is the request for Advocacy and Witness Fees filed by a Participant whose Petition to Participate has been granted. The information that must be included in the Application for an Advocacy Award is outlined in subsection (d).

(4) "Designated Hearing Officer" will be the Director of the Department or his or her designee. The Designated Hearing Officer shall determine the Advocacy Award to be awarded to a Participant for a particular Proceeding. An appeal of an Advocacy Award or denial of an Application for an Advocacy Award will be submitted to the Director.

(5) "Interim Advocacy Award" is the amount the Designated Hearing Officer awards as a result of a request for Interim Compensation. An Interim Advocacy Award does not require or preclude the Designated Hearing Officer from granting an Advocacy Award at a later stage of the Proceeding.

(6) "Interim Compensation" is a one-time request for Advocacy and Witness Fees made by a Participant. The purpose of Interim Compensation is to allow a Participant to request compensation although a Proceeding is ongoing and the Participant may incur future costs. The Participant requesting Interim Compensation must still file a Petition to Participate and an Application for an Advocacy Award. A request for Interim Compensation does not require or preclude a Participant from requesting additional Advocacy and Witness Fees at a later stage of the Proceeding.

(7) "Legislatively Authorized Guidance" means guidance issued by the Department that has been exempted from the processes mandated by the Administrative Procedures Act.

(8) "Market Rate" is the prevailing rate for comparable services in the private sector in the Los Angeles and San Francisco Bay Areas. The rate a Participant uses to determine the Advocacy and Witness Fees shall not exceed the Market Rate.

(9) "Participant" means a person or organization whose Petition to Participate, filed under subsection (c) has been granted by the Designated Hearing Officer.

(10) "Petition to Participate" is the request by a person or organization to participate in a Proceeding and seek an award of Advocacy and Witness Fees that is submitted to the Director. The information that must be included in the Petition to Participate is outlined in subsection (c).

(11) "Proceeding" mean an administrative decision-making process relating to legislatively authorized guidance, the adoption of any regulation, or the issuance of an order or decision by the Director, including a decision not to adopt a regulation or take an action. For purposes of this article, an order or decision shall not include the resolution of individual grievances, complaints, or cases.

(12) "Represents the Interests of Consumers" means the Participant has a record of advocacy on behalf of health care consumers in administrative or legislative proceedings. A Participant that represents, in whole or in part, any entity regulated by the Department shall not be eligible for compensation.

(13) "Submit to the Director" means to send material to The Director electronically at dmhc.ca.gov or via regular mail addressed to The Director, Department of Managed Health Care, 980 9th Street, Suite 500, Sacramento, CA 95814.

(14) "Substantial Contribution" means the Participant significantly assisted the Department during a Proceeding by presenting relevant issues, evidence, or arguments which were helpful and seriously considered, and the Participant's involvement resulted in more relevant, credible, and non-frivolous information being available to the Director.

(c) Procedure for Petition to Participate.

(1) The Petition to Participate shall be Submitted to the Director no later than the end of the final public comment period of the rulemaking proceeding in which the person or organization seeks to become involved. For legislatively authorized guidance, orders, or decisions, the Petition to Participate shall be submitted within ten (10) working days after the legislatively authorized guidance, order, or decision, or decision not to issue an order or decision, becomes final. If the Petition to Participate is granted, as long as the information contained in the Petition to Participate remains true and accurate, the Participant will be deemed eligible to seek Advocacy Awards in all future Proceedings and will not be required to submit another Petition to Participate.

(2) The Petition to Participate shall contain the following, as applicable:

(A) The name of the person or representative, organization name, mailing address, telephone number, and e-mail address.

(B) A showing that the person or organization Represents the Interests of Consumers, including a description of the person or organization's experience advocating on behalf of consumers in administrative or legislative proceedings.

(C) Names and titles of the members of the organization's governing body.

(D) A description of the organization's general purpose, size, and structure.

(E) Under what statute the organization is formed or incorporated, including whether it is a non-profit corporation.

(F) An identification of the Proceeding in which the person or organization seeks to participate.

(G) A clear and concise statement of the person or organization's interest in the Proceeding, which explains why participation is needed to represent the interest of consumers.

(H) An estimate of the Advocacy and Witness Fees that may be sought.

(I) The Petition to Participate shall include a statement that the facts contained therein are true and correct to the best of the knowledge of the person verifying the information.

(3) After the Petition to Participate is submitted, the person or organization shall promptly disclose to the Department any material changes in the information submitted in the Petition to Participate. The Department may require the Participant to submit an updated Petition to Participate even if a previous Petition to Participate had been granted.

(4) Upon receipt, the Director will refer the Petition to Participate to the Designated Hearing Officer who will review the information.

(5) Within thirty (30) days of the Director's receipt of a completed Petition to Participate, the Designated Hearing Officer shall rule on whether the Petition to Participate shall be granted. The Petition to Participate may be denied if the Designated Hearing Officer elects not to award compensation related to the Proceeding, determines that the person or organization does not meet eligibility requirements, or determines that the Petition to Participate does not meet the requirements of this regulation or the governing statute.

(6) If a Petition to Participate has been granted, the Participant is eligible to submit an Application for an Advocacy Award. The granting of a Petition to Participate neither guarantees an Advocacy Award nor requires a Participant to submit an Application for an Advocacy Award.

(d) Application for an Advocacy Award.

(1) The Participant shall Submit to the Director an Application for an Advocacy Award no later than sixty (60) days following the effective date of a regulation; the effective date of an order or decision by the Director, or the decision not to issue an order or decision; or the date of issuance of legislatively authorized guidance. An Application for an Advocacy Award may be submitted during the pendency of a Proceeding.

(2) An Application for an Advocacy Award shall include:

(A) A detailed and itemized description of the Advocacy and Witness Fees for which the Participant seeks compensation;

(B) Legible time and/or billing records, created contemporaneously when the work was performed, which show the date and the exact amount of time spent on each specific task in thirty (30) minute increments. If the Participant submits a request for Interim Compensation during the pendency of a proceeding, the Application shall include the specific time period for which the Interim Compensation is sought;

(C) The hourly rate of compensation for each witness or advocate acting on behalf of the Participant; a short justification for each hourly rate, which may include copies of or citations to previously approved hourly rates; each witness or advocate's resume or curriculum vitae;

(D) A description of the ways in which the Participant has made a Substantial Contribution to the Proceeding, supported by specific citations to each specific task as necessary;

(E) A clear and concise statement of the Participant's interest in the Proceeding, which explains why participation is needed to represent the interest of consumers; and

(F) A copy of the Participant's Petition to Participate and a statement that the facts contained therein remain true and correct to the best of the knowledge of the person verifying the information.

(3) As used in this subdivision, the phrase "each specific task" refers to activities including, but not limited to:

(A) Telephone calls or meetings/conferences, identifying the parties participating in the telephone call, meeting/conference and the subject matter(s) discussed;

(B) Legal pleadings or research, identifying the pleading or research and the subject matter(s);

(C) Letters, correspondence, emails, or memoranda, identifying the parties and the subject matter(s);

(D) Attendance at hearings, specifying when the hearing occurred, subject matter of the hearing, and the names of the Participant's witnesses or advocates who appeared and provided testimony at the hearing, if any; and

(E) Written comments submitted during a defined comment period.

(e) Processing an Application for an Advocacy Award.

(1) Upon receipt, the Participant's Application for an Advocacy Award shall be posted on the Department's website be referred to the Designated Hearing Officer for the Proceeding within a reasonable time.

(2) Within thirty (30) days of posting an Application for an Advocacy Award on the Department's website, any person participating in the Proceeding who questions or objects to anything included in the Participant's Application for an Advocacy Award, including the rate the Participant used to calculate the Advocacy or Witness Fees, shall Submit to the Director an objection to the Application for an Advocacy Award. The Director will refer the objection to the Designated Hearing Officer.

(3) The Designated Hearing Officer may request additional information or documentation from the Participant to clarify or substantiate the Application for an Advocacy Award and may audit the records and books of the Participant to verify the basis for the amount of Advocacy and Witness Fees requested.

(4) Except for situations in which Interim Compensation was awarded, the Designated Hearing Officer will not grant more than one Advocacy Award to the same Participant for the same Proceeding.

(5) Within sixty (60) days following the posting of an Application for an Advocacy Award on the Department's website, the Designated Hearing Officer shall issue a written decision which states whether the Participant has made a Substantial Contribution to the Proceeding and, if so, the Advocacy Award to be granted. The decision will be posted on the Department's website and will be sent, electronically or via regular mail, to all Participants in the Proceeding within a reasonable time.

(6) Within thirty (30) days of posting and sending the Designated Hearing Officer's decision, a Participant who is dissatisfied with the decision may Submit to the Director an appeal of the decision. The appeal should state the relief the Participant seeks and the reasons why the decision should be modified or changed. The Director, or his or her designee, may request additional information if he or she deems it would be helpful in reaching a decision. The review shall be of the written record and limited to whether the Designated Hearing Officer's

initial decision constituted an abuse of discretion. The Director or his or her designee's decision will be final and no further administrative remedy will be available to the Participant.

NOTE: Authority cited: Sections 1341 and 1344, Health and Safety Code. Reference: Section 1348.9, Health and Safety Code.

History:

1. New section filed 6-20-2003; operative 7-20-2003 (Register 2003, No. 25).
2. Amendment filed 3-28-2016; operative 4-1-2016 pursuant to Government Code section 11343.4(b)(3) (Register 2016, No. 14).

§ 1011. Assessment for University of California Analysis of Proposed Mandate Legislation.

(a) For the fiscal years 2004–05 and 2005–06, the Department shall assess each full service plan its share of the amount necessary to fund the Health Care Benefits Fund for that fiscal year. The amount necessary for each fiscal year will be determined by the Department and the Department of Insurance in consultation with the University of California (University) and will be based on the amount necessary to fund the actual and necessary expenses of the University, not to exceed $2 million, in the analysis of legislative health care benefit mandates for the fiscal year.

(b) The total amount owed by all full-service health plans will be 87.6% of the total amount necessary to fund the Health Care Benefits Fund. That percentage is based on the ratio between persons enrolled in full-service health care service plans and those persons enrolled in health reimbursement plans regulated by the Department of Insurance as reported in the publication "Accident & Health Covered Lives 2002" (Revised December 11, 2003) published by the Department of Insurance in May, 2002.

(c) The Department shall annually calculate each full-service health plan's portion of the amount specified in subsection (b) as follows:

(1) The Department shall calculate the per-enrollee cost by dividing the amount of revenues required to be paid by all full-service health care service plans, by the total number of enrollees in this state that are enrolled in all full-service plans as of the March 31 immediately preceding the date of the assessment.

(2) The Department shall calculate each plan's annual fee by multiplying the per-enrollee cost determined pursuant to paragraph (1) of this subsection (c) by the number of enrollees in the plan as of the March 31 immediately preceding the date of the assessment.

(d) The Department shall notify affected plans of the amount of the assessment on or before June 15 of each fiscal year and all amounts due under the assessments will be due and payable from the affected plans on or before the first day of August immediately following the date of the notice.

(e) Any amount that remains due from a plan for assessments issued for the 2002–2003 and 2003–2004 fiscal years (pursuant to Section 127662 of the California Health and Safety Code) that have not been paid to the Department by May 31, 2004, will be added to the amount of the assessment due under the notice to be issued on or before June 15 of each fiscal year.

NOTE: Authority cited: Sections 1344, 1346 and 127662, Health and Safety Code. Reference: Sections 1356, 127660, 127661, 127662, 127663, 127664 and 127665, Health and Safety Code.

History:

1. New section filed 6-2-2004; operative 7-2-2004 (Register 2004, No. 23).

ARTICLE 3
Electronic Filing

Section
1300.41.8. Electronic Filing.

§ 1300.41.8. Electronic Filing.

(a) Definitions:

(1) "Electronic" means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities;

(2) "Electronic signature" means an electronic sound, symbol, or process attached to or logically associated with an electronic record, executed or adopted by a party with the intent to represent a manual signature.

(b) Notwithstanding any other provision of the regulations contained in title 28 of the CCR, plans shall file electronically any document required or permitted by law to be filed with the Department, or its designated agent, except as specified in subsection (d).

(c) Signatures:

(1) The Plan shall submit to the Director for approval, the manner, type, and format of signatures, including electronic signatures, which shall be required by the Department to be affixed to all filings.

(2) Prior to submitting electronically, the plan shall certify, under penalty of perjury, that all statements within all documents filed electronically with the Department are true and correct.

(3) Electronic signatures may be used to sign a legally effective declaration under penalty of perjury.

(4) If notarization is required, an electronic signature to be notarized must be accompanied by the electronic signature of a notary public and must include all other information to render the notarization effective under California law.

(5) The signature requirements apply to all plans, and their designated agents or representatives.

(d) The Director may grant a one-time limited exemption upon a satisfactory showing that a plan lacks the electronic capacity to satisfy the requirements for electronic filings.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1341.8, 1349, 1351, 1352, 1386 and 1387, Health and Safety Code; Sections 1633.1-1633.17, Civil Code (Uniform Electronic Transactions Act); and Section 16.5, Government Code.

History:

1. New section filed 12-27-2001 as an emergency; operative 12-27-2001 (Register 2001, No. 52). A Certificate of Compliance must be transmitted to OAL by 4-24-2002 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 4-24-2002 as an emergency; operative 4-24-2002 (Register 2002, No. 17). A Certificate of Compliance must be transmitted to OAL by 8-22-2002 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 4-24-2002 order transmitted to OAL 6-28-2002 and filed 8-8-2002 (Register 2002, No. 32).
4. New article 3 heading filed 8-12-2002; operative 9-11-2002 (Register 2002, No. 33).

CHAPTER 2
Health Care Service Plans

Article
1. Exemptions
2. Administration
3. Plan Applications and Amendments

4. Solicitors
5. Advertising and Disclosure
6. Appeals on Cancellation
7. Standards
8. Self-Policing Procedures
9. Financial Responsibility
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11. Examinations
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13. Books and Records
14. Miscellaneous Provisions
15. Charitable or Public Activities

History:
1. Change without regulatory effect renumbering former Title 10, Chapter 3, Subchapter 5.5 (sections 1300.43-1300.826) to new Title 28, Division 1, Chapter 1 (sections 1300.43-1300.826) filed 12-22-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 51).
2. Editorial renumbering of former chapter 1 to new chapter 2 (Register 2001, No. 50).

ARTICLE 1
Exemptions

Section
1300.43. Small Plans.
1300.43.1. New Plans.
1300.43.2. Extension for Enrollers Under Medi-Cal Program.
1300.43.3. Ambulance Plans: Conditional Exemption.
1300.43.4. Employee Welfare Benefit Plans. [Repealed]
1300.43.5. Exemption for Licensees of Insurance Commissioner. [Repealed]
1300.43.6. Moribund Plans.
1300.43.7. Student Emergency Care Arrangements.
1300.43.8. Public Agencies.
1300.43.9. Unlicensed Solicitors and Solicitor Firms.
1300.43.10. Nonprofit Retirees' Plan.
1300.43.11. Exemption for Solicitors of Nonprofit Retirees' Plans.
1300.43.12. Medi-Cal Dental Contract.
1300.43.13. Mutual Benefit Plans.
1300.43.14. Employee Assistance Programs.
1300.43.15. Foreign Plans.

§ 1300.43. Small Plans.

A health care service plan or specialized health care service plan which provides health care services or specialized health care services only to the employees of one employer, or only to the employees of employers under common ownership and control, which is administered solely by the employer, and which does not have more than five subscribers (regardless of the number of persons enrolled based upon their relationship to or dependence upon such subscribers) is exempt from all provisions of the Act and the rules thereunder, except Sections 1381, 1384 and 1385. Such plans are exempt from any rules adopted pursuant to such sections unless such rules are made specifically applicable to plans exempted under this section.

NOTE: Authority cited: Section 6, Chapter 941, Statutes 1975, and Section 1344, Health and Safety Code. Reference: Knox-Keene Health Care Service Plan Act of 1975.

History:
1. New Subchapter 5.5, Articles 1-14 (1300.43-1300.99, not consecutive) filed 6-1-76; effective thirtieth day thereafter (Register 76, No. 23).

§ 1300.43.1. New Plans.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

History:
1. Amendment filed 11-30-76 as an emergency; effective upon filing (Register 76, No. 49). For prior history, see Register 76, No. 42.
2. Reinstatement of section as it existed prior to emergency amendment filed 11-30-76, by operation of Section 11422.1(b), Government Code (Register 77, No. 24).
3. Repealer filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

§ 1300.43.2. Extension for Enrollers Under Medi-Cal Program.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

History:
1. New section filed 8-12-76 as an emergency; effective upon filing (Register 76, No. 33).
2. Amendment filed 9-30-76 as an emergency; effective upon filing (Register 76, No. 40).
3. Amendment filed 10-12-76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 42).
4. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.43.3. Ambulance Plans: Conditional Exemption.

(a) Definitions. For the purposes of this section:

(1) "Ground ambulance services" means the emergency, including advanced life support services, and non-emergency transportation of an enrollee by an individual licensed pursuant to Articles 1 and 2 of Chapter 2.5 of Division 2 of the Vehicle Code where health care services are provided to an enrollee for the duration of such transportation.

(2) "Air ambulance services" means the emergency, including advanced life support services, and non-emergency transportation of an enrollee by legally authorized air ambulance where health care services are provided to the enrollee for the duration of such transportation.

(b) A health care service plan which lawfully operates air and/or ground ambulances and provides pursuant to a plan contract only air and/or ground ambulance services to subscribers and enrollees in ambulances owned or leased by it and operated by its employees (hereinafter "Ambulance Plan") is exempted from all provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code section 1340 et seq.) except those provisions specified herein, and subject to the condition that the Ambulance Plan complies with each of the following requirements:

(1) Every Ambulance Plan shall directly provide ground and/or air ambulance services for its enrollees throughout the Ambulance Plan's service area exclusively in ambulances owned or leased by it and operated by its employees.

(2) At the time of initial enrollment or renewal, every plan contract between an Ambulance Plan and a group or individual subscriber, and every disclosure form, evidence of coverage or plan brochure shall prominently display as a separate article the following legend, in boldface type and font size not smaller than the font size used in the general body of the document, either on the first page or on another page if referenced as "See Important Notices on Page [insert page number] Prior to Purchase" in boldface type and font size not smaller than the font size used in the general body of the document on the front page:

(A) "BEFORE YOU PURCHASE: If you are currently enrolled in a health maintenance organization (HMO) or other health insurance, the benefits provided by an Ambulance Plan may duplicate the benefits provided by your HMO or other health insurance. If you have a question regarding whether your HMO or other health insurance offers benefits for ambulance services, you should contact that other company directly."

(B) "WARNING: This Ambulance Plan is not an insurance program. It will not compensate or reimburse another ambulance company that provides

emergency transportation to you or your family. This may occur when the 911 Emergency System has independently determined that another company could provide more expeditious service or is next in the rotation to receive a call. This might also occur when this Ambulance Plan is unable to perform within a medically appropriate timeframe due to a mechanical or maintenance problem or being on another call." Immediately following this warning, the Ambulance Plan shall include the words, "sign or initial here," and include a line for the subscriber's signature or initials.

(C) "COMPLAINTS: For complaints regarding this Ambulance Plan, first attempt to call the plan at [plan's toll-free telephone number]. If the Ambulance Plan fails to resolve the complaint to your satisfaction, contact the Department of Managed Health Care at 1-888-466-2219. The Department's website is *http://www.healthhelp.ca.gov*. You may obtain complaint forms and instructions online."

(D) "OPERATING UNDER CONDITIONAL EXEMPTION: This Ambulance Plan is operating pursuant to an exemption from the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code section 1340 et seq.)."

The Ambulance Plan may amend the wording of the legend to use its name and personal pronouns.

(3) Ambulance Plans that fail to comply with all of subsection (b)(2), including obtaining the signature or initials of subscribers next to or under the "WARNING" statement, shall be responsible for paying, reimbursing, or covering the enrollee's cost for ambulance transportation services provided by another ambulance company, less any compensation received from the subscriber's HMO, health insurer, or managed care organization, if any, and less any applicable overall annual deductible or any co-payment.

(4) An Ambulance Plan shall operate in compliance with the requirements of each local emergency medical services agency (Health and Safety Code section 1797.94) that regulates emergency services in any portion of the plan's service area and that has developed an emergency medical services plan (Health and Safety Code section 1797.76) for an emergency medical services system (Health and Safety Code section 1797.78), implemented pursuant to the authority granted in Health and Safety Code section 1797.105(b).

(5) Ambulance Plan shall offer or sell plan contracts only to or for persons who do not live or work in the plan's service area, or to or for persons who will be in the plan's service area for a temporary period of time and for an activity covered by the Ambulance Plan, as specified in the Ambulance Plan contract. Ambulance Plans must clearly disclose that services are only available or provided within the ambulance plan's service area. Every Ambulance Plan shall comply with the following sections of the Health and Safety Code: 1360, 1363.1, 1365(a), 1365.5, 1366, subsections (a), (b), (c), (d), (e)(1), (f), (g), and (h)(1) of section 1367, 1368, 1368.01, 1368.02(b), 1373(a), 1379, 1381, subsections (a), (d), and (f) of 1384, and 1385, except that approval by the Department under section 1368(a)(1) is waived.

(6) Every Ambulance Plan shall maintain a procedure whereby enrollees, or authorized persons on their behalf, may submit grievances to the plan and in each case receive from the plan a written acknowledgement within five days of receipt of the grievance and a written response sent within 30 days of receipt of the grievance indicating what the plan will do to resolve the grievance. Both the acknowledgement and the response shall include a notice that the enrollee may contact the Department of Managed Health Care through the Department's toll-free telephone number after the grievance has been pending with the plan for at least 30 days.

(7) No Ambulance Plan contract shall require, nor shall the Ambulance Plan or any contracting provider collect, a co-payment of greater than 50 percent of an ambulance or other emergency care provider's negotiated fee-for-service rate pursuant to a contract with the ambulance service, or, in the absence of such a contract, 50 percent of the ambulance company's usual, customary, and reasonable rate (within the meaning of Business and Professions Code section 657(c)) for the particular service, or $500, whichever amount is less. An Ambulance Plan that does not impose any co-payments may impose an overall annual deductible of a specified dollar amount applicable to all covered services, provided that the deductible for an enrollee shall not exceed:

(A) 200 percent of the amount of prepaid or periodic charge for one year for the enrollee; or

(B) 200 percent of the amount of prepaid or periodic charge for one year for the family, whichever is less.

(8) Every Ambulance Plan operating ground or air ambulances shall:

(A) If operating a ground ambulance, provide proof to the Director upon request that the Ambulance Plan currently complies with Articles 1 and 2 of Chapter 2.5 of Division 2 of the California Vehicle Code, including but not limited to license and certification requirements, and with professionally recognized standards of patient care and safety in emergency medical services and transport.

(B) If operating an air ambulance, provide proof to the Director upon request that the Ambulance Plan currently complies with regulations established by the Federal Aviation Administration and with professionally recognized standards of patient care and safety in emergency medical air services and transport.

(9) Every Ambulance Plan operating air ambulances shall comply with all applicable federal, state, and local laws. Ambulance plans may use the "Guidelines for Air Medical Crew Education," revised and copyrighted 2004 and published by the Association of Air Medical Services, when determining the scope of their educational programs for purposes of training air crews.

(10) No Ambulance Plan shall receive prepaid or periodic charges pursuant to its plan contract for more than one year in advance.

(11) Every Ambulance Plan shall deliver:

(A) To each prospective subscriber, upon presenting a plan contract for offer or sale, a disclosure form, combined disclosure form and evidence of coverage, or copy of its plan contract,

(B) Annually, to each subscriber a copy of its plan contract and evidence of coverage, and

(C) To each subscriber and enrollee a membership card or other form of identification easily carried by the subscriber or enrollee that indicates that the subscriber or enrollee is an Ambulance Plan member and that lists phone numbers and other instructions for activating ambulance transport.

(12) The plan contract and any disclosure form and evidence of coverage used by the Ambulance Plan, shall comply with Health and Safety Code sections 1362 and 1363 and the rules of the Director of the Department of Managed Health Care pursuant to and including sections 1300.63, 1300.63.1, 1300.63.2, and 1300.63.3 of title 28.

(13) Every Ambulance Plan must maintain documentation demonstrating compliance with all the conditions of the exemption and provide to the Department of Managed Health Care all or any part of such documentation as required by the Department within 30 days of request.

(14) No Ambulance Plan shall purport to rely on the exemption pursuant to this section if the Director has issued an order of termination pursuant to subsection (c).

(c) An Ambulance Plan's exemption pursuant to this section may be terminated by order of the Director, upon a determination that such action is in the public interest and for the protection of enrollees, or for any of the following reasons:

(1) The services of the Ambulance Plan are not accessible to enrollees.

(2) The Ambulance Plan, or a person employed by the Ambulance Plan, has failed to comply with licensing or certification requirements imposed by law.

(3) The Ambulance Plan is operating in an unsafe, unfair, unreasonable or discriminatory manner as to its enrollees or as to its enrollment practices.

(4) The financial condition of the Ambulance Plan is such that its continued operation will constitute a substantial risk to its subscribers and enrollees.

(5) The Ambulance Plan has engaged in conduct proscribed by the Health and Safety Code section 1386(b), subsections (5), (6), (7), (8), (9), (10), (11), or (14).

(6) The Ambulance Plan has been or is subject to a limitation, requirement, condition, adverse action, or disciplinary action taken by a licensing agency or an emergency medical services agency that would materially impair its ability to perform its plan contracts or constitute or result in a violation of the provisions of this section or of the referenced provisions of the Act.

(7) The Ambulance Plan has violated any condition of this exemption.

(d) An Ambulance Plan's exemption pursuant to this section shall terminate automatically by operation of law upon the plan's failure to comply with any of the conditions set forth in subsection (b).

(e) An Ambulance Plan whose exemption has been terminated by operation of law because of failure to comply with the conditions set forth in subsection (b) or by order of the Director under subsection (c) shall be in violation of section 1349 of the Health and Safety Code and shall be subject to all of the provisions of the Knox-Keene Health Care Service Plan Act of 1975, including but not limited to the provisions relating to discipline and enforcement procedures.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343(b), Health and Safety Code.

History:

1. New section filed 9-30-76 as an emergency; effective upon filing (Register 76, No. 40).
2. Certificate of Compliance filed 1-27-77 (Register 77, No. 5).
3. Amendment filed 4-2-79; effective thirtieth day thereafter (Register 79, No. 14).
4. Editorial correction of subsections (a)7.f. and (b)(6) (Register 80, No. 4).
5. Change without regulatory effect amending section filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
6. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
7. Change without regulatory effect updating title references in Notice filed 12-22-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 51).
8. Change without regulatory effect amending subsection (a)—form filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).
9. Repealer and new section heading and section and amendment of Note filed 7-24-2003; operative 8-23-2003 (Register 2003, No. 30).
10. Amendment of subsections (b)(2)(C), (b)(5) and (b)(9) filed 5-7-2014; operative 7-1-2014 (Register 2014, No. 19).

§ 1300.43.4. Employee Welfare Benefit Plans. [Repealed]

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

History:

1. Amendment filed 3-6-78 as an emergency; designated effective 3-6-78 (Register 78, No. 10). For prior history, see Register 77, No. 36.
2. Certificate of Compliance filed 4-20-78 (Register 78, No. 16).
3. Amendment filed 8-14-78 as an emergency; designated effective 8-15-78 (Register 78, No. 33).

4. Certificate of Compliance filed 11-8-78 (Register 78, No. 45).
5. Repealer filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).

§ 1300.43.5. Exemption for Licensees of Insurance Commissioner. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

History:
1. New section filed 12-20-77 as an emergency; effective upon filing (Register 77, No. 52).
2. Certificate of Compliance filed 4-4-78 (Register 78, No. 14).
3. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.43.6. Moribund Plans.

A health care service plan which is a general acute care hospital whose business as a plan is limited to providing, administering, or otherwise arranging for the provision of health care services to members of one moribund group of not more than 250 members is exempted from the provisions of the Knox-Keene Health Care Service Plan Act of 1975, subject to each of the following conditions:

(a) That such plan is licensed as a health facility pursuant to Chapter 2 (commencing with Section 1250) of the Health and Safety Code, and is not insolvent.

(b) That such plan has not accepted any new members for the last twenty years and does not accept any new members for the duration of this exemption.

(c) That such plan receives prepaid or periodic charges, if any, from members of such group in an amount not exceeding $5 per member per month and has received no substantial payment or transfer of property from or on behalf of such contracting group during the last twenty years.

(d) That such plan derives not more than one-half of one percent of its annual income from prepaid or periodic charges paid by or on behalf of members of such group, and has a minimum net worth of $15,000,000 based upon its most recent certified financial statements (prepared as of a date within the preceding 15 months).

(e) That such plan establish and maintain a grievance procedure substantially complying with Section 1300.68.

(f) That such plan deliver to each subscriber and enrollee within 60 days of the adoption of this section, and thereafter to any subscriber or enrollee upon request, the following written notice:

> "(Name of plan) IS A HEALTH CARE SERVICE PLAN OPERATING PURSUANT TO AN EXEMPTION FROM THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975 PROVIDED BY RULE OF THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE OF THE STATE OF CALIFORNIA."

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

History:
1. New section filed 6-13-78 as an emergency; effective upon filing (Register 78, No. 24).
2. Certificate of Compliance filed 8-18-78 (Register 78, No. 33).
3. Editorial correction of subsection (f) (Register 95, No. 12).
4. Change without regulatory effect amending subsection (f) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
5. Change without regulatory effect amending subsection (f) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.43.7. Student Emergency Care Arrangements.

There is exempted from the provisions of the Act any nonprofit corporation or association all of whose members are licensed physicians and which is a health care service plan as defined by subdivision (f) of Section 1345 only by reason of health care service plan contracts with one or more colleges or universities pursuant to which such nonprofit corporation or association furnishes or arranges only emergency health care services and health care services ancillary thereto to members of the student body of, employees of, and visitors to such colleges or universities, provided that each of the following conditions is met:

(a) At least 95 percent of the cost of health care services furnished pursuant to such contracts is furnished by employees or members of such nonprofit corporation or association or contracting providers.

(b) All services furnished by members pursuant to such contracts are furnished pursuant to provider contracts which comply with Section 1379 of the Act.

NOTE: Authority cited: Section 1343, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

History:
1. New section filed 8-22-78; effective thirtieth day thereafter (Register 78, No. 34).

§ 1300.43.8. Public Agencies.

NOTE: Authority cited: Section 1343, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

History:
1. New section filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).
2. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.43.9. Unlicensed Solicitors and Solicitor Firms.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

History:
1. New section filed 11-9-79 as an emergency; effective upon filing (Register 79, No. 45). A Certificate of Compliance must be filed within 120 days or emergency language will be repealed on 3-9-80.
2. Repealed by operation of Section 11422.1(c), Government Code (Register 80, No. 24).

§ 1300.43.10. Nonprofit Retirees' Plan.

A health care service plan which was registered under the Knox-Mills Health Plan Act as in effect on June 30, 1976, whose activity as a plan is limited to reimbursing part or all of the cost of health care services as a supplement to Medicare (Parts A and B) to persons who were retired from professions associated with higher learning after having been employed therein for not less than 10 cumulative years and such persons' spouses, providing all such persons are enrolled in Medicare, is exempted from the provisions of Section 1349 of the Knox-Keene Health Care Service Plan Act of 1975, subject to each of the following conditions:

(a) That such plan is a nonprofit corporation which does not engage, directly or indirectly, in any for profit business, which is not affiliated with (Rule 1300.45(c)) a corporation or other entity which engages, directly or indirectly, in any for profit business, and which does not contract or otherwise arrange for the performance by persons other than its directors, officers or employees of any portion of its administrative or other functions.

(b) That such plan is exempted from federal income tax as an organization described in Section 501(c)(3) of the Internal Revenue Code and from state income tax on similar grounds.

(c) That such plan is a charitable corporation subject to, and in compliance with, the Uniform Supervision of Trustees for Charitable Purposes Act.

(d) That such plan does not directly provide any health care services through entity-owned or contracting health facilities or providers.

(e) That such plan has a tangible net equity within the meaning of Section 1300.76(b) of not less than $300,000, including liquid tangible assets in an amount not less than $300,000, based upon its most recent certified financial statement (prepared as of a date within the preceding 15 months and such other date as may be requested by the Director pursuant to Section 1384 of the Act) and its most recent quarterly and monthly uncertified statements prepared on a basis consistent with the annual certified statement, with additional liquid tangible assets in an amount not less than $1,000 for each person enrolled in excess of 400; provided that the maximum number of enrollees shall not exceed 500.

(f) That not more than 15% of the total charges paid by or on behalf of subscribers or enrollees for enrollment in, or for health care benefits from, such plan is expended for administrative costs, including all costs of solicitation and enrollment; except that such plan may expend additional sums of money for administrative costs excluding costs of solicitation and enrollment provided that such money is not derived from revenue obtained from subscribers or enrollees.

(g) That such plan issues a uniform health care service plan contract to all subscribers

(1) which provides, except for a permissible calendar year deductible not to exceed $100 per enrollee, full coverage for all copayments and deductibles relating to allowable charges under Medicare (Parts A and B) for all health care services covered by Medicare (Parts A and B) pursuant to Title XVIII of the Social Security Act as amended, and not less than 50% of the reasonable charges for each health care service which is not covered by Medicare but is covered by such plan; provided, however, that such coverage may be subject to a lifetime limitation allowing not less than $300,000 of benefits per lifetime and

(2) which provides that an enrollment or subscription may not be cancelled except upon grounds complying with Section 1365 of the Act.

(h) That such plan provides to each subscriber a disclosure statement covering the provisions of its health care service plan contract which complies substantially with the provisions of Section 1363 of the Act and which also states, if such is the case, that such contract does not cover, and that subscribers and enrollees will be solely liable for,

(1) any charges in excess of allowable charges under Medicare with respect to health care services covered by Medicare,

(2) any charges in excess of reasonable charges for any health care services covered by such plan but not covered by Medicare and any copayments related to such health care services, and

(3) any permissible plan deductible.

(i) That no less than 75% of the officers and of the directors of such corporation are persons who are retired from the professions associated with higher learning after having been employed therein not less than 10 cumulative years, are enrolled in Medicare, and are enrolled in such plan subject to terms and conditions no more favorable than any other enrollee, and that no officer or director receives any compensation from such corporation.

(j) That such plan solicits enrollments or subscriptions in this state only through persons who are officers or employees of such plan.

(k) That such plan establishes and maintains a grievance procedure substantially complying with Section 1300.68 of these rules.

(*l*) That such plan not represent any contract of such plan as a Medicare supplement contract and discloses to each prospective subscriber and enrollee when presenting any information regarding the plan, and again at the time of application, the following written notice:

"THE HEALTH PLAN CONTRACT OFFERED BY (Name of plan) DOES NOT MEET THE REQUIREMENTS FOR CERTIFICATION AS A MEDICARE SUPPLEMENT CONTRACT PURSUANT TO APPLICABLE STATE OR FEDERAL LAW, AND HAS NOT BEEN CERTIFIED. PERSONS DESIRING INFORMATION REGARDING CERTIFIED MEDICARE SUPPLEMENT COVERAGE SHOULD CONTACT THEIR LOCAL MEDICARE OFFICE."

(m) That such plan delivers to each subscriber and enrollee within 60 days of the adoption of this section, and annually thereafter, the following written notice:

"(Name of plan) IS A HEALTH CARE SERVICE PLAN OPERATING PURSUANT TO AN EXEMPTION FROM THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975. COMPLAINTS REGARDING THIS PLAN, THE ADMINISTRATION THEREOF, AND THE SERVICES PROVIDED THEREBY MAY BE DIRECTED TO THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE OF THE STATE OF CALIFORNIA."

(n) That such plan provides written notice to the Director of its intent to rely on the exemption provided by this section, executed by a duly authorized officer of such plan, together with a signed opinion of legal counsel to the effect that such plan complies with subsections (a), (b), (c), (d) and (g) of this section.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

History:

1. New section filed 11-21-79; effective thirtieth day thereafter (Register 79, No. 47).
2. Amendment filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).
3. Change without regulatory effect amending subsections (e), (m) and (n) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
4. Change without regulatory effect amending subsection (m) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.43.11. Exemption for Solicitors of Nonprofit Retirees' Plans.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code.

Reference: Section 1343, Health and Safety Code.

History:

1. New section filed 11-21-79; effective thirtieth day thereafter (Register 79, No. 47).
2. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.43.12. Medi-Cal Dental Contract.

The contract of the Department of Health Services which is entered as the result of successful bidding in response to said Department's request for proposal and which requires the contractor to provide only dental benefits for the state's Medi-Cal beneficiaries pursuant to Section 14104.3 of the Welfare and Institutions Code and incorporates the terms and provisions set forth in the request for proposal, is exempt from the provisions of the Act, if the successful bidder ("entity") is not already licensed under the Act, for the period indicated below, subject to each of the following:

(a) The entity engages in no activities as a plan other than those pursuant to the Medi-Cal dental contract described above or pursuant to a separate exemption in the Act or these rules.

(b) The entity properly files an application for licensure under the Act, as required by Sections 1351 and 1356 of the Act, prior to executing the contract referred to above, except that the information contained in the application submitted at the time of filing need not include information not required to be provided to the Department of Health Services pursuant to its request for proposal, so long as the additional information required by Section 1351 of the Act or by the application form provided by the Director is filed as an amendment to the license application within six weeks of the date of execution of the contract referred to above, or any longer period as the Director by order may allow under the Director's waiver authority set forth in Section 1344(a) of the Act.

(c) The entity reasonably pursues the completion of its application and compliance with the provisions of the Act and applicable rules thereunder.

(d) The entity, for the duration of the exemption provided by this section, shall be subject to the provisions of Sections 1351.1, 1381, 1384, and 1385 of the Act, and may be examined by the Director in the manner and subject to the arrangements provided in Section 1382 of the Act.

(e) The exemption provided by this section shall be effective only until the earlier of

(1) final action by the Director on the application, or

(2) the expiration of nine months after execution of the contract referred to above, except that said nine month period may be waived by order of the Director for any additional one month periods under the Director's waiver authority set forth in Section 1344(a) of the Act.

(f) For the purposes of this section, the term "order" means a written waiver applicable to a specific case issued by the Director pursuant to Section 1344(a) of the Act.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Sections 1343, 1344, 1351, 1351.1, 1353, 1356, 1381, 1382, 1384 and 1385, Health and Safety Code.

History:

1. New section filed 3-9-84; effective thirtieth day thereafter (Register 84, No. 10).
2. Change without regulatory effect amending subsections (b) and (d)-(f) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.43.13. Mutual Benefit Plans.

A health care service plan which is a bona fide mutual benefit society within the meaning of this section and which was registered under the Knox-Mills Health Plan Act as in effect on June 30, 1976 is exempted from the provisions of the Knox-Keene Health Care Service Plan Act, except as otherwise indicated below, subject to each of the following conditions:

(a) That such a plan is a corporation organized and operating as a California nonprofit corporation; does not engage, directly or indirectly, in any for-profit business; is not affiliated (Rule 1300.45(c)) with any other plan or with any corporation or other entity which engages, directly or indirectly, in any for-profit business; and does not contract or otherwise arrange for the performance of any portion of its administrative functions by persons other than its officers, directors, or employees.

(b) That such plan consists of a mother lodge and not more than one subordinate lodge; provided, however, that such mother lodge and any such subordinate lodge are located in a county whose population exceeds 1,500,000 persons.

(c) That the assets and funds available for the payment of health care services are held in trust by and under the sole control of the mother lodge

exclusively for the benefit of the beneficiary members of the mother lodge and any subordinate lodge.

(d) That such plan is exempted from federal income tax as an organization described in Section 501(c)(8) of the Internal Revenue Code and from state income tax on similar grounds.

(e) That such plan is in compliance with the Uniform Supervision of Trustees for Charitable Purposes Act (Article 7 (commencing with Section 12580) of Chapter 6 of Part 2 of Division 3 of Title 2 of the Government Code.)

(f) That such plan not practice any discrimination in violation of state or federal law or constitutional provision.

(g) That the beneficial membership in such plan is limited to beneficial members of the mutual benefit society (including only the mother lodge and any subordinate lodge) and consists of a total of not more than 800 persons.

(h) That such plan not receive any prepaid or periodic charges, except that admission fees of not more than $500 per each beneficial or social member may be received and dues of not more than $100 per each beneficial or social member per year may be received, provided, however, that no part of any admission fees or membership dues may be deposited in the health care trust or used to pay for or reimburse any part of the cost of health care services.

(i) That such plan, at all times while it relies upon this exemption, has a tangible net equity within the meaning of Section 1300.76(b) of not less than $500,000, including liquid tangible assets in an amount not less than $500,000, based upon its most recent annual certified financial statement and its most recent quarterly and monthly statements prepared on a basis consistent with the annual certified statement, with additional liquid tangible assets in an amount not less than $1,000 for each beneficial member in excess of 700; provided that the maximum number of beneficial members shall not exceed 800.

(j) That such plan, upon request of the Director, pursuant to Section 1384(a) of the Act, submits to the Director a copy of its most recent annual certified financial statement, and, upon request of the Director pursuant to Section 1384(f) of the Act, submits to the Director its most recent quarterly and monthly statements prepared on a basis consistent with the annual certified statement.

(k) That such plan issues to all beneficial members health care service plan contracts which provide at least all of the benefits indicated below, except that such contracts may diminish or qualify any of the benefits indicated below through the use of such copayments, limitations, and other terms as may be determined from time to time by vote of the plan's beneficial members:

(1) Physician services (including consultation and referral) through contracting physicians;

(2) Hospital inpatient services through at least one contracting nonprofit, nongovernmental hospital;

(3) Hospital outpatient services through at least one contracting nonprofit, nongovernmental hospital when prescribed by the treating, contracting physician.

(*l*) That all of the plan's contracts with providers comply with, and recite that the contracting providers are bound by, the provisions of Section 1379 of the Act.

(m) That such plan provides to each beneficial member a disclosure statement covering the provisions of its health care service plan contract which complies substantially with the provisions of Section 1363 of the Act.

(n) That the officers and directors of such corporation are enrolled in such plan subject to terms and conditions no more favorable than any other beneficial

member, and that no officer or director receives any compensation from such corporation.

(o) That such plan solicits beneficial members in this state only through persons who are officers, directors, or employees of such plan, and not by means of any unsolicited telephone call or written or printed communication or by radio, television, or similar communications media.

(p) That such plan establishes and maintains a grievance procedure substantially complying with Section 1368 of the Act.

(q) That such plan delivers to each beneficial member within 60 days of the effective date of this section, and annually thereafter, the following written notice:

> "(Name of Plan) IS A HEALTH CARE SERVICE PLAN OPERATING PURSUANT TO AN EXEMPTION FROM THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975. COMPLAINTS REGARDING THIS PLAN, THE ADMINISTRATION THEREOF, AND THE SERVICES PROVIDED THEREBY MAY BE DIRECTED TO THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE OF THE STATE OF CALIFORNIA."

(r) That such plan provides, within 60 days of its initial reliance on this section, and within 30 days of any subsequent request of the Director therefor, written notice to the Director of its intent to rely on the exemption provided by this section, executed by a duly authorized officer of such plan, together with a signed opinion of legal counsel to the effect that such plan complies with subsections (a), (b), (c), (d), (e), (f), (g), (h), (i), (k), (*l*), and (m) of this section.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Sections 1343 and 1344, Health and Safety Code.

History:

1. New section filed 6-5-84; effective thirtieth day thereafter (Register 84, No. 23).
2. Change without regulatory effect amending subsections (j) and (q)-(r) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
3. Change without regulatory effect amending subsection (q) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.43.14. Employee Assistance Programs.

(a) A health care service plan which, pursuant to a contract with an employer, labor union or licensing board within the Department of Consumer Affairs, consults with employees, members of their families or licensees of such board to identify their health, mental health, alcohol and substance abuse problems and refer them to health care providers and other community resources for counseling, therapy or treatment, is exempt from the provisions of the Act (other than Sections 1360, 1360.1, 1368 and 1381, relating to advertising, client grievance procedures and the inspection of records by the Director) if the plan complies with each of the following provisions, and the contracts of a licensed health care service plan are exempt from the provisions of the Act if they comply with each of the following provisions:

(1) The plan has filed a notice with the Director as provided in subsection (c) within the preceding 24 months.

(2) The purpose of the contract, insofar as it relates to the provision of services to clients is either

(A) to maintain or improve employee efficiency through identification and referrals for counseling, treatment or therapy, in connection with personal problems affecting employee performance and the contract does not provide for counseling, treatment or therapy with respect to health, mental health, alcohol or substance abuse problems or

(B) to identify alcohol and substance abuse problems or mental health or health problems of DCA licensees and refer them to appropriate health care providers or organizations for treatment, and the plan does not provide for counseling, treatment or therapy with respect to health, mental health, alcohol or substance abuse problems.

(3) No client or member of his or her family, directly or indirectly shall pay any prepaid or periodic charge under the contract or pay any copayment, fee or other charge for any service rendered under the contract in connection with a health, mental health, alcohol or substance abuse problem. The payment of regular union dues by an employee, a license fee by a DCA licensee, or of a benefit payment by an employer on behalf of an employee and members of the employee's family which does not affect the employee's compensation or other benefits is not a "prepaid or periodic charge" for the purpose of this subsection.

(4) If such plan, its employees or contracting consultants, or an affiliate of any of the foregoing, has a financial interest in referrals made under the contract in connection with a health, mental health, alcohol or substance abuse problem, such person prior to making any such referral shall disclose to the contracting employer, union or state licensing agency and to the person who is referred, the existence of such financial interest; provided that neither the plan nor its employees shall receive any payment, fee or commission directly or indirectly from any person to whom an employee, licensee or family member is referred for counseling, treatment or therapy. The disclosure requirement to the employer may be a single blanket disclosure provided it identifies the providers to which referrals will be made and identifies the financial interest involved.

(5) The number of sessions with any client under the contract shall not exceed 3 within any six month period.

(6) Except as otherwise provided in Division 2 (commencing with Section 500) of the Business and Professions Code, the plan shall maintain a record for a period of not less than two years of each session with a client concerning a health, mental health, alcohol or substance abuse problem, and each consultation excluded from the definition of "session." The record shall include the name of or identifier for the client, the date and purpose of the session and the outcome if any, including the name of the provider to which the client was referred. The employee assistance program contracts and the records specified pursuant to subparagraph (6) shall be available for inspection by the Director as provided in Section 1381 of the Act.

(7) The plan and the personnel, facilities and equipment of the plan, including that employed under contract, shall be licensed or certified when required by applicable law and persons engaged in identification and referral who are not licensed under Division 2 of the Business and Professions Code shall be certified by any of the following organizations:

(A) Any organization accredited by the National Commission for Accreditation of Alcohol/Drug Abuse Counselors' Credentialing Bodies, Inc.

(B) Alcoholism Council of California.

(C) California Association of Alcoholism and Drug Abuse Counselors.

(D) Association of Labor-Management Administrators and Consultants on Alcoholism.

(8) Unless the plan is licensed under the Act, no prepaid fees shall be collected more than 45 days in advance.

(b) For the purposes of this section the following definitions apply:

(1) "Client" means the employee, the employee's family member, the DCA licensee or other person eligible for the services provided under the plan contract.

(2) "DCA licensee" means a licensee of the Department of Consumer Affairs.

(3) "Session" means any in-person or telephone consultation with the client in connection with the client's health, mental health, alcohol or substance abuse problems, excluding a consultation that occurs in an acute emergency situation, a consultation after referral for motivation or re-referral or a consultation due to a management, state licensing agency or union request for information or assessment regarding work performance issues.

(c) The notice specified in subsection (a)(1) shall be in the following form and contain the information specified below:

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

NOTICE OF EMPLOYEE ASSISTANCE PROGRAM
EXEMPTION RULE 1300.43.14,
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT

( ) Original Notice ( ) Amendment to Notice Dated _____

The person/entity named in Item 1 below files this notice/amended notice claiming the exemption pursuant to Rule 1300.43.14 under the Knox-Keene Health Care Service Plan Act:

1. Legal name of person or entity filing this notice: _____

2. Address of principal office, and if different, mailing address:

_____

_____

3. Fictitious names used in connection with the operation of employee assistance programs (if none, so specify):

_____

4. Identify each location at which the plan maintains records subject to inspection by the Director under Rule 1300.43.14(a)(6) (if space is insufficient, continue on separate sheet):

_____

_____

_____

5. Name, title, address and telephone number of representative who may be contacted concerning this notice:

6. The person/entity filing this notice declares hereby that it is in compliance with the provisions of Rule 1300.43.14, and undertakes to amend this notice within 30 calendar days of any material change in the information specified in its current notice as filed with the Director of the Department of Managed Health Care.

Date of Notice _____

_____
(Name of Person/Entity Filing Notice)

_____
(Signature of Authorized Officer)

_____
(Printed Name and Title of Signatory)

Verification:

I certify (or declare) under penalty of perjury under the laws of the State of California that I have read this Notice and its attachments thereto and know the contents thereof and that the statements therein are true and correct.

Executed at _____ on _____
(City and State) (Date)

_____
(Signature)

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

History:
1. New section filed 6-12-87; operative 6-12-87 (Register 87, No. 28).
2. Change without regulatory effect amending section filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
3. Change without regulatory effect amending subsections (a)-(a)(1), (a)(6) and (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
4. Change without regulatory effect amending subsection (c)—form filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.43.15. Foreign Plans.

(a) There is exempted from the provisions of the Act (other than Sections 1360, 1360.1, 1381 and 1395) any plan whose activity in this state is limited to the offer and sale of plan contracts for enrollees who are residents of or domiciled in a foreign country, provided:

(1) the provision of health care services by the plan, and the receipt of consideration from persons located in this State, does not violate any law of the foreign country in which the enrollee resides or any law of the United States,

(2) the annual premium per enrollee does not exceed $200 (US),

(3) the solicitors or solicitor firms authorized to solicit on behalf of the plan are physically present in this state, and

(4) the plan has filed a notice with the Director as provided in subsection (b) within the preceding 24 months.

(b) The notice specified in subsection (a) shall be in the following form and contain the information specified below:

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

NOTICE OF FOREIGN PLAN EXEMPTION
RULE 1300.43.15, KNOX-KEENE HEALTH CARE
SERVICE PLAN ACT

( ) Original Notice ( ) Amendment to Notice Dated _____

The person/entity named in Item 1 below files this notice/amended notice claiming the exemption pursuant to Rule 1300.43.15 under the Knox-Keene Health Care Service Plan Act:

1. Legal name of person or entity filing this notice:

2. Address of principal office, and if different, mailing address:

3. List name, address and telephone number of authorized solicitors or solicitor firms who will be soliciting on behalf of the plan in this state. (Continue on separate sheet if space is insufficient.)

4. Name, title, address and telephone number of representative who may be contacted concerning this notice:

5. The person/entity filing this notice declares hereby that it is in compliance with the provisions of Rule 1300.43.15, and undertakes to amend this notice within 30 calendar days of any material change in the information specified in it current notice as filed with the Director of the Department of Managed Health Care.

Date of Notice _____

_____
(Name of Person/Entity Filing Notice)

_____
(Signature of Authorized Officer)

_____
(Printed Name and Title of Signatory)

Verification:

I certify (or declare) under penalty of perjury under the laws of the State of California that I have read this Notice and its attachments thereto and know the contents thereof and that the statements therein are true and correct.

Executed At _____ on _____ 19_____

_____
(Signature)

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

History:

1. New section filed 9-8-88; operative 10-8-88 (Register 88, No. 38).
2. Change without regulatory effect amending subsections (a)(4) and (b) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
3. Change without regulatory effect amending subsection (b)—form filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

ARTICLE 2
Administration

Section
1300.44. Interpretive Opinions.
1300.44.1. Application for Exemption from Rule.
1300.45. Definitions.
1300.46. Prohibition of Bonuses or Gratuities in Solicitations.
1300.47. Advisory Committee on Managed Health Care.

§ 1300.44. Interpretive Opinions.

NOTE: Authority cited: Section 1344, Health and Safety Code.

History:

1. Repealer filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

§ 1300.44.1. Application for Exemption from Rule.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1344, 1351 and 1352, Health and Safety Code.

History:

1. Amendment of subsection (b) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Repealer filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

§ 1300.45. Definitions.

In addition to the definitions contained in Section 1345 of the Act, the following definitions apply to the interpretation of these rules and the Act:

(a) "Act" means the Knox-Keene Health Care Service Plan Act of 1975.

(b) "Advertisement" includes the disclosure form required pursuant to Section 1363 of the Act.

(c)(1) An "affiliate" of a person is a person controlled by, under common control with, or controlling such person.

(2) A person's relationship with another person is that of an "affiliated person" if such person is, as to such other person, a director, trustee or a member of its executive committee or other governing board or committee, or that of an officer or general partner, or holds any other position involving responsibility and authority similar to that of a principal officer or general partner; or who is the holder of 5% or more of its outstanding equity securities; or who has any such relationship with an affiliate of such person. An affiliate is also an affiliated person.

(d) The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting shares, debt, by contract, or otherwise.

(e) The term "certified" or "audited," when used in regard to financial statements, means examined and reported upon with an opinion expressed by an independent public or certified public accountant.

(f) "Code" means the California Health and Safety Code.

(g) "Copayment" means an additional fee charged to a subscriber or enrollee which is approved by the Director, provided for in the plan contract and disclosed in the evidence of coverage or the disclosure form used as the evidence of coverage.

(h) "Department" means the California Department of Managed Health Care.

(i) "Facility" means

(1) any premises owned, leased, used or operated directly or indirectly by or for the benefit of a plan or any affiliate thereof, and

(2) any premises maintained by a provider to provide services on behalf of a plan.

(j) "Family unit" means a unit composed of a subscriber and each person whose eligibility for benefits is based upon such person's relationship with, or dependency upon, such subscriber.

(k) "Hospital based plan" means a health care service plan which owns, operates or is affiliated with a hospital as an integral part of delivering health care services.

(*l*) "Material": A factor is "material" with respect to a matter if it is one to which a reasonable person would attach importance in determining the action to be taken upon the matter.

(m) "Primary care physician" means a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, or for initiating referral for specialist care. A primary care physician may be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner.

(n) "Principal creditor" means

(1) a person who has loaned funds to another for the operation of such other person's business, and

(2) a person who has, directly or indirectly, 20 percent or more of the outstanding debts of a person.

(o) "Principal officer" means a president, vice-president, secretary, treasurer or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

(p) "Surcharge" means an additional fee which is charged to a subscriber or enrollee for a covered service but which is not approved by the Director,

provided for in the plan contract and disclosed in the evidence of coverage or the disclosure form used as the evidence of coverage.

(q) The term "generally accepted accounting principles," when used in regard to financial statements, assets, liabilities and other accounting items, means generally accepted accounting principles as used by business enterprises organized for profit. Accordingly, Financial Accounting Standards Board statements, Accounting Principles Board opinions, accounting research bulletins and other authoritative pronouncements of the accounting profession should be applied in determining generally accepted accounting principles unless such statements, opinions, bulletins and pronouncements are inapplicable. Section 510.05 of the AICPA Professional Standards, in and of itself, shall not be sufficient reason for determining inapplicability of statements, opinions, bulletins and pronouncements.

NOTE: Authority cited: Sections 1344 and 1352, Health and Safety Code. Reference: Sections 1351, 1351.1 and 1352, Health and Safety Code.

History:

1. Amendment of subsection (c) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. New subsection (q) filed 4-27-79; effective thirtieth day thereafter (Register 79, No. 17).
3. Amendment of subsection (e) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
4. Amendment of subsection (c) filed 12-17-85; effective thirtieth day thereafter (Register 85, No. 51).
5. Change without regulatory effect amending subsections (g)-(h) and (p) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
6. Change without regulatory effect amending subsection (h) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.46. Prohibition of Bonuses or Gratuities in Solicitations.

No person subject to the provisions of the Act shall offer or otherwise distribute any bonus or gratuity to potential subscribers for the purpose of inducing enrollment or to existing subscribers for the purpose of inducing the continuation of enrollment.

§ 1300.47. Advisory Committee on Managed Health Care.

Each member of the Advisory Committee on Managed Health Care shall file with the Director a statement setting forth the following:

(a) The firm with which such member is employed or affiliated and the capacity in which employed or affiliated.

(b) Whether such firm is a health care service plan or solicitor firm under the Act or is a provider, or a fiscal intermediary for a plan, or furnishing services, goods or facilities to any plan, solicitor firm or provider.

(c) Whether such member has any financial interest in any firm specified in (b) or receives compensation from such firm.

(d) The name of each plan in which the member is enrolled, or has been enrolled during the preceding 10 years.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference:

Section 1347, Health and Safety Code.

History:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Change without regulatory effect amending section heading and first paragraph filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
3. Change without regulatory effect amending section heading and first paragraph filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

ARTICLE 3
Plan Applications and Amendments

Section
1300.49. General Licensure Requirements.
1300.50. Notice of Intention to Apply for Plan License.
1300.51. Application for License as a Health Care Service Plan or Specialized Health Care Service Plan.
1300.51.1. Individual Information Sheet.
1300.51.2. Consent to Service of Process.
1300.51.3. Preparation and Amendment of Application for License As a Health Care Service Plan Under Section 1300.51.
1300.52. Amendments to Plan Application.
1300.52.1. Notice of Material Modification.
1300.52.2. Change in Plan Personnel.
1300.52.3. Filings and Actions Relating to Charitable or Public Activities.
1300.52.4. Standards for Amendments and Notices of Material Modification.

§ 1300.49. General Licensure Requirements.

(a) Definitions

As used in this section:

(1) "Global risk" means the acceptance of a prepaid or periodic charge from or on behalf of enrollees in return for the assumption of both professional and institutional risk.

(2) "Institutional risk" means the assumption of the cost for the provision of hospital inpatient, hospital outpatient, or hospital ancillary services to subscribers or enrollees undertaken by a person, other than services performed pursuant to the person's own license under section 1253 of the Health and Safety Code, in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(3) "Limited health care service plan" means a person with a health care service plan license with waivers issued by the Department or its predecessor prior to January 1, 2000 for the provision of, or the arranging, payment, or reimbursement for the provision of, health care services to subscribers or enrollees of another health care service plan under a contract or other arrangement whereby the person assumes both professional and institutional risk.

(4) "Prepaid or periodic charge" for the purposes of this section means any amount of compensation, either at the start or end of a predetermined period, for assuming the risk, or arranging for others to assume the risk, of delivering or arranging for the delivery of the contracted-for health care services for subscribers or enrollees that may be fixed either in amount or percentage of savings or losses in which the entity shares.

(5) "Professional risk" means the assumption of the cost for the provision of physician, ancillary, or pharmacy services undertaken by physicians or other licensed or certified providers to subscribers or enrollees in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(6) "Restricted health care service plan" means a person with a health care service plan license issued by the Department for the provision of, or the arranging, payment, or reimbursement for the provision of, health care services to subscribers or enrollees of another full service or specialized health care service plan under a contract or other arrangement whereby the person assumes both professional and institutional risk but does not directly market, solicit, or sell health care service plan contracts.

(b) (1) Any person who assumes global risk shall obtain a license to operate a health care service plan pursuant to section 1349 of the Health and Safety Code.

(2) Pursuant to section 1343 of the Health and Safety Code, the Director shall grant an exemption from this section to any person upon review and a finding that the action is in the public interest and not detrimental to the protection of subscribers, enrollees or persons regulated under the Knox-Keene Act. A person requesting an exemption shall submit the following information for consideration by the Director:

(A) The filing of Exhibit GG, Financial Viability, and Exhibit HH, Projected Financial Viability, of the application for licensure, pursuant to rule 1300.51 of this title. The Exhibits shall include current financial statements and projected changes that have or are expected to occur upon the assumption of global risk. A person that already files audited financial statements with the Department may request an exemption from filing Exhibit GG;

(B) The total percentage of annualized income of institutional risk the person will assume and how it will be assumed;

(C) The contract(s) for the assumption of global risk;

(D) The estimated number of subscribers and enrollees for whom the person will provide health care services;

(E) The geographic service area(s) under the global risk arrangement(s) in which the person intends to operate; and

(F) Any other information the person believes is appropriate or relevant for the Director to consider when reviewing the exemption request.

(G) Persons requesting an exemption shall submit the request to the following address: OPLInquiries@dmhc.ca.gov or submit a hard copy to the Department of Managed Health Care, ATTN: Office of Plan Licensing, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

(3) When reviewing the information submitted under subdivision (b)(2) of this regulation, the Director shall consider the following criteria:

(A) The person's portion of contracted global risk when compared to the person's overall business;

(B) The portion of market share the person assumes for global risk in the geographical region compared to the market share assumed by other persons within the region, and whether disruption will occur in the marketplace if the person fails to maintain financial solvency;

(C) The financial capacity to assume a portion of global risk without jeopardizing enrollee access to basic health care services in the geographical region;

(D) The potential impact on the health care marketplace in the geographical region in which the person operates, including the impact on contracted institutional and professional providers, if the person is unable to maintain financial solvency; and,

(E) The issuance of an exemption will not negatively impact public interest or protection of the public, subscribers, enrollees, or persons subject to the Knox-Keene Act, if the person assumes global risk.

(4) The Director shall issue the decision on the request for exemption from licensure under this section within 30 days of receipt of the request by the Department.

(c) (1) (A) A restricted health care service plan may contract with and accept global risk from only a full service health care service plan or a specialized health care service plan to provide or arrange health care services for that entity's subscribers or enrollees.

(B) A restricted health care service plan may not market, solicit, or sell health care service plan contracts to individual members of the public, employers, or any other person or group.

(2) An applicant seeking licensure as a restricted health care service plan shall file:

(A) An application for licensure in accordance with section 1351 of the Health and Safety Code and rule 1300.51 of this title. The application for licensure shall include all exhibit types, and within each exhibit as relevant, shall specify the functions for which the applicant restricted health care service plan will be responsible and which functions shall be the responsibility of the full service health care service plan or specialized health care service plan with which the restricted health care service plan contracts.

(B) All contractual agreements between the applicant restricted health care service plan and the full service health care service plan, or specialized health care service plan, with which the applicant restricted health care service plan contracts.

(C) A Restricted Health Care Service Plan Responsibility Statement, dated November, 2018, hereby incorporated by reference, describing the obligations of both the applicant restricted health care service plan and the full service health care service plan or specialized health care service plan with which the applicant restricted health care service plan contracts. The Restricted Health Care Service Plan Responsibility Statement shall disclose all requirements of the Knox-Keene Act and this title which remain the sole responsibility of the full service health care service plan or specialized health care service plan and which health care services will be the responsibility of the applicant restricted health care service plan. This statement must be signed by both the full service health care service plan or specialized health care service plan and the applicant restricted health care service plan.

(3) Pursuant to the network adequacy requirements of the Knox-Keene Act and this chapter, including those requirements set forth in sections 1367, 1367.03, and 1375.9 of the Health and Safety Code, as well as rules 1300.51, 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of this title, the applicant restricted health care service plan shall maintain its own contracted provider network that ensures adequate access to all health care services for which it maintains responsibility pursuant to the Restricted Health Care Service Plan Responsibility Statement.

(4) Restricted health care service plans licensed by the Department as of July 1, 2019 may continue to engage in business as restricted health care service plans under this section.

(d) Limited health care service plans licensed by the Department or its predecessor as of July 1, 2019 may continue to engage in business as limited health care service plans.

(e) This section shall apply only to contracts issued, amended, or renewed on or after July 1, 2019.

NOTE: Authority cited: Sections 1344 and 1349, Health and Safety Code. Reference: Sections 1343.5, 1345, 1349, 1351 and 1375.1, Health and Safety Code.

History:

1. New section filed 3-5-2019; operative 7-1-2019 (Register 2019, No. 10).

§ 1300.50. Notice of Intention to Apply for Plan License.

NOTE: Authority cited: Section 1344, Health and Safety Code.

History:

1. Repealer filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

§ 1300.51. Application for License as a Health Care Service Plan or Specialized Health Care Service Plan.

(a) An application for license as a health care service plan or specialized health care service plan shall be filed in the form specified in subsection (c) and contain the information specified in this section and prepared as required by Rule 1300.51.3.

(b) Applications filed prior to the effective date of subsection (c) (revised plan application form) and which remain pending on that date will be processed; however, amendments to such applications filed prior to licensure shall be filed upon the form specified in subsection (c) in accordance with the instructions specified in Rule 1300.51.3, and in accordance with the correlation table for the old and new applications provided in Form HP 1300.51-COR. Such amendments will be required only to update the information contained in the application and to remedy deficiencies in the information provided therein.

(c) Revised Health Care Service Plan Application Form.

OFFICIAL USE ONLY DEPARTMENT OF MANAGED CARE

FEE PAID $_____ LICENSE NO. _____
RECEIPT NO. _____

Date of Filing: FILING FEE: _____
(To be completed by Applicant.) Not refundable except pursuant to Section 250.15, Title 10, California Code of Regulations.

PLAN LICENSE APPLICATION
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT
(EXECUTION PAGE)

A. Identification of Plan.

1. Name of Applicant.
   a. Legal name: _____
   b. Please list all fictitious names you intend to use
   _____
   _____
   _____

2. Applicant's Principal Executive Office.
   a. Street Address: _____
   _____
   b. Mailing Address: _____
   c. Telephone Number: _____
   d. Fax Number: _____
   e. Email Address: _____

3. Person who is to receive communications regarding this filing. (NOTE: Prior to licensure, the Department will correspond only with this person.)
   a. Name: _____
   b. Title: _____
   c. Address: _____
   d. Telephone Number: _____
   e. Fax Number: _____
   f. Email Address: _____

4. EXECUTION: The applicant has duly caused this application to be signed on its behalf by the undersigned, thereunto duly authorized.

_____ By: _____
(Applicant) (Type the name of the authorized signatory for Applicant or Licensee)
Title: _____

I certify (or declare) under penalty of perjury under the laws of the State of California that I have read this application and the exhibits and attachments thereto and know the contents thereof, and that the statements therein are true and correct.

Executed at (City & State) _____
Executed on (Date) _____

By_____
(Type the Name of the authorized signatory certifying the contents of this e-Filing on behalf of Applicant or Licensee)
Title: _____

B. Type of Filing: Indicate the type of filing by checking the single applicable box in Item Nos. 1-7, below, and listing all Exhibits at Item No. 8 below.
1. [ ] Original application for a plan license.
2. [ ] Amendment #_____ to a pending license application initially filed
2nd, 3rd, etc.
on _____, Associated Filing No. _____

3. [ ] Notice of a proposed material modification in the form required by Rule 1300.52.1.
4. [ ] Amendment #_____ to a pending notice of material modification
2nd, 3rd, etc.
initially filed on _____Associated Filing No. _____
5. [ ] Amendment filed by a licensee pursuant to Section 1352(a) because of a change in' the information contained in the original application.
6. [ ] Amendment #_____ to a pending amendment filed pursuant to
2nd, 3rd, etc.
section 1352(a) initially filed on _____; Associated Filing No. _____
7. [ ] Report/Other electronic submission filed by licensee. (Specify type in Exhibit E-1)
8. Scope of Filing: Exhibits included in this filing (Specify subsections, e.g., F-1-f) _____
_____
_____

C. Type of Plan Contract(s): Indicate the type of a plan contract(s) by checking and completing the statements which most nearly describe the plan:
1. [ ] Full Service Health Plan Contracts, which provide as benefits at least the six basic health care services listed in Section 1345(b) of the Act. (Check types below as appropriate.)
[ ] Commercial
[ ] Waxman-Duffy prepaid health plan contract
[ ] Other Medi-Cal (Explain) _____

[ ] MediCare Supplement
[ ] Other (Explain) _____

2. Specialized Health Plan Contract(s):
[ ] Dental [ ] Vision [ ] Mental Health
[ ] Other (Explain) _____

3. [ ] Contracts with subscribers and enrollees which are not limited to a single specialized area of health care but do not provide as benefits at least the six basic health care services listed in Section 1345(b) of the Act.

D. Name and address or officer or partner of applicant who is to receive compliance and informational communication from the Department and is responsible for disseminating the same within applicant's organization. (NOTE: After licensure, and except with respect to amendments and material modifications, the Department will correspond only with this person, unless the Department and applicant agree to other arrangements.)

1. Name: _____
2. Title: _____
3. Address: _____
4. Telephone Number: _____
5. Fax Number: _____
6. Email Address: _____

E. Other Agencies:

1. If applicant is seeking or intends to seek federal qualification under the Federal Health Maintenance Organization Act of 1973, check here [ ] .

2. If the applicant has made or intends to make any filing relating to its plan to any other state or federal agency, check here [ ], and attach Exhibit D-2 identifying each such agency, and the nature, purpose and (projected) date of each such filing.

Additional Exhibits: An original application for health care service plan license must include the completed form specified in this subsection and the exhibits required by Subsection (d).

(d) Exhibits to Plan Application.

E. Summary of Information in Application.

1. Summary Description of Plan Organization and Operation. Provide as Exhibit E-1 a summary description of the organization and operation of applicant's business as a health care service plan, covering the highlights and essential features of the information provided in response to the other portions of this application which is essential or desirable to an effective overview of the applicant health care service plan business.

2. Summary Description of Start-up. Provide as Exhibit E-2 a concise description of applicant's start-up program and its assumptions. Indicate applicant's projected date for the beginning of plan operations, and discuss the factors which require such date.

F. Organization and Affiliated Persons.

1. Type of Organization.

a. Corporation. If applicant is a corporation, and attach as Exhibits F-1-a-i, F-1-a-ii and F-1-a-iii, respectively, the Articles of Incorporation, Bylaws, and the Corporation Information Form. (Form HP 1300.51-A)

b. Partnership. If applicant is a partnership, and attach as Exhibits F-1-b-i, and F-1-b-ii, respectively, the Partnership Agreement, and the Partnership Information Form. (Form HP 1300.51-B)

c. Sole Proprietor. If applicants a sole proprietorship, and attach as Exhibit F-1-c the Sole Proprietorship Information Form. (Form HP 1300.51-C)

d. Other Organization. If applicant is any other type of organization, and attach as Exhibit F-1-d, Articles of Association, trust agreement, or any other

applicable documents, and any other organizational documents relating to the conduct of the internal affairs of the applicant, and attach as Exhibit F-1-d-ii the Information Form for other than Corporations, Partnerships, and Sole Proprietorships. (Form HP 1300.51-D)

e. Public Agency. If applicant is a public agency, and attach as Exhibit F-1-e-i a description of the public agency, its legal authority, organization, decision making body. Also attach as Exhibit F-1-e-ii a description of the division or unit of the public agency which is to be responsible for operating the plan, its legal authority, organization, and decision making role. Also attach as Exhibit F-1-e-iii the name and address of the local public agency which is the plan.

f. Individual Information Sheet. Attach as Exhibit F-1-f, an Individual Information Sheet (Form HP 1300.51.1) for each natural person named in any exhibit in Item F-1.

2. Contracts with Affiliated Persons, Principal Creditors and Providers of Administrative Services.

a. Persons to Be Identified. Attach as Exhibit F-2-a list identifying each individual or entity who is a party to a contract with applicant, if such contract is one for the provision of administrative services to the applicant or any such party is an Affiliated Person or Principal Creditor (Rule 1300.45(c) and (n)) or of the applicant. As to each such person, show the following information in; columnar form:

(i) The names in alphabetical order.

(ii) The exhibit and page number of the contract (including loans and other obligations).

(iii) The type of contract of loan.

(iv) Each relationship which such individual or entity bears to the applicant (officer, director, partner, trustee, member, Principal Creditor, employee, administrative services provider, health care services provider, or shareholder).

(v) Whether (yes or no) such individual or entity is intended to become a Principal Creditor (Rule 1300.45(n)) of applicant.

(vi) Whether (yes or no) such individual or entity is intended to become an "Affiliated Person" of applicant, or to become an Affiliated Person in any capacity other than that disclosed in item F-2-a-iv.

b. Copies of Contracts. Attach as Exhibit F-2-b a copy of each contract (other than a contract for the provision of administrative services or health care services furnished pursuant to Items K or N below) identified in Item F-2-a. Preceding the first page of each such contract, attach a summary sheet which

(1) identifies the contract,

(2) specifies its terms, including its expiration date, and

(3) if a loan or obligation, specifies the unpaid balance of principal and interest and states whether applicant is in default upon the loan or obligation.

3. Other Controlling Persons. Does any individual or entity not named as a contracting party in Item F-2 or any exhibit thereto have any power, directly or indirectly, to manage, influence, or administer the operation, or to control the operations or decisions, of applicant?

If the appropriate response to this item is "yes," attach as Exhibit F-3 a statement identifying each such person or entity and explaining fully, and summarizing every contract or other arrangement or understanding (if any) with each such person. (Each such contract should be submitted pursuant to Subsection F-2 or Subsection G-2, as appropriate.)

4. Criminal, Civil and Administrative Proceedings. Within the preceding 10 years, has the applicant, its management company, or any Affiliate of the applicant (Rule 1300.45(c)), or any controlling person, officer, director or other person occupying a principal management or supervisory position in such

plan, management company or Affiliate, or any person intended to hold such a relationship or position, been convicted of or pleaded nolo contendere to a crime, or been held to have committed any act involving dishonesty, fraud or deceit in a judicial or administrative proceeding to which such person was a party?

If "yes," attach a separate exhibit as to each such person designated Exhibit F-4, identifying such person and fully explaining the crime or act committed. Also, attach a copy of the exhibit for an individual to any Individual Information Sheet required by Item F-1-f for such individual.

5. Employment of Barred Persons. Has the plan engaged or does the plan intend to engage, as an officer, director, employee, associate, or provider, any person named in any order of the Director pursuant to Section 1386(c) or Section 1388(d) of the Act? If the appropriate response to this item is "yes," attach as Exhibit F-5 a statement identifying each such person and explaining fully.

G. Miscellaneous.

1. Consent to Service of Process. If applicant is not a California corporation, attach as Exhibit G-1 a Consent to Service of Process, in the form required by Rule 1300.51.2.

2. Disclosure of Financial Information. Attach as Exhibit G-2, authorizations for the disclosure of financial records of the applicant, and of any association, partnership or corporation controlling, controlled by or otherwise affiliated with the applicant pursuant to Section 1351.1 of the Act. (See Items F-3 and F-5.)

HEALTH CARE DELIVERY SYSTEM

H. Geographical Area Served.

NOTE: The applicant is required to demonstrate that, throughout the geographic regions designated as the plan's Service Area, a comprehensive range of primary, specialty, institutional and ancillary services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.

For the purpose of evaluating the geographic aspects of availability and accessibility, consideration will be given to the actual and projected enrollment of the plan based on the residence and place of work of enrollees within and, if applicable, outside the service area, including the individual and group enrollment projections furnished in Items CC, DD and EE of this application.

An applicant for plan license must demonstrate compliance with the accessibility requirement in each of the areas specified in paragraphs (i) through (iv) below, either by demonstrating compliance with the guideline specified in such paragraphs or, in the alternative, by presenting other information demonstrating compliance with reasonable accessibility. These guidelines apply only with respect to initial license applications and provide presumptively reasonable standards in the absence of actual operating experience. Such guidelines are not intended to express minimum standards of accessibility either for applicants or for licensees nor to create any inference that a plan which does not meet these guidelines does not meet the requirement of reasonable accessibility.

(i) Primary Care Providers. All enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees.

(ii) Hospitals. In the case of a full-service plan, all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated hospital which has a capacity to serve the entire dependent enrollee population

based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services.

(iii) Hospital Staff Privileges. In the case of a full-service plan, there is a complete network of contracting or plan-employed primary care physicians and specialists each of whom has admitting staff privileges with at least one contracting or plan-operated hospital equipped to provide the range of basic health care services the plan has contracted to provide.

(iv) Ancillary Services. Ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription on the primary care provider are available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider.

1. Description of Service Area. As Exhibit H-1, attach a narrative description of the applicant's service area and the geographic area in which its enrollees (actual and/or projected) live and work and list all U.S. Postal ZIP Code numbers included in the service areas. If the applicant has more than one service area, each service area should be separately described. To the extent possible, service areas should be delineated by political or natural boundaries. (If applicant uses sub-service areas or regions within its service areas for the purpose of allocating the provision of health care services by providers to enrollees, include that information in the description of the considerations which underlie the geographic distribution of the applicant's contracting and plan-operated providers.)

2. Map of Service Area. As Exhibit H-2, attach a map or maps upon which the information specified below is indicated by the specified system of symbols. The map(s) employed should be of convenient size and of the largest scale sufficient to include the applicant's entire service area and the surrounding area in which the actual or projected enrollees live or work. The use of good-quality city street maps or the street and highway maps available for various metropolitan areas, and regions of the state, such as are commonly available from automobile associations or retail service stations is preferred. The map or maps should show the following information:

a. Such geographic detail, including highways and major streets, as is generally portrayed on the kinds of maps referred to above.

b. The boundaries of applicant's service area.

c. The location of any contracting or plan-operated hospital and, if separate, each contracting or plan operated emergency health care facility. Hospitals are to be designated by an "H" and emergency care facilities by an "E."

d. The location of primary care providers, designated by a "P." For convenience, the primary care providers within any mile-square area may be considered as being at one location within that area.

e. The location of all other contracting or plan-operated health care providers including the following: Dental, designated by a "D." Pharmacy, designated by an "Rx." Laboratory, designated by an "L." Eye Care, designated by an "O." Specialists and ancillary health care providers, designated by an "S."

f. The location of all subscriber groups which have submitted letters of intent or interest to join the applicant's plan designated by a "G." (See Item CC-3.)

3. Index to Map. As Exhibit H-3, attach an index to the map or maps furnished as Exhibit H-2 which shows, for each symbol placed on the map for a hospital, emergency care facility, primary care provider or ancillary provider, the following information:

a. For each hospital, its total beds and the number of beds available to enrollees of the plan.

b. For each symbol for primary care providers, the number of full-time equivalent primary care providers represented by that symbol.

c. For each interested subscriber group, the name of the group and the projected number of enrollees from that group.

I. Description of Health Care Arrangements.

NOTE: Providers of Health Care Services. The information in this item is for the purpose of assessing the adequacy of the applicant's health care provider arrangements.

If the service area of the plan and the distribution of its enrollees is so geographically limited that all plan health care providers are readily available and accessible to all enrollees, no geographic division of the provider information required in this part need be made.

However, if applicant's service area is divided into separate provider networks for regions within the service area, the information required in this Item-1 must be furnished separately for each such region and provider network.

1. Physicians Services.

a. Individual Physicians. As Exhibit I-1-a list all individuals who provide covered physician services as employees of the plan or, whether directly or through an association or other entity, as contracting providers: For each physician, furnish the following information.

(i) Name.

(ii) License Number.

(iii) Type of service as determined by board certification and eligibility. Primary care physicians should be designated as general practice, pediatrics, obstetrics, gynecology and internal medicine. Specialists should be designated as allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, surgeries, otolaryngology, urology, and other designated as appropriate.

(iv) The plan-owed or contracting hospitals at which the physician has admitting staff privileges.

(v) The professional address of the physician.

(vi) The physician's relationship to the plan (employed by or contracting with the plan, or contracting through an IPA or one of the parties identified in Item I-1-a.

(vii) The percentage of the physician's time allocated to enrollees of the plan.

(viii) The business hours of the physician's office (i.e., Monday through Friday 8-5, closed Wednesdays).

b. Physician Associations. For all entities other than individuals or independent practice associations who contract with applicant to provide physician services, and each plan-operated facility at which physician services are rendered by employees of the plan, as Exhibit I-1-b furnish the following information for each such contractor or facility:

(i) The name of the contractor or facility.

(ii) The street address of the contractor or facility at which the physician services are rendered for the particular region or provider network.

(iii) The type of entity (professional corporation, sole proprietor, partnership, etc.).

(iv) The number of physicians rendering services for the plan by reason of such contract or by employment at such facility, and the number of "full-time equivalent" physicians being provided to enrollees of the plan.

2. Hospitals. Attach as Exhibit I-2 a list of all hospitals which are operated by or contract with the plan. Provide the following information for each hospital:

a. Its legal name and any "dba" (fictitious name under which it does business).

b. Its address.

c. Its license number.

d. Whether it is a member of the American Hospital Association, whether it is currently accredited by the Joint Commission on the Accreditation of Hospitals, (JCAH) and the expiration date of its current accreditation.

e. Its bed capacity and rate of occupancy.

f. Its emergency room capabilities.

g. A list and full description of all services available to enrollees. Applicant may use a JCAH form or the equivalent.

h. Its relationship with applicant (owned by, contracting provider, joint venture with applicant, etc.).

3. All Other Providers of Health Care Services. Attach as Exhibit I-3 a list of all providers of health care service contracting with or owned by the applicant which are not included in the physician and hospital listings. For each such provider, furnish the following information:

a. The legal name of the provider and any "dba."

b. Its address.

c. Its license number.

d. The health care services it provides to enrollees of the plan (e.g., home health agencies, ambulance company, laboratory, pharmacy, skilled nursing facility, surgi-center, mental health, family planning, etc.).

e. Its hours of operation and the provision made for after-hours service.

f. An appropriate measure of the provider's capacity to provide health care service, the existing utilization of such services by other than enrollees of the plan and the projected use of the services by enrollees.

g. The provider's relationship to the plan (owned by, contracting with, etc.).

4. Calculation of Provider-Enrollee Ratios. As Exhibit I-4, furnish a calculation of the adequacy of the applicant's provider arrangements for each region or provider network within applicant's service area. This should be based on the full range of the health care services covered by the applicant's full-service or specialized plan contracts, the extent to which contracting and planned-owned or employed providers are available to provide such services, the enrollee population served by such providers and the adequacy of the provider system in each category based on standard utilization data. Assumptions employed in such calculations should be stated, including the extent to which paraprofessionals and allied health personnel will be used by applicant or providers and the protocols and method of supervision of such personnel.

5. Applicant's Standards of Accessibility. Attach as Exhibit I-5 a detailed description of the applicant's standards with respect to the accessibility and its procedures for monitoring the accessibility of services. Standards should be expressed in terms of the level of accessibility which the applicant has as its objective and the minimum level of accessibility below which corrective action will be taken. Cover each of the following:

a. the availability of appointments for primary care and specialty services,

b. the availability of after hours and emergency services,

c. an assessment of probable patient waiting times for scheduled appointments,

d. the proximity of specialists, hospitals, etc. to sources of primary care, and

e. a description of applicant's system for monitoring and evaluating accessibility. (Discuss applicant's system for monitoring problems that develop, including telephone inaccessibility, delayed appointment dates, waiting time for appointments, other barriers to accessibility, and any problems or dissatisfaction identified through complaints from contracting providers or grievances from subscribers or enrollees.)

f. the contractual arrangements utilized by the applicant to assure the monitoring of accessibility and conformance to standards of accessibility by contracting providers.

6. Referrals. Attach as Exhibit I-6 a detailed description of applicant's system of documentation of referrals to physicians or other health professionals. Include:

a. the provisions made for written documentation of the referral policies and procedures,

b. the procedures for following up on contracting and noncontracting referrals, including turnaround times, and

c. applicant's arrangements for paying for services delivered by noncontracting providers.

J. Internal Quality of Care Review System.

Applicant is required to demonstrate that it has a system for the review of the quality of health care to identify, evaluate and remedy problems relating to access, continuity and quality of care, utilization and the cost of services. The following exhibits require a description and explanation of the system, including narrative, organization and process charts and review criteria. See Rule 1300.70.

1. Organization and Operation. As Exhibit J-1, furnish a description of the basic structure, organization and authority of the applicant's quality of care review system, including:

a. An organization chart showing the key persons, the committees and bodies responsible for the conduct of the review system, the provisions for support staff and the relationship of such persons, committees and bodies to the general organization of the plan. See Item J-4 below.

b. A narrative explanation of the review system covering the matters depicted in the organization chart and the following: the key persons involved, their titles and their qualification; the extent and type of support staff; the areas of authority and responsibility of the key persons and the committees, if divided among persons and committees; the frequency of meetings of the committees and the portion of their time devoted to the review system by key persons. See Item J-4 below.

2. Standards and Norms. Attach as Exhibit J-2 a description of the standards and norms of the system (including any measurement of deviation in their application), and indicate how these standards and norms will be communicated to providers.

3. Operation of System. Attach as Exhibit J-3 a description of the operation of the review system, including the frequency and scope of audits, the utilization of the audit results and the procedures and methods for the enforcement of the standard and norms of the system.

4. Administration of System by Providers. If portions of the review system are administered by contracting providers, by affiliates of the applicant or by other persons who are not officers or employees of the applicant, attach Exhibit J-4 identifying those portions of the system together with the providers, affiliates or persons administering them on behalf of the applicant, and describe and furnish copies of the contractual provisions which assure the maintenance of the system to the standards of the applicant and those of the Act and the rules thereunder.

5. Monitoring of Provider Administration. Attach as Exhibit J-5, a description of the contractual arrangements which will be employed to enable the plan to monitor, and require, compliance with the quality of care review system, to the extend such system is administered by such contracting providers.

K. Contracts with Providers.

1. Copies of Contracts. Attach as Exhibit K-1 a copy of each contract made, or to be made, between applicant and each provider of health care services. If a contract shows the payment to be rendered a provider, delete such minimum portion of the contract as is necessary to prevent disclosure of such information, by blanking out or other suitable means.

a. If standard form contracts are used, only a specimen of each type of form contract need be filed together with any variations to be used in the terms and provisions of such standard forms, other than in the amount of payments to providers.

b. The contracts and other information submitted in this exhibit will be available for public inspection (see Section 1351(d)).

2. Compliance with Requirements. Attach as Exhibit K-2 a statement in tabular form for each provider contract, and for each standard form contract and its variations, if any, specifying the provisions of such contract which comply with the following provisions of the act and rules:

Section 1379
Rule 1300.67.1(a) and (c)
Rule 1300.67.2(b), (c) and (f)
Rule 1300.67.4(a)(9) and (10)
Rule 1300.67.8(a), (b), (c) and (d)
Rule 1300.68
Rule 1300.70
Rule 1300.51, Item J-5

3. Compensation of Health Care Providers. Attach as Exhibit K-3 one copy of the following provisions from each provider contract, or proposed provider contract, from which payment information was deleted in Exhibit K-1 and clearly mark the extracts from each contract "confidential":

a. The title page of the contract or other information sufficient to identify the contract submitted as Exhibit K-1 to which the extract relates and the providers who are parties. '

b. The effective date of the contract and its expiration date.

c. The provisions describing the mechanism by which payments are to be rendered to the provider, including any risk sharing arrangement, clearly identified by the name of the provider.

d. The provider's signature on the execution page of the contract, with the name of the provider typed beneath the signature.

ADMINISTRATION OF THE PLAN

L. Organization Chart.

Attach as Exhibit L an organization chart which shows the lines of responsibility and authority in the administration of the applicant's business as a health care service plan. One chart should be limited to the applicant itself, showing its management and operational structure, including the names and titles of key positions and its board. If necessary, a second chart should show the total management structure of the business in all areas, and including the key positions and departments of the applicant and those in any affiliate and/or contracting provider of health care and/or administrative services, including but not limited to the particular management functions required in the administration of a health care delivery system. The charts are to show the names of the corporations, partnerships and other entities involved in such administration, their boards, committees, and key management positions involved, giving the names of the boards, committees and positions and the persons serving therein.

M. Narrative Information.

1. Attach as Exhibit M-1 a narrative explanation of the organization chart, including the responsibility and authority of each entity, board, committee and position and identifying the persons who serve on such boards and committees and in such positions.

2. Attach as Exhibit M-2, a statement as to each individual who is a member of a board or committee or who occupies a position specified in Exhibit L and Exhibit M-1, covering the following:

a. Name.

b. Each position (e.g., director, officer, committee member, key management personnel and the managers of key departments) such person holds which is indicated in Exhibits L and M-1, whether with applicant, an affiliate or a contracting provider of health, administrative or other services. Also state the person's principal responsibilities and authority in each position, and the portion of the individual's time devoted to each principal function.

c. A resume or similar description of such person's training and experience during the preceding five years (or longer, if desired) which are relevant to the duties and responsibility in applicant's business as a health care service plan.

N. Contracts for Administrative Services.

1. As Exhibit N-1, attach a copy of each contract which applicant has for administrative or management services, or consulting contracts, or which applicant intends to have for the Health Plan.

2. As Exhibit N-2, describe applicant's administrative arrangements to monitor the proper performance of such contracts and the provisions which are included in them to protect applicant, its plan business and its enrollees and providers in the event there is a failure of performance or the contract is terminated.

O. Attach as Exhibit O a statement describing how the Health Plan organization will provide for separation of medical services from fiscal and administrative management to assure that medical decisions will not be unduly influenced by fiscal and administrative management. Describe what controls will be put into place to assure compliance with this requirement. Refer to appropriate items in Exhibit "J," Internal Quality of Care Review System.

SUBSCRIBER CONTRACTS, DISCLOSURES, AND RELATIONS

NOTE: In Items P and Q, the applicant is required to include as exhibits copies of the health care service contracts it will issue, including standard form contracts and any variations in the provisions of those forms. In addition, the applicant is required to identify the particular provisions of these contracts which comply with the provisions of the Act and rules listed at the end of this note, or which vary from those provisions. The applicant is also required to explain its proposed variations (if any) from the Act or rules, giving the reasons and justifications for such variances.

The provisions of the Act and rules required to be covered in the information furnished pursuant to Items P and Q are the following:

All Plan Contracts

Section 1345 (definitions)

Section 1362 (definitions)

Section 1363 (only if used for evidence of coverage)

Section 1365

Section 1367.6

Section 1367.8

Section 1373

Section 1373.4

Rule 1300.45 (definitions)
Rule 1300.63(a) (only if used as evidence of coverage)
Rule 1300.63.1 (only if used as evidence of coverage)
Rule 1300.63.2 (only if used as evidence of coverage)
Rule 1300.67.4
Rule 1300.68(b)
Group Contracts Only
Section 1367.2
Section 1367.3
Section 1367.5
Section 1367.7
Section 1373.1
Section 1373.2
Section 1373.5
Section 1373.6
Section 1374
Section 1374.10

P. Group Health Care Service Plan Contracts.

1. Copies of Contracts. Attach as Exhibit P-1 a copy of each group contract which is to be issued by applicant. With respect to contracts based on a standard form, only a specimen of each standard form need be submitted, accompanied by Exhibit P-2.

2. Variations in Standard Form. Attach as Exhibit P-2, if applicant uses standard form group contracts, a schedule or explanation of the variations which will be made in the terms and provisions of such contracts when issued. If no variations will be made, so state.

3. Compliance with Requirements. Attach as Exhibit P-3 a schedule in tabular form for each group contract and each standard form group contract, identifying the particular provision of such contract which complies with each relevant provision of the Act and the rules listed in the preface note to this part, covering also any variations made in standard form contracts. As to any provision which varies from the applicable provision of the Act or rules, identify such provision in Exhibit P-3 and furnish Exhibit P-4.

4. Variance with Requirements. As Exhibit P-4, attach a statement with respect to each variance which the applicant proposes to make from the Act or rules in its group contracts, indicating the reasons for the variance and, if applicable, the circumstances under which the variance from the Act or rules is proposed to be used.

Q. Individual Health Care Service Plan Contracts.

1. Copies of Contracts. Attach as Exhibit Q-1 a copy of each individual contract which is to be issued by applicant. With respect to contracts based on a standard form, only a specimen of each standard form need be submitted, accompanied by Exhibit Q-2.

2. Variations in Standard Form. Attach as Exhibit Q-2, if applicant uses standard from individual contracts, a schedule or explanation of the variations which will be made in the terms and provisions of such contracts when issued. If no variations will be made from the standard form, so state.

3. Compliance with Requirements. Attach as Exhibit Q-3 a schedule in tabular form for such individual contract and each standard form individual contract, identifying the particular provision of such contract which complies with each relevant provision of the Act and rules listed in the preface note to this part, covering also any variations to be made in standard form contracts. As to any provision which varies from the applicable provision of the Act or rules, identify such provision in Exhibit Q-3 and furnish Exhibit Q-4.

4. Variance from Requirements. As Exhibit Q-4, attach a statement with respect to each variance which the applicant proposes to make from the Act or rules in its individual plan contracts, indicating the reasons for the variance and, if applicable, the circumstances under which the variance from the Act or rules is proposed to be used.

R. (Reserved for future use.)

S. Disclosure Forms.

1. Attach as Exhibit S-1 a copy of each disclosure form which applicant proposes to use, and identify by name and by exhibit number the contract or contracts in Exhibit P-1 or Q-1 with which the disclosure form will be used. If the disclosure forms vary in text, format and arrangement in a manner which may make it difficult to identify and compare alternatives and their effect upon the contract, include an explanation which indicates how such difficulties will be avoided.

2. Attach as Exhibit S-2 a statement in tabular form for each disclosure form submitted as Exhibit S-1 above, identifying the section, paragraph, or page number of the disclosure form which shows compliance with each of the following sections of the Act or rules (following the parenthetical instructions set forth in the note immediately preceding Item P above, if there are multiple disclosure forms):

Section 1345 (definitions)
Section 1362 (definitions)
Section 1363(a)(1) through (8)
Section 1363(a)(10)
Section 1378(g) (if disclosing group contract)
Rule 1300.67(a)(1)
Rule 1300.63(b)(1) through (14)

T. Evidence of Coverage.

1. Attach as Exhibit T-1 a copy of each evidence of coverage which applicant proposes to use. Each evidence of coverage should relate to one form of plan contract which must be identified by name and by exhibit number; however, an evidence of coverage for alternative plans or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the contract and if the alternative contracts are clearly identified by name or exhibit number.

2. Attach as Exhibit T-2 a statement in tabular form for each evidence of coverage submitted as Exhibit T-1 above, the section, paragraph, or page number of the evidence of coverage which shows compliance with each of the following sections of the Act or rules (following the parenthetical instructions set forth in the note immediately preceding Item P above, if there are multiple evidences of coverage):

Section 1345 (definitions)
Section 1362 (definitions)
Rule 1300.63(a)(1)
Rule 1300.63.1(b)(1) and (2)
Rule 1300.62.2(b)(1) and (2)
Rule 1300.63.2(c)(1) through (16)
Rule 1300.69(i)

U. Combined Evidence of Coverage and Disclosure Forms.

Applicant may combine the evidence of coverage and disclosure form into one document if it complies with each of the requirements set forth in Rule 1300.63.2.

1. Attach as Exhibit U-1 a copy of each combined evidence of coverage and disclosure form. Each combined evidence of coverage and disclosure form should

relate to one form of plan contract; however, a combined evidence of coverage and disclosure form offering alternative plans or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the contract.

2. Attach as Exhibit U-2 a statement in tabular form for each combined evidence of coverage and disclosure form submitted as Exhibit U-1 above, the section, paragraph or page number which shows compliance with each of the following sections of the Act or Rules (following the parenthetical instructions set forth in the note immediately preceding Item P above, if there are multiple combined evidences of coverage and disclosure forms):

Section 1345 (definitions)

Section 1362 (definitions)

Rule 1300.63.2(b)(1) and (2)

Rule 1300.63.2(c)(1) through (27)

Rule 1300.69(i)

V. Advertising.

Attach as Exhibit V a copy of any advertising which is subject to Section 1361 of the Act and which applicant proposes to use. With respect to each proposed advertisement indicate the contract(s) by name and by exhibit number(s) to which said advertisement relates and identify the segment of the public to which the advertisement is directed.

W. Enrollee/Subscriber Grievance Procedures.

1. Attach as Exhibit W-1 a copy of its written grievance procedure adopted or to be adopted by applicant to comply with all of the provisions of Section 1368 of the Act and Rules 1300.68, 1300.85 and 1300.85.1.

2. Attach as Exhibit W-2, copies of the compliant forms and the written explanation of its grievance procedure which the plan will make available to enrollees and subscribers.

3. If the written procedure furnished as Exhibit W-1 does not identify the key personnel of applicant and provider organizations that will be responsible for carrying out its grievance procedures and the review of its results, attach Exhibit W-3 giving the name and title of each such person and identifying their responsibility for carrying out the procedure.

X. Public Policy Participation.

1. If applicant is in compliance with the requirements of the Federal Health Maintenance Organization Act of 1973 and intends to rely on such compliance to satisfy the provisions of Section 1369 of the Act, attach as Exhibit X-1 documentation necessary to validate compliance with the Health Maintenance Organization Act.

2. Unless applicant has satisfied the provisions of Section 1369 of the Act in the manner indicated in Subsection X-1, above, attach as Exhibit X-2 a description of applicant's procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan, including at least the following:

a. the composition of applicant's governing board,

b. the composition of the standing committee established which shall participate in establishing the public policy of the plan as defined in Section 1369 of the Act, the frequency of said committee's meetings, the frequency of receipt by applicant's governing body of said committee's reports and recommendations, and the procedures established by the governing body for dealing with such reports and recommendations;

c. the means by which subscribers and enrollees participating in established public policy will be given access to information and information regarding

the specific nature and volume of complaints received by applicant and their disposition;

d. specific identification by name and section or paragraph number of pertinent provisions of applicant's bylaws and/or other governing documents (as submitted in response to Item F) which set forth the procedures for public policy participation for subscribers and enrollees; and

e. the manner and frequency with which applicant will furnish to its subscribers and enrollees a description of its system for their participation in establishing public policy and communicate material changes affecting public policy to subscribers and enrollees.

MARKETING OF PLAN CONTRACTS

Y. Marketing of Group Contracts.

Attach as Exhibit Y a statement describing the methods by which applicant proposes to market group contracts, including the use of employee or contracting solicitors or solicitor firms, their method or form of compensation and the methods by which applicant will obtain compliance with Rules 1300.59, 1300.61, 1300.76.2, and 1300.85.1.

Z. Marketing of Individual Contracts.

Attach as Exhibit Z a statement describing the methods by which applicant proposes to market individual plan contracts, including the use of employee or contracting solicitors or solicitor firms, their method or form of compensation and the methods by which applicant will obtain compliance with Rules 1300.59, 1300.61, 1300.76.2, and 1300.85.1.

AA. Supervision of Marketing.

Attach as Exhibit AA a statement setting forth applicant's internal arrangements to supervise the marketing of its plan contracts, including the name and title of each person who has primary management responsibility for the employment and qualification of solicitors, advertising, contracts with solicitors and solicitor firms and for monitoring and supervising compliance with contractual and regulatory provisions.

BB. Solicitation Contracts.

1. Attach as Exhibit BB-1 a list of all persons (other than any employee of the plan whose only compensation is by salary) soliciting or agreeing to solicit the sale of plan contracts on behalf of the applicant. For each such person, identify by exhibit number that person's contract furnished pursuant to Item BB-2 and, if such contract does not show the rate of compensation to be paid, specify the person's rate of compensation.

2. Attach as Exhibit BB-2, a copy of each contract or proposed contract between applicant and the persons named in Exhibit BB-1 for soliciting the sale of or selling plan contracts on behalf of applicant. If a standard form contract is used, furnish a specimen of the form, identify the provision and terms of the form which may be varied and include a copy of each variation.

3. If the rate of compensation for any solicitor or for any plan contract exceeds 5 percent of the prepaid or periodic charge for the contract(s) on an annual basis, attach as Exhibit BB-3 a statement explaining and justifying the rate of compensation in each such case.

CC. Group Contract Enrollment Projections.

NOTE: All projections required by Items CC, DD, EE and HH are to cover the period commencing from its commencement of operations as a licensed health care service plan until the applicant's financial statement projections under Item HH demonstrate that it has reached the break-even point (or for one year, whichever is longer) and for an additional period of one year thereafter. For the initial period, all projections are to be on a monthly basis. For the additional year, all projections are to be on a quarterly basis.

1. Projections. Attach as Exhibit CC-1 projections of applicant's enrollments under group contracts for the periods specified in the above note. (Medi-Cal, Medicare, and Medicare supplemental programs are to be treated as individual contracts under Item DD below.) Exhibit CC-1 is to contain the following information with respect to each anticipated group contract:

a. The name of the group.

b. The number of potential subscribers in the group.

c. The locations within and around applicant's service area in which the potential subscribers and enrollees live and work.

d. The estimated date (or period after licensing) for entry into the group contract.

e. Identification of the plan contract anticipated with the group, by reference to Exhibit P-1. If more than one type of group contract is expected with a group, each contract must be covered separately.

f. The projected number of (1) subscribers and (2) enrollees (including subscribers), on a monthly basis for the initial period specified in the above note and quarterly for the following year.

g. State whether the contract will be "community rated" or "experience rated."

h. Evaluation of the competition for each group.

2. Substantiation of Projections. Attach as Exhibit CC-2 for each group contract specified in Exhibit CC-1 a description of the facts and assumptions used in connection with the information specified in that exhibit and include documentation of the source and validity of such facts and assumptions.

3. Letters of Interest. Attach as Exhibit CC-3 letters of interest or intent from each group listed in Exhibit CC-1, on the letterhead of the group and signed by its representative.

DD. Individual Contract Enrollment Projections.

1. Projections. Attach as Exhibit DD-1 a projection of applicant's sales of individual contracts for the periods specified in the note in Item CC above. Programs involving Medi-Cal, Medicare and Medicare supplemental coverages are to be treated as individual contracts. The exhibit is to contain the following information as to each type of individual contract:

a. A description (e.g., ethnic, demographic, economic, etc.) of each target population.

b. The estimated number of persons in each target population.

c. The distribution of the target population within and around applicant's service area.

d. The projected number of (1) subscribers and (2) enrollees (including subscribers) expected to be obtained from each target population, on a monthly basis for the initial period and quarterly for the following year.

e. State whether the contract will be "community rated" or "experience rated."

f. Evaluation of the competition within the target area.

2. Substantiation of Projections. Attach as Exhibit DD-2 a statement of the facts and assumptions employed with respect to the information furnished for each contract and target population listed in Exhibit DD-1 and furnish documentation, including reliable market surveys, validating the facts and assumptions.

EE. Summary Enrollment Projections.

Attach as Exhibit EE summary enrollment projections on a monthly basis for the initial period specified in the note to Item CC and on a quarterly basis for the following year. Such enrollment projections should reflect the breakdown of enrollment by groups, individuals, Medi-Cal, Medicare, and others.

FF. Prepaid and Periodic Charges.

1. Determination of Prepaid Charges. Attach as Exhibit FF-1, a description of the method used by applicant to determine the prepaid or periodic charges fixed for individual and group contracts, including the method by which administrative and other indirect costs are allocated. Describe the facts and assumptions upon which such charges are based (e.g., contract mix, family size) and furnish supporting documentation to substantiate the validity of the facts and assumptions used.

2. Schedule of Prepaid Charges. Attach as Exhibit FF-2-a complete schedule of the prepaid or periodic charges assessed subscribers under each group contract identified in response to Item P and attach as Exhibit FF-2-b a schedule of the prepaid or periodic charges assessed subscribers under each individual contract identified in response to Item Q.

3. Collection of Prepaid Charges. Attach as Exhibit FF-3 a description of the manner in which applicant will collect prepaid and periodic charges and copayments from subscribers and enrollees under its group and individual contracts. If prepaid or periodic charges will be paid by subscribers to an entity other than the plan, identify the entity and specify the measures used by the plan to safeguard and account for such funds (see Rules 1300.76.2, 1300.85 and 1300.85.1).

FINANCIAL VIABILITY

GG. Current Financial Viability, Including Tangible Net Equity.

1. Financial Statements.

a. Attach as Exhibit GG-1-a the most recent audited financial statements of applicant, accompanied by a report, certificate, or opinion of an independent certified public accountant or independent public accountant, together with all footnotes to said financial statements.

b. If the financial statements attached as Exhibit GG-1-a are for a period ended more than 60 days before the date of filing of this application, also attach as Exhibit GG-1-b financial statements prepared as of date no later than 60 days prior to the filing of this application consisting of at least a balance sheet, a statement of income and expenses, and any accompanying footnotes; these more recent financial statements need not be audited, so long as they are prepared in accordance with generally accepted accounting principles.

2. Tangible Net Equity. Attach as Exhibit GG-2 a calculation of applicant's tangible net equity in accordance with Rule 1300.76, based on the most recent balance sheet submitted as Exhibit GG-1-a or b above.

HH. Projected Financial Viability

1. Attach as Exhibit HH-1, the following projected financial statements of the applicant reflecting actual and projected changes which have, or which are expected to occur between the date of its most recent financial statements furnished pursuant to Item GG and the date specified for the commencement of its operations as a plan in Item E above. The projected financial statements must be prepared in accordance with generally accepted accounting principles and on a basis consistent with the financial statements supplied in Item GG.

a. Applicant's projected balance sheet as of the start up date of the plan. (See Item E)

b. Applicant's projected statement of income and expenses covering the period between the date of the most recent financial statements furnished in Item GG and the date specified in Item E.

c. A calculation of applicant's projected tangible net equity in accordance with Rule 1300.76 as of the date specified in Item E and in accordance with its projected balance sheet.

2. Attach as Exhibit HH-2, projected financial statements as of the close of each month during applicant's initial period of operations, as defined in the note to Item CC, and as of the close of each quarter for the following year, prepared on a consistent basis with the financial statements furnished for Item HH-1, including the following:

a. Applicant's projected balance sheet as of the close of such month or quarter.

b. Applicant's projected statement of income and expense for such month or quarter.

c. Applicant's projected cash-flow statement for such month or quarter.

d. A calculation of applicant's tangible net equity pursuant to Rule 1300.76 as of such month or quarter.

e. A calculation of applicant's administrative costs pursuant to Rule 1300.78 for such month or quarter.

3. Furnish the following information to substantiate the assumptions and conclusions upon which the projections required by Items HH-1 and HH-2 are based:

a. Attach as Exhibit HH-3-a the complete results of feasibility studies obtained by applicant as normally required by conventional lending institutions, including at least the following: legal, marketing/enrollment, providers and financial.

b. Attach as Exhibit HH-3-b an actuarial report which includes at least the following information for all enrollees reflected in Exhibit EE as covered by contracts which are community rated:

(i) Utilization rates for each medical expense item reflected in applicant's income statements furnished pursuant to Item HH-2, expressed in terms of utilization units per member per month, including the methodology and source of data used to determine such rates.

(ii) The cost per utilization unit for each medical expense item reflected in the income statement, including the methodology and source of data used to determine such costs.

(iii) The per member per month cost for each medical expense item.

(iv) The methodology and source of data used to estimate copayments, coordination of benefits, and reinsurance recoveries, including the expression of such items on a per member per month basis.

(v) Inflation estimates used in the projections and the source utilized to determine such estimates.

c. For each contract which is designated as experience rated (as summarized in Exhibit EE) attach as Exhibit HH-3-c an actuarial report for the contract which conforms to the requirements stated in Item HH-3-b.

d. Attach as Exhibit HH-3-d a summary schedule which reflects the breakdown of the total revenue and expense included in the projected income statements in Exhibit HH-2-b by community rated contacts and experience rated contracts.

e. As Exhibit HH-3-e the assumptions made by the applicant to determine the time lag between the delivery by covered health care services and applicant's payment for those services. Also indicate all other assumptions made in preparing the projected cash flow statements in Item HH-2-c.

f. Attach as Exhibit HH-3-f-i a detailed description of any measures taken or proposed to be taken by applicant to maintain compliance with the tangible net equity requirement under Rule 1300.76 and the financial viability requirement under Rule 1300.76.1 in view of losses and expenditures prior to reaching a break-even point in its operations. This information should include a schedule setting forth the amounts of any additional needed funding and the dates when such amounts will be infused into applicant. If such arrangements involve

arrangements for additional capital, to subordinate or postpone the payment of accounts, notes or other obligations of the plan or other agreements, cite the exhibit numbers of such agreements and identify their applicable provisions, if supplied elsewhere in the application, or if not otherwise furnished, attach copies of such agreements or proposed agreements, identifying the parties thereto and their relationship to the plan and its affiliates.

If any funding is to be obtained from an entity other than a national bank or a bank incorporated under the laws of this state, attach as Exhibit HH-3-f-ii a copy of such entity's most recent annual audited and quarterly unaudited financial statements.

4. Reimbursements. Attach as Exhibit HH-4 the following information regarding applicant's projected reimbursements:

a. Monthly and quarterly projections as specified in the note to Item CC for each of the following (see instruction in Item 4-b):

(i) Payments to reimburse noncontracting providers for covered health care services furnished to enrollees (see Section 1377(a)).

(ii) Payments to reimburse enrollees for covered health care services furnished by noncontracting providers (see Section 1377(a)).

(iii) Total reimbursements for services by noncontracting providers (1) plus (2) (see Section 1377(a)).

(iv) Fee-for-service payments to reimburse contracting providers for covered health care services.

(v) Total reimbursements (3) plus (4).

(vi) Total expenditures by applicant for covered health care services.

(vii) The ratio of total reimbursements to total health care expenditures (5) divided by (6).

(viii) The ratio of reimbursements for services by noncontracting providers to total expenditures (3) divided by (6).

b. Describe and substantiate the facts and assumptions upon which the projections are based, including those for fee-for-service payments to contracting providers and document the source and validity of such assumptions. (Actuarial studies or comparable information should be furnished in response to these items.)

c. If the ratio of total reimbursements to total expenditures in Item 4-a (viii) exceeds 10%, specify the measures by which applicant will comply with Section 1377(a) of the Act and Rules 1300.77 and 1300.77.3. If applicant will maintain reserves as specified in Section 1377(a)(1) of the Act, specify the size of the reserve and the fiscal impact upon applicant arising from its maintenance.

d. If the ratio of total reimbursements to total expenditures in Item 4-a(vii) exceeds 10%, specify the measures by which applicant will comply with Section 1377(b) of the Act and Rules 1300.77.1, 1300.77.2 and 1300.77.3.

5. Administrative Costs. If applicant's administrative costs (as defined in Rule 1300.78) as projected for its initial period of operation (as specified in the Note to Item CC and calculated pursuant to Item HH-2-e) exceed 25% of the prepaid or periodic charges paid by or on behalf of subscribers, and if such administrative costs exceed 20% of such charges for the following year, attach as Exhibit HH-5 a calculation of the percentage of administrative costs to such charges for both such periods and furnish information which explains the necessity for the level of administrative costs projected and the manner in which applicant will reduce such costs to not more than 15% of such charges within five years after licensure.

6. Provision for Extraordinary Losses. The following requirements require an initial applicant to submit legible copies of the actual policies of insurance (including any riders or endorsements) or specimen copies of the policies of

insurance which show all of the terms and conditions of coverage, or with respect to those items expressly allowing for self-insurance, allow applicant to provide evidence of self-insurance at least as adequate as insurance coverage.

a. Attach as Exhibit HH-6-a evidence of adequate insurance coverage or self-insurance to respond to claims for damages arising out of furnishing health care services (malpractice insurance).

b. Attach as Exhibit HH-6-b evidence of adequate insurance coverage or self-insurance to respond to claims for tort claims, other than with respect to claims for damages arising out of furnishing health care services.

c. Attach as Exhibit HH-6-c evidence of adequate insurance coverage or self-insurance to protect applicant against losses of facilities upon which it has the risk of loss due to fire or other causes. Identify facilities covered by individual policies and indicate the basis upon which applicant believes that the insurance thereon is adequate.

d. Attach as Exhibit HH-6-d, evidence of fidelity bond coverage for at least the amounts specified in Rule 1300.76.3, in the form of a primary commercial blanket bond or a blanket position bond written by an insurer licensed by the California Insurance Commissioner, providing 30 days' notice to the Director of the Department of Managed Health Care prior to cancellation, and covering each officer, director, trustee, partner and employee of the plan, whether or not compensated.

e. Attach as Exhibit HH-6-e evidence of adequate workmen's compensation insurance coverage against claims which may arise against applicant.

II. Fiscal Arrangements.

1. Maintenance of Financial Viability. Attach as Exhibit II-1 a statement describing applicant's arrangements to comply with Section 1375.1(b) of the Act and Rule 1300.75.1(a)(2). If applicant will maintain insurance under these provisions, furnish a specimen of the policy, the name of the insurer and the premium cost to the policy.

2. Capitation Payments to Providers. If applicant intends to pay some or all providers on a capitation basis, attach as Exhibit II-2 a statement indicating the percentage of contracting providers who will be compensated on that basis, a description of the method used to determine and adjust the capitation rates, and substantiate by means of calculations or other information that such capitation rates are adequate to reasonably assure the continuance of the applicant/provider relationship.

3. Risk of Insolvency. Attach as Exhibit II-3 a description of the manner in which applicant will provide for each of the following in the event of applicant's insolvency:

a. The continuance of benefits to enrollees for the duration of the contract period for which payment has been made.

b. The continuance of benefits to enrollees until their discharge, for those enrollees confined in an in-patient health care facility on the date of insolvency.

c. Payments to noncontracting providers for services rendered.

4. Provider Claims. Attach as Exhibit II-4 a statement describing applicant's system for processing claims from contracting providers and noncontracting providers for payment, and from subscribers and enrollees for reimbursement, including, the rules defining applicant's obligation to reimburse, the standards and procedures for applicant's claims processing system (including receipt, identification, handling, screening, and payment of claims), the timetable for processing claims, procedures for monitoring the claims processing system, and procedures for reviewing the claims processing system in view of complaint from contracting or noncontracting providers or grievances from subscribers

or enrollees. The records maintained regarding fee-for-service reimbursements must be in accordance with the provisions of Rule 1300.77.4.

5. Other Business. If the applicant is or will engage in any business other than as a health care service plan, attach as Exhibit II-5 a statement describing such other business, its relationship to applicant's business as a plan, and the anticipated financial risks and liabilities of such other business. If the financial statements and projections in Exhibits GG-1-a, GG-1-bb, HH-1 and HH-2 do not include such other business, explain.

(e) Information Forms Required by Item F-1 of Subsection (d):

(1) Corporation Information Form.

STATE OF CALIFORNIADEPARTMENT OF
MANAGED HEALTH CARE
CORPORATION INFORMATION FORM
EXHIBIT F-1-a-iii

To be used in response to Item F-1-a of Form HP 1300.51.

1. Name of Applicant (as in Item 1-a):

_____

Full Name — First Middle and Last Names

2. State of Incorporation:

_____

3. Date of Incorporation:

_____

Full Date — Month, Day, Year

4. Is applicant a nonprofit corporation?

[ ] Yes [ ] No

5. Is applicant exempted from taxation as a nonprofit corporation?

[ ] Yes [ ] No

6. Names of principal officers, directors and shareholders: List (a) each person who is a director or principal officer or who performs similar functions or duties and (b) each person who holds of record or beneficially over 5% of the voting securities of applicant or over 5% of applicant's equity securities. If this is an amended exhibit, place an asterisk (*) before the names for whom a change in title, status or stock ownership is being reported and a double asterisk (**) before the names of persons which are added to those furnished in the most recent previous filing.

_____

Full Name — First Middle and Last Names

Title or
Status: _____

Relationship Beginning
Date: _____ _____

Date — Month Day, Year Percentage

Class of Equity or Security: _____

_____

Full Name — First Middle and Last Names

Title or
Status: _____

Relationship Beginning
Date: _____ _____

Date — Month Day, Year Percentage

Class of Equity or Security: _____

_____
Full Name — First Middle and Last Names
Title or
Status: _____
Relationship Beginning
Date: _____ _____
Date — Month Day, Year Percentage
Class of Equity or Security: _____

7. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

(2) Partnership Information Form.

STATE OF CALIFORNIADEPARTMENT OF
MANAGED HEALTH CARE
PARTNERSHIP INFORMATION FORM
EXHIBIT F-1-ii

To be used in response to Item F-1-b of Form HP 1300.51.

1. Name of Applicant (as in Item 1-a):

_____
Full Name — First Middle and Last Names

2. State of organization:

_____

3. Date of organization:

_____
Full Date — Month, Day, Year

4. Names of Partners and Principal Management: List all general, limited and special partners and all persons who perform principal management functions. If this is an amended exhibit, place an asterisk (*) before the names of persons for whom a change in title, status or partnership interest is being reported and place a double asterisk (**) before the names of persons which are added to those furnished in the most recent previous filing.

_____
Full Name — First Middle and Last Names
Title or
Duties: _____
Relationship Beginning
Date: _____ _____
Date — Month Day, Year Capital Contribution Percentage
Type of Partner_____

_____
Full Name — First Middle and Last Names
Title or
Duties: _____
Relationship Beginning
Date: _____ _____
Date — Month Day, Year Capital Contribution Percentage
Type of Partner_____

_____
Full Name — First Middle and Last Names
Title or
Duties: _____
Relationship Beginning
Date: _____ _____
Date — Month Day, Year Capital Contribution Percentage
Type of Partner_____

5. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

(3) Sole Proprietor Information Form.

CALIFORNIADEPARTMENT OF
MANAGED HEALTH CARE
SOLE PROPRIETORSHIP INFORMATION FORM
EXHIBIT F-1-c

To be used in response to Item F-1-c of Form HP 1300.51.

1. Name of Applicant (as in Item 1-a):

_____
Full Name — First Middle and Last Names

2. Residence Address:

_____
Street Address or P O Box Number

_____
City, State ZIP Code

3. Names of persons performing principal management functions:

List each person who occupies a principal management position or who performs principal management functions for the applicant. If this is an amended exhibit, place an asterisk (*) before the names of persons for whom a change in title or duties is being reported and place a double asterisk (**) before the names of persons which are being added to those furnished in the most recent previous filing of this exhibit.

_____
Full Name — First Middle and Last Names
Title or
Duties: _____
Relationship Beginning
Date: _____
Date — Month Day, Year

_____
Full Name — First Middle and Last Names
Title or
Duties: _____
Relationship Beginning
Date: _____
Date — Month Day, Year

_____
Full Name — First Middle and Last Names

Title or
Duties: _____
Relationship Beginning
Date: _____
Date — Month Day, Year

4. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

(4) Information Form for Miscellaneous Types of Entities.

CALIFORNIADEPARTMENT OF
MANAGED HEALTH CARE
INFORMATION FORM FOR MISCELLANEOUS TYPES OF ENTITIES
EXHIBIT F-1-d

To be used in response to Item F-1-d of Form HP 1300.51.

1. Name of Applicant (as in Item 1-a):

_____
Full Name — First Middle and Last Names

2. State of organization:

_____

3. Date of organization:

_____
Full Date — Month Day, Year

4. Form of Organization (describe briefly):

_____
_____
_____
_____
_____
_____
_____

5. Names of Principal Officers and Beneficial Owners: List below the names of (a) each person who is a principal officer or trustee of the applicant or who performs principal management functions, and (b) each person who owns of record or beneficially over 5% of any class of equity security of the applicant. If this is an amended exhibit, place an asterisk (*) before the name of each person for whom a change in title, status or interest is reported, and a double asterisk (**) before the name of persons which are added to those reported in the most recent previous filing.

_____
Full Name — First Middle and Last Names
Title or
Duties: _____
Relationship Beginning
Date: _____
Date — Month Day, Year
Class Percentage
Class of Equity or Security: _____

_____
Full Name — First Middle and Last Names
Title or
Duties: _____

Relationship Beginning
Date: _____
Date — Month Day, Year
Class Percentage
Class of Equity or Security: _____

_____
Full Name — First Middle and Last Names
Title or
Duties: _____
Relationship Beginning
Date: _____
Date — Month Day, Year
Class Percentage
Class of Equity or Security: _____

6. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

_____
_____
_____

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1351, 1351.1, 1352, 1359, 1363, 1367, 1367.2, 1367.3, 1367.4, 1367.5, 1367.6, 1367.7, 1367.8, 1367.9, 1367.15, 1368, 1369, 1370, 1370.1, 1373, 1373.1, 1373.2, 1373.4, 1373.5, 1373.6, 1373.7, 1373.8, 1374, 1374.7, 1374.10, 1374.11, 1374.12, 1375.1, 1376, 1378, 1386, 1399.62 and 1399.63, Health and Safety Code.

History:
1. Amendment of Item 23-C filed 12-20-77 as an emergency; effective upon filing (Register 77, No. 52).
2. Amendment filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
3. Amendment of Item 23 filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
4. Amendment of Item 22-G filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).
5. Amendment filed 12-17-85; effective thirtieth day thereafter (Register 85, No. 51).
6. Change without regulatory effect amending subsection (c) filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
7. Change without regulatory effect amending subsections (c), (d)F.5., (d)HH.6.d., (e)(1), (e)(2), (e)(3) and (e)(4) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
8. Change without regulatory effect amending subsection (d)HH.6.d., (e)(1)-(4)(forms), filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).
9. Amendment of subsection (c) filed 10-26-2004; operative 11-25-2004 (Register 2004, No. 44).

§ 1300.51.1. Individual Information Sheet.

An individual information sheet required pursuant to these rules shall be in the following form:

CONFIDENTIAL
See Note to Item 5
DEPARTMENT OF MANAGED HEALTH CARE
State of California
INDIVIDUAL INFORMATION SHEET
under the
Knox-Keene Health Care Service Plan Act of 1975
(California Health & Safety Code Sec. 1340 et. seq.)
1. Name of Applicant:_____ File No. _____
2. Exact full name of person completing this statement:_____
First Middle Last

3. Physical Description:
Sex _____ Hair _____ Eyes _____ Height _____
Weight _____
4. Birthdate: _____ Birthplace: _____
5. Social Security No. or Taxpayer Ident. No: _____

NOTE: The inclusion of your social security number is not required but is voluntary. It is solicited pursuant to Sections 1344 and 1351 of the Health and Safety Code. It may be used to conduct a background investigation by the Department, the California Department of Justice Information Branch, or by other federal, state or local law enforcement agencies. This form, including the social security number, will be held confidential, but is a public record and available to the public pursuant to the Public Records Act (Gov. Code Section 6250), at the discretion of the Director.

6. Residence Telephone: _____
7. Business Telephone: _____
8. Current Residence Address: _____
Number and Street City State Zip

9. Employment for the last 5 years (list most recent first and include any employment with a plan or any person or entity which is or was affiliated with a plan (Section 1300.45(c)):

From to Present	Employer Name and Address	Occupation and Duties

NOTE: Attach separate schedule if space is not adequate.

10. Business contacts, dealings and affiliations (see section 1300.45(c)(2)) with health care service plans during the last 5 years (but including, for example, such roles as director, stockholder, consultant, manager, provider and supplier, and such dealings as sales, leasing, and any contractual relationships) (list most recent business contacts and dealings first):

From to Present	Plan Name and Address	Relationship and Duties

NOTE: Attach separate schedule if space is not adequate.

11. Have you ever had a certificate, license, permit registration or exemption issued pursuant to the Business and Professions Code or Health and Safety Code denied, revoked or suspended or been otherwise subject to disciplinary action, while you were in the employ of the applicant, or while you had a contract with the applicant as a provider or otherwise? [ ] Yes [ ] No

If "yes" state the date of the action and the administrative body taking such action.

_____
_____

_____
_____
_____
_____

12. Have you ever been convicted or pled *nolo contendere* to a misdemeanor involving moral turpitude or any felony, other than traffic violations?
[ ] Yes [ ] No
If the answer is "yes" give details:

_____
_____
_____
_____
_____
_____

13. Have you ever changed your name or ever been known by any name other than that herein listed? (Including a married person's prior surname, if any.)
[ ] Yes [ ] No
If so, explain. Change in name through marriage or court order should also be listed.
EXACT DATE OF EACH NAME CHANGE MUST BE LISTED.

_____

14. Have you ever engaged in business under a fictitious firm name either as an individual or in the partnership or corporate form? [ ]
Yes [ ] No
If the answer is "yes" set forth particulars:

_____

VERIFICATION

I, the undersigned, state that I am the person named in the foregoing Individual Information Sheet, that I have read and signed said Individual Information Sheet and know the contents thereof, including all exhibits attached thereto; and that the statements made therein, including any exhibits attached thereto, are true.

I certify/declare under penalty of perjury that the foregoing is true and correct.

Executed at _____
City County State
this _____ day of _____

_____
(Signature of Declarant)

NOTE: If this form is signed outside California complete the verification before a notary public in the space provided below.

State of _____ County of _____ Dated _____ at _____

_____
(Signature of Affiant)

Subscribed and sworn to before me, _____
Notary Public in and for said County and State

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference:

Section 1351, Health and Safety Code.

History:
1. Amendment filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).
2. Amendment filed 12-17-85; effective thirtieth day thereafter (Register 85, No. 51).
3. Change without regulatory effect amending section filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
4. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
5. Change without regulatory effect amending section filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.51.2. Consent to Service of Process.

The consent to service of process required pursuant to these rules shall be in the following form:

TO THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE OF THE STATE OF CALIFORNIA

CONSENT TO SERVICE OF PROCESS KNOW ALL MEN BY THESE PRESENTS:

That the undersigned, _____(a corporation organized under the laws of the State of ___) (a partnership) (an individual) (other _____) hereby irrevocably appoints the Director of the Department of Managed Health Care of the State of California, or his successor in office, to be his (its) attorney to receive service of any lawful process in any noncriminal suit, action or proceeding against him (it), or his (its) successor, executor, or administrator which arises under the Knox-Keene Health Care Service Plan Act of 1975 or any rule or order thereunder after this consent has been filed, with the same force and validity as if served personally on the undersigned.

For the purpose of compliance with the Corporations Code of the State of California, notice of the service and a copy of the process should be sent by registered or certified mail to the undersigned at the following address:

_____
Name
_____
Street Address
_____
City State Zip Code
Dated: _____
_____By _____Title _____
State of California)
County of _____)

On _____ before me, (here insert name and title of the officer, personally appeared _____ personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature _____(Seal)

Any certificate of acknowledgement taken in another state shall be sufficient in the State of California if it is taken in accordance with the laws of the place where the acknowledgement is made.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1351, Health and Safety Code and Section 1189, Civil Code.

History:
1. Amendment filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
3. Change without regulatory effect amending section and Note filed 12-7-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 49).
4. Change without regulatory effect amending section filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
5. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
6. Change without regulatory effect amending section filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.51.3. Preparation and Amendment of Application for License As a Health Care Service Plan Under Section 1300.51.

(a) General Instructions.

(1) Type the information requested in the English language using black ribbon.

(2) Complete each item on the application, and type "N/A" in the right hand margin for those items which are not applicable.

(3) Number each exhibit as specified in the item to which the exhibit responds. If several exhibits are required under the same letter/number designation, add a sequential letter or roman numeral as indicated in the following example. Example: If Item Q-1 calls for copies of the specified documents, an applicant employing three different documents would label them as follows: Exhibit Q-1-a; Exhibit Q-1-b; Exhibit Q-1-c.

(4) Arrange all exhibits in sequential order. Attach a "tab" to the right margin of the first page of each major exhibit or series of exhibits to facilitate ready reference.

(5) Submit originals only when requested. Otherwise, submit clearly legible mechanical reproductions.

(6) Submit requested information as an exhibit if the space provided in the application form itself is insufficient. Use the procedure detailed in Item (3), above, to indicate the exhibit number.

(7) Submit three complete copies of the original license application and each amendment submitted prior to licensure to the Department's Sacramento Office to the attention of the Health Plan Division Filing Clerk.

(b) Amendment of an Application.

(1) An amendment to application either before or after issuance of a license must comply with Rule 1300.52. However, Rules 1300.52.1 and 1300.52.2 apply only after an applicant has been licensed.

(c) Updating Application Prior to Licensure. In addition to complying with Rule 1300.52, an amendment to a pending application shall comply with the following:

(1) Material changes (see Rule 1300.45(1)) to information previously submitted in connection with an application (as amended to date) shall be submitted as an amendment to the license application immediately, except as provided in subsection (f) of Rule 1300.52.

(2) Nonmaterial changes to the information previously submitted in connection with an application (as amended to date) may be accumulated and shall be submitted as an amendment to the license application monthly or within 30 days (or other period requested by the Director) of each such change.

(3) Financial statements and calculations of tangible net equity previously submitted in connection with an application (as amended to date) shall be updated to an amendment to the license application which shall consist of quarterly financial statements (see Rule 1300.84.2a(1), (2), and (3)) and a calculation of applicant's tangible net equity as of the closing date of such

quarter, and shall be filed within 30 days after the close of each quarter of applicant's fiscal year.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1351 and 1352, Health and Safety Code.

History:

1. New section filed 12-17-85; effective thirtieth day thereafter (Register 85, No. 51).
2. Change without regulatory effect amending subsection (a)(7) filed 8-24-92; operative 9-23-92 (Register 92, No. 35).
3. Change without regulatory effect amending subsection (a)(7) filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
4. Change without regulatory effect amending subsection (c)(2) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.52. Amendments to Plan Application.

An amendment to a plan application pursuant to subdivision (a) of Section 1352 of the Act shall be filed in the Department's Sacramento Office to the attention of the Health Plan Division Filing Clerk, upon the form contained in Section 1300.51 and shall include an original and two complete copies and comply with the following:

(a) The following portions of the application specified in Rule 1300.51 need not be amended after the issuance of a license:

Item E Summary of Information in Application
Item H-2 Map of Service Area.
Item H-3 Index to Map.
Item V Advertising.
Item CC Group Contract Enrollment Projections.
Item DD Individual Contract Enrollment Projections.
Item EE Summary of Enrollment Projections.
Item GG Current Financial Visibility Including Tangible Net Equity.
Item HH Projected Financial Viability.

(b) The amendment must be accompanied by a copy of the Execution Page of the application, and all portions of those pages must be completed.

(c) Attach to the Execution Page only those pages of the application and/or those exhibits which are changed by the amendment.

(d) If a page of the application is amended, complete all items on that page and "redline" or otherwise clearly designate the changed item.

(e) If an exhibit, other than a list required by Item 13A, 13C or 24D of the old application form or Item I-1, I-2 or I-3 of the new application is being amended.

(1) Furnish the complete exhibit as amended, bearing the same number as the original exhibit, with the changed portions of the exhibit "redlined" or otherwise clearly designated, or

(2) Furnish the pages of the exhibit which are amended, each page to be marked with the exhibit number and the page number of the exhibit, and with the changed portions "redlined" or otherwise clearly designated. If this method of amendment is employed, the applicant shall refile the entire exhibit as amended whenever more than 10% of its pages have been amended or promptly upon the request of the Director.

(f) A list furnished pursuant to Items 13A, 13C or 24D of the old application or Item I-1, I-2 or I-3 of the new application need be amended only when 10 percent or more of the names contained in the list for a service area have been changed. When amended, the complete list (or the list for the service area) shall be furnished following the instructions for the particular item, with each added item "redlined" and the names of persons deleted from the list shown at the end under the heading "deletions."

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1351, 1351.1, 1352, 1359, 1363, 1367, 1367.2, 1367.3, 1367.5, 1367.6, 1367.7, 1367.8, 1367.9, 1367.15, 1368, 1369, 1370, 1370.1, 1373, 1373.1, 1373.2, 1373.4, 1373.5, 1373.6, 1373.7, 1373.8, 1374, 1374.7, 1374.10, 1374.11, 1374.12, 1375.1, 1376, 1377, 1378, 1386, 1399.52 and 1399.63, Health and Safety Code.

History:

1. Amendment filed 12-17-85; effective thirtieth day thereafter (Register 85, No. 51).
2. Change without regulatory effect amending first paragraph filed 8-24-92; operative 9-23-92 (Register 92, No. 35).
3. Change without regulatory effect amending first paragraph filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
4. Change without regulatory effect amending subsection (e)(2) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.52.1. Notice of Material Modification.

A notice of material modification of its operations or of any plan contract pursuant to subdivision (b) of Section 1352 of the Act shall be filed as an amendment to the application as provided in Section 1300.52, and there shall be attached to such amendment, preceding the Execution Page, the following form:

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA
NOTICE OF MATERIAL MODIFICATION

Pursuant to Health and Safety Code Sec. 1352(b)

1. Name of applicant: _____

2. Department of Managed Health Care File Number: _____

3. The fee for filing this application will be forwarded upon receipt of the billing therefore from the Director of the Department of Managed Health Care, pursuant to Health and Safety Code Section 1352(d) or pursuant to Section 1399.73 if this application involves a conversion or restructuring.

4. Pursuant to Subdivision (b) of Section 1352 of the Health and Safety Code, applicant requests approval of the material modification of its plan and/or operations, within the time specified below:

(Check appropriate box)

( ) Within the 20 business-day period provided in Section 1352(b).

( ) Applicant extends the time for action upon this notice by the Director until _____

( ) Applicant requests accelerated approval by the Director for the following reasons:

_____
_____
_____
_____
_____
_____

5. Conversion or Restructuring. If this application involves a conversion or restructuring, the applicant shall fully disclose information which describes the proposed transaction and demonstrates how the charitable trust requirements of Section 1399.72(c) of the Act will be satisfied. In addition, the applicant shall submit a copy of all of its original and amended articles of incorporation and bylaws, and a report as described in Section 1399.70(a) of the Act. If this application involves a restructuring, the applicant shall also submit a public benefit program as described in Section 1399.71(b) of the Act.

6. Exempt Restructuring Transaction. If this application involves a transaction or transactions described in Section 1399.71(e) of the Act, the applicant shall fully disclose information which describes the transaction or

transactions and demonstrates how the applicable conditions of exemption of Section 1399.71(e) of the Act will be satisfied.

7. Nonprofit Mutual Benefit Health Care Service Plans.

a. Assets subject to a charitable trust obligation. If this application involves a conversion or restructuring of a nonprofit mutual benefit health care service plan with any or all of its assets subject to a charitable trust obligation, the applicant shall submit information pursuant to Item 5 or Item 6 above and, if applicant believes that partial assets are subject to a charitable trust obligation, the applicant shall fully disclose information which: (i) describes why less than all of its assets are not subject to any charitable trust obligation, (ii) explains whether any charitable trust obligation terminated for any assets previously held subject to a charitable trust obligation, and (iii) demonstrates how every noncharitable trust obligation will be satisfied.

b. Assets not subject to a charitable trust obligation. An applicant that is a nonprofit mutual benefit health care service plan must comply with Item 7. a. above unless it has established that none of its assets are subject to a charitable trust obligation. If the applicant believes that this application involves a conversion or restructuring of a nonprofit mutual benefit health care service plan with no assets subject to any charitable trust obligation, the applicant shall submit a copy of all its original and amended articles of incorporation and bylaws and fully disclose information which: (i) describes the proposed transaction, (ii) describes why all its assets are not subject to any charitable trust obligation, (iii) explains whether any charitable trust obligation terminated for any assets previously held subject to a charitable trust obligation, and (iv) demonstrates how every noncharitable trust obligation will be satisfied.

Date: _____

_____
Signature of Authorized Officer

_____
Title

NOTE: Authority cited: Sections 1344 and 1399.74, Health and Safety Code. Reference: Sections 1352, 1399.70, 1399.71, 1399.72, 1399.73, 1399.74 and 1399.75, Health and Safety Code.

History:

1. Amendment of form paragraph 3, new form paragraphs 5 and 6 and new Note filed 6-20-96 as an emergency; operative 6-20-96 (Register 96, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-18-96 or emergency language will be repealed by operation of law on the following day.
2. Amendment of form paragraph 3, new form paragraphs 5 and 6 and new Note refiled 10-15-96 as an emergency; operative 10-18-96 (Register 96, No. 42). A Certificate of Compliance must be transmitted to OAL by 2-12-97 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 10-15-96 order, including new form paragraphs 7.-7.b., transmitted to OAL 2-3-97 and filed 2-24-97 (Register 97, No. 9).
4. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
5. Change without regulatory effect amending section filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.52.2. Change in Plan Personnel.

Pursuant to subdivision (c) of Section 1352 of the Act, a plan shall file an amendment to its applications in the form required by Section 1300.52, when there are any of the following changes in personnel of the plan, of any management company of the plan, or of any parent company of such plan or management company:

(a) There is an addition or deletion of a director, trustee, principal officer, general partner, general manager or principal management persons, or persons occupying similar positions or performing similar functions, or a substantial and material change in the duties of any such person.

(b) There is the addition or deletion of a limited partner, shareholder or owner of an equity interest in the plan, whose interest exceeds 5 percent of the total partnership interests, shares or equity interests, or there is a change in the interest of any partner, shareholder or owner of an equity interest exceeding 5 percent of the total partnership interests, shares or equity interests.

(c) There is the addition or deletion of a principal creditor, as defined in Section 1300.45, a material change in the terms of the obligation to a principal creditor, a material increase or decrease in the amount due a principal creditor other than (except in the case of a demand obligation) by the normal terms of the obligation, or a default in the obligation to a principal creditor.

§ 1300.52.3. Filings and Actions Relating to Charitable or Public Activities.

(a) Amendments to a plan application or notices of material modifications filed pursuant to Section 1352 or any other reports or filings under the Act shall not be deemed to be notices or requests for approval or ruling pursuant to Article 2, Part 11, Division 2, Title 1 of the Corporations Code or special reports pursuant to Section 1300.84.7, nor shall any such notices or requests for approval or ruling or special reports be deemed to be amendments to a plan application or notices of material modifications of a plan or its operations pursuant to Section 1352 or other reports or filings under the Act. However, this section shall not prevent a plan from filing notices or requests pursuant to Article 2 (commencing with Section 10820), Part 11, Division 2, Title 1 of the Corporations Code and/or special reports pursuant to Section 1300.84.7 concurrently with materials being filed under Section 1352 and utilizing common exhibits, subject to the provisions of Section 1300.824(c).

(b) Orders and other actions of the Director pursuant to Section 1352 or other provision of the Act, and the effects thereof, are limited to the effects contemplated under the Act and are of no effect or consequence in connection with any other law administered by the Director. Similarly, actions of the Director under any other law are of no effect or consequence in relation to Section 1352 or other provision of the Act.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1352, Health and Safety Code.

History:

1. New section filed 4-16-82; effective thirtieth day thereafter (Register 82, No. 16).
2. Change without regulatory effect amending subsection (b) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.52.4. Standards for Amendments and Notices of Material Modification.

Notwithstanding anything to the contrary in Sections 1300.52, 1300.52.1, 1300.52.2, and 1300.52.3, the following standards shall apply to amendments and notices of material modification to a plan license application once a health care service plan has been issued its license. These standards shall apply to full-service health care service plans and specialized health care service plans.

(a) General Statement of Requirements.

(i) If a plan makes a change that (A) constitutes an amendment to its plan license application and (B) is not listed in subsection (d) of this Section 1300.52.4, then the plan shall file an amendment with the Department. If the

plan makes a change that is listed in subsection (d) of this Section 1300.52.4, then the plan shall file a notice of material modification with the Department.

(ii) The plan shall include in any amendment or notice of material modification any document or other information specifically required by one of the items set forth in Section 1300.51, which is pertinent to the amendment or material modification. Other information may be required if it is determined by the Department to be necessary in order to make a finding under the Act that the amendment or material modification is in the public interest and consistent with the intent and purpose of the Act.

(b) Specific Standards for Amendments.

(i)(A) In the event of any change to one or more of the items specified in Section 1351 of the Act, the plan shall file an amendment to its plan license application within 30 days after the plan implements that change, unless the change requires the filing of an amendment pursuant to clause (ii) of this subsection (b) or a notice of material modification pursuant to subsection (d) of this Section 1300.52.4. A change that is the subject of an amendment required to be filed pursuant to this subsection shall become effective on the date implemented.

(B) Notwithstanding the immediately subsection (b)(i)(A) of Section 1300.52.4: (I) if the plan has not been continuously licensed under the Act for the preceding 18 months and has not had group contracts in effect at all times during that period, then, to the extent the amendment includes any new or modified plan contract, disclosure form, or evidence of coverage, the change shall not be effective until 30 calendar days after the date the amendment was filed with the Department; and (II) to the extent the amendment includes any new or modified plan contract, disclosure form, or evidence of coverage that relates to an individuals health care service plan contract, the change shall not be effective until 30 calendar days after the date the amendment was filed with the Department.

(ii) In the event of any change described in Section 1352(c) of the Act, the plan shall file an amendment in accordance with the requirements of Section 1300.52.2. A change that is the subject of an amendment required to be filed pursuant to this subsection (b)(ii) shall be effective on the date implemented.

(c) Limited Enforcement or Disciplinary Action in Specified Circumstances Regarding Amendments.

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

(d) Specific Standards for Notices of Material Modification.

If a plan proposes to make any of the following changes, the plan shall file a notice of material modification with the Department.

(i) An expansion, or a contraction or reduction, of the plan's approved service area.

(ii) The offering of a new health care service plan contract by the plan in any service area if the plan proposes to use a network of providers that is materially different from the network used for any other plan contract currently being offered by the plan.

(iii) A merger, consolidation, acquisition of a controlling interest, or sale of the plan or of all or substantially all of the assets of the plan, directly, or indirectly.

(iv) The plan's initial offering of a plan contract for small employers, which requires the filing of a notice of material modification pursuant to Section 1357.15 of the Act. A subsequent change with regard to the plan's small employer plan contracts shall be filed as an amendment pursuant to subsection (b) of this Section 1300.52.4, unless the change otherwise would require the filing of a notice of material modification.

(v) The plan's initial offering of a point-of-service contract, which requires the filing of a notice of material modification pursuant to Section 1374.69 of the Act. A subsequent change with regard to the plan's point-of-service plan contracts shall be filed as an amendment pursuant to subsection (b) of this Section 1300.52.4 unless the change otherwise would require the filing of a notice of material modification.

(vi) A change of plan name, which requires the filing of a notice of material modification pursuant to Section 1300.66.

(vii) A change that would have a material effect on the plan or on its health care service plan operations.

NOTE: Authority cited: Section 1351, Health and Safety Code. Reference: Sections 1352 and 1352.1, Health and Safety Code.

History:
1. New section filed 11-30-98; operative 11-30-98 pursuant to Government Code section 11343.4(d) (Register 98, No. 49).
2. Change without regulatory effect amending subsection (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

ARTICLE 4
Solicitors

Section
1300.57. Solicitor Application.
1300.57.1. Solicitor Firm Application by Person Not Licensed by Insurance Commissioner.
1300.57.2. Amendment to Solicitor Firm Application.
1300.57.3. Fees Payable by Licensed Insurance Agents and Brokers.
1300.57.4. Solicitor Financial Records Authorization.
1300.59. Plan Assurances Prior to Solicitation.
1300.59.1. Examination Fee.
1300.59.2. Waiver of Examination Requirements.

§ 1300.57. Solicitor Application.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1357 and 1358, Health and Safety Code.

History:
1. Amendment filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.57.1. Solicitor Firm Application by Person Not Licensed by Insurance Commissioner.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1357, Health and Safety Code.

History:
1. Amendment filed4-27-79; effective thirtieth day thereafter (Register 79, No. 17).
2. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.57.2. Amendment to Solicitor Firm Application.

History:
1. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.57.3. Fees Payable by Licensed Insurance Agents and Brokers.

History:
1. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.57.4. Solicitor Financial Records Authorization.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1357, Health and Safety Code.

History:
1. New section filed 11-9-77 as an emergency; effective upon filing (Register 77, No. 46).
2. Certificate of Compliance filed 2-6-78 (Register 78, No. 6).
3. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.59. Plan Assurances Prior to Solicitation.

Prior to allowing any person to engage in acts of solicitation on its behalf, each plan shall reasonably assure itself that such person has sufficient knowledge of its organization, procedures, plan contracts, and the provisions of the Act and these rules to do so lawfully.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1359, Health and Safety Code.

History:
1. Repealer and new section filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.59.1. Examination Fee.

History:
1. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.59.2. Waiver of Examination Requirements.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1359, Health and Safety Code.

History:
1. Amendment filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

ARTICLE 5
Advertising and Disclosure

Section

1300.61. Filing of Advertising and Disclosure Forms.
1300.61.1. Exempt Advertising.
1300.61.3. Deceptive Advertising.
1300.63. Disclosure Form.
1300.63.1. Evidence of Coverage.
1300.63.2. Combined Evidence of Coverage and Disclosure Form.
1300.63.3. Experimental Disclosure.
1300.63.50. Medicare Supplement Additional Disclosure. [Repealed]
1300.64.50. Medicare Supplement Application Information. [Repealed]
1300.64.51. Medicare Supplement “Buyer’s Guide.” [Repealed]
1300.64.52. Standards for Marketing Medicare Supplement Contracts. [Repealed]
1300.64.53. Reporting of Multiple Coverage. [Repealed]
1300.64.54. Replacement Contracts: Elimination of Waiting Periods. [Repealed]
1300.64.55. Permitted Compensation Arrangements for the Sale of Medicare Supplement Contracts. [Repealed]

§ 1300.61. Filing of Advertising and Disclosure Forms.

(a) Two copies of a proposed advertisement shall be filed. An advertisement is "filed" within the meaning of Section 1361 of the Act when a true copy thereof, accurately showing the final appearance of the advertisement, is received. To minimize the expense of changes in advertising copy, it may be submitted in draft form for preliminary review subject to the later filing of a proof or final copy, and the later filing of a proof or final copy may be waived when the draft copy is presented in a manner reasonably representing the final appearance of the advertisement. The text of audio or audio/visual advertising should indicate any directions for presentation, including voice qualities and the juxtaposition of the visual materials with the text.

(b) The Director will not issue letters of nondisapproval of advertising. If the person submitting the advertisement requests an order shortening the 30-day waiting period under Section 1361 of the Act, such order will be issued when an appropriate showing of the need therefor is made.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1361, Health and Safety Code.

History:

1. Change without regulatory effect amending subsection (b) and adding Note filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.61.1. Exempt Advertising.

History:

1. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.61.3. Deceptive Advertising.

Without limitation upon the meaning of subdivision (a) of Section 1352.1 and subdivisions (a) and (c) of Section 1361 of the Act, an advertisement or other consumer information is untrue, misleading or deceptive if:

(a) It represents that reimbursement is provided in full for the charge for services, unless the payment by the plan fully satisfies the liability to the provider.

(b) It represents that reimbursement is provided for the customary charges for services, unless the actual experience of the plan is that there is no balance billed for covered services.

(c) It represents that the plan, solicitor firm or solicitor or any provider or other person associated therewith is licensed or regulated by the Department of Managed Health Care or other governmental agency, unless such statement is required by law or regulation or unless such statement is accompanied by a satisfactory statement which counters any inference that such licensing or regulation is an assurance of financial soundness or the quality or extent of services. The phrase "a federally qualified health maintenance organization" and equivalent terms shall not be deemed deceptive advertising when used to refer to an organization which is so qualified under the Health Maintenance Organization Act of 1973. The display, on a plan contract which supplements Medicare with hospital or medical coverage, of the particular emblem approved by the federal Department of Health and Human Services and indicating that such contract meets the certification requirements of 42 U.S.C. 1395ss and the regulations of the Health Care Financing Administration thereunder, or, in lieu of such emblem, of such information, if any, regarding certification as may be approved in writing as to form and content by the Director, shall not be deemed deceptive when (1) the Director has found that such contract complies with the provisions of the Act and these rules and by written notification has authorized the plan to so display such emblem or, in lieu of such emblem, such expressly

approved information, if any, regarding certification and has not revoked such authorization, and (2) such contract, and any related disclosure form, evidence of coverage, printed material, and advertising, contains no untrue information regarding the emblem and does not otherwise violate this subsection.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1352.1, 1360 and 1361, Health and Safety Code.

History:

1. New subsection (c) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).
3. Change without regulatory effect amending subsection (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
4. Change without regulatory effect amending subsection (c) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.63. Disclosure Form.

(a) The disclosure form required under subdivision (a) of Section 1363 of the Act shall conform to the following requirements.

(1) The text shall be printed in at least 10-point block type. Titles and captions shall be in at least 12-point to 15-point bold face type.

(2) It shall be written in clear, concise, easily understood language.

(3) It should relate to one form of plan contract; however, disclosure forms offering alternative plans or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the contract.

(4) It shall be presented in an easily readable format.

(b) The disclosure form shall be arranged and captioned in the following manner, except as may otherwise be permitted by the Director.

(1) The name of the plan and, if necessary, a designation of the plan contract described in the form.

(2) The title of the form (e.g., "disclosure form," "summary of contract provisions").

(3) A statement in at least 10-point bold face type to the effect that the disclosure form is a summary only and that the plan contract itself should be consulted to determine the governing contractual provisions.

(4) A statement to the effect that a specimen copy of the plan contract will be furnished on request.

(5) The caption "Principal Benefits and Coverages," followed by a description of such benefits and coverages.

(6) The caption "Principal Exclusions and Limitations on Benefits," followed by a description of the principal exclusions, exceptions, reductions and limitations that apply, and arranged in a uniform manner with the preceding section of the form.

(7) The caption "Prepayments Fees" followed by a statement of the methods by which such premium may be paid; the full premium charge of the plan; and a statement of the authority to change the fees during the term of the contract.

(8) The caption "Other Charges," followed by a description of each co-payment, co-insurance, or deductible requirement that may be incurred by the member or the member's family in obtaining coverage under the plan.

(9) The caption "Choice of Physicians and Providers," followed by a description of the nature, extent and circumstances under which choice is permitted. This section shall include, if applicable, a subcaption "Liability of Subscriber or Enrollee for Payment" followed by a description of the financial liability which is, or may be, incurred by the subscriber, enrollee or a third party by reason of the exercise of such choice.

(10) If applicable, the caption "Reimbursement Provisions," followed by a description of the circumstances under which reimbursements are made under

the plan contract, the extent of reimbursement, and the method of claim for reimbursement.

(11) The caption "Facilities," followed by a statement of the principal facilities available under the plan contract, including their location and a description of the services, provided. The hours of availability of both emergency and nonemergency services should be indicated, either specifically or by general description. However, if the Director approves in advance, a plan may provide a telephone number from which information as to the identity and location of provider facilities defined in subsection (i)(2) of Section 1300.45 may be obtained, in lieu of listing such provider facilities.

(12) The caption "Renewal Provisions," followed by a statement of the terms under which the plan contract may be renewed by the group or the plan member, including any reservation by the plan of any right to change premiums or other plan contract provisions.

(13) In the case of group contracts, the caption "Individual Continuation of Benefits," followed by a statement of the terms and conditions under which subscribers and enrollees may remain in the plan, as provided pursuant to Subdivision (g) of Section 1373 of the Act.

(14) The caption "Termination of Benefits," followed by a statement of the terms and conditions for cancellation or termination of benefits, including a statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon a member who is hospitalized or undergoing treatment for an ongoing condition.

(c) In the event the receipt of benefits or reimbursements to subscribers or enrollees under the plan contract is subject to significant delays, based upon the current experience of the plan, the disclosure form may be required by the Director to disclose such facts.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1363, Health and Safety Code.

History:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Change without regulatory effect amending subsections (b), (b)(11) and (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.63.1. Evidence of Coverage.

(a) Each plan shall furnish to each individual subscriber, and make available to group contract holders for dissemination to all persons eligible under the group contract, either an evidence of coverage or a copy of the plan contract, which shall conform to the requirements of this section. The Director may permit the evidence of coverage and the disclosure form prescribed by Section 1300.63 to be presented in a single document if the purposes of each are fulfilled.

(b) Except as may be otherwise permitted by the Director, the evidence of coverage shall conform to the requirements of subsection (a) of Section 1300.63 and the following requirements:

(1) It shall be clearly entitled "Evidence of Coverage."

(2) The portions of the text specifying (1) limitations, exclusions, exceptions and reductions; (2) rights of cancellation; (3) restrictions on renewal or reinstatement; (4) rights of the health plan to change benefits; (5) subsequent providers; and (6) liability of members in the event of nonpayment by the health plan, shall be in type not less than 2 points larger than the text relating to other provisions and in no event less than 12 point type.

(3) It shall be divided into sections, each of which shall have a title identifying the nature of the information contained therein.

(4) The evidence of coverage when taken as a whole, with consideration being given to format, typography and language, must constitute a fair disclosure of the provisions of the health plan.

(c) The evidence of coverage shall contain at a minimum the following information:

(1) The name of the health plan, the principal address from which it conducts its business and its telephone number.

(2) The definitions for the words contained therein that have meanings other than those attributed to them by the public in general usage.

(3) The manner in which the member can determine who is or may be entitled to benefits.

(4) The time and date or occurrence upon which coverage takes effect including a specification of any applicable waiting periods.

(5) The time and date or occurrence upon which coverage will terminate.

(6) The conditions upon which cancellation may be effected by the health plan or by the member, and a statement that a subscriber or enrollee who alleges that an enrollment or subscription has been cancelled or not renewed because of the enrollee's or subscriber's health status or requirements for health care services may request a review of cancellation by the Director.

(7) The conditions for and any restrictions upon the member's right to renewal or reinstatement.

(8) The amount of the periodic payment to be made by the member, the time by which the payment must be made, and the address at or to which the payment shall be made, except that a member under group coverage may be referred to the group contract holder for information regarding any sums to be withheld from the member's salary or to be paid by the member to the employer or group contract holder.

(9) A complete statement of all benefits and coverages and the related limitations, exclusions, exceptions, reductions, copayments, and deductibles.

(10) A statement of any restriction on assignment of sums payable to the member by the health plan.

(11) The exact procedure for obtaining benefits including the procedure for filing claims. The procedure for filing claims must state the time by which the claim must be filed, the form in which it is to be filed and the address at or to which it shall be delivered or mailed.

(12) Any procedures required to be followed by the member in the event any dispute arises under the contract, including any requirement for arbitration.

(13) The address and telephone number designated by the health plan to which complaints from members are to be directed, and a description of the plan's grievance procedure.

(14) A statement to the effect that, by statute, every contract between the health plan and a provider shall provide that in the event the health plan fails to pay the provider, the member shall not be liable to the provider for any sums owed by the health plan.

(15) A statement to the effect that in the event the health plan fails to pay a noncontracting provider, the member may be liable to the noncontracting provider for the cost of the services.

(16) An appropriate statement to fulfill the requirement of Section 1300.69(i)(1), unless the plan undertakes to mail such information annually.

(17) A statement which shall be set forth in boldface type not less than 2 points larger than the type required by subsection (b)(2): "This evidence of coverage constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage."

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1360 and 1363, Health and Safety Code.

History:

1. Amendment of subsection (c)(16) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment of subsection (c) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
3. Change without regulatory effect amending subsections (a), (b) and (c)(6) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.63.2. Combined Evidence of Coverage and Disclosure Form.

Notwithstanding Sections 1300.63 and 1300.63.1 of these rules, a plan may combine the evidence of coverage and disclosure form into a single document if such plan complies with each of the following requirements:

(a) Each plan shall furnish to each individual subscriber, and make available to group contract holders for dissemination to all persons eligible under the group contract, either a single document consisting of a combined evidence of coverage and disclosure form or a copy of the plan contract, which shall conform to the requirements of this section.

(b) Except as may be otherwise permitted by the Director, the combined evidence of coverage and disclosure form shall conform to the following requirements:

(1) It shall be clearly entitled "Combined Evidence of Coverage and Disclosure Form."

(2) The text shall be printed in at least ten point block type. Titles and captions shall be in at least twelve point to fifteen point boldface type.

(3) It shall be written in clear, concise, easily understood language.

(4) It should relate to one form of plan contract; however, combined evidence of coverage and disclosure forms offering alternative plans or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the contract.

(5) It shall be presented in an easily readable format.

(6) The combined evidence of coverage and disclosure form when taken as a whole, with consideration being given to format, typography and language, must constitute a fair disclosure of the provisions of the health plan.

(c) The combined evidence of coverage and disclosure form shall contain at a minimum the following information:

(1) The name of the health plan, the principal address from which it conducts its business and its telephone number.

(2) A statement that the specimen of the plan contract will be furnished on request.

(3) The definitions for the words contained therein that have meanings other than those attributed to them by the public in general usage.

(4) The manner in which the member can determine who is or may be entitled to benefits, except that a member under group coverage may be referred to the group contract holder for such information.

(5) The time and date or occurrence upon which coverage takes effect including a specification of any applicable waiting periods.

(6) The time and date or occurrence upon which coverage will terminate.

(7) The conditions upon which cancellation may be effected by the health plan or by the member, and a statement that a subscriber or enrollee who alleges that an enrollment or subscription has been cancelled or not renewed because of the enrollee's or subscriber's health status or requirements for health care services may request a review of cancellation by the Director.

(8) The conditions for and any restrictions upon the member's right to renewal or reinstatement.

(9) The caption "Prepayment Fees" followed by a statement of the methods by which such premium may be paid; the full premium charge of the plan; and a statement of the authority to change the fees during the term of the contract.

(10) The amount of the periodic payment to be made by the member, the time by which the payment must be made, and the address at or to which the payment shall be made, except that a member under group coverage may be referred to the group contract holder for information regarding any sums to be withheld from the member's salary or to be paid by the member to the employer or group contract holder.

(11) A complete statement of all benefits and coverages and the related limitations, exclusions, exceptions, reductions, copayments, and deductibles.

(12) The caption "Other Charges," followed by a description of each copayment, coinsurance, or deductible requirement that may be incurred by the member or the member's family in obtaining coverage under the plan.

(13) A statement of any restriction on assignment of sums payable to the member by the health plan.

(14) The exact procedure for obtaining benefits including the procedure for filing claims. The procedure for filing claims must state the time by which the claim must be filed, the form in which it is to be filed, and the address at or to which it shall be delivered or mailed.

(15) Any procedures required to be followed by the member in the event any dispute arises under the contract, including any requirement for arbitration.

(16) The address and telephone number designated by the health plan to which complaints from members are to be directed, and a description of the plan's grievance procedure.

(17) The caption "Choice of Physicians and Providers," followed by description of the nature, extent and circumstances under which choice is permitted. This section shall include, if applicable, a subcaption "Liability of Subscriber or Enrollee for Payment" followed by a description of the financial liability which is, or may be, incurred by the subscriber, enrollee or a third party by reason of the exercise of such choice.

(18) A statement to the effect that, by statute, every contract between the health plan and a provider shall provide that in the event the health plan fails to pay the provider, the member shall not be liable to the provider for any sums owed by the health plan.

(19) A statement to the effect that in the event the health plan fails to pay noncontracting providers, the member may be liable to the noncontracting provider for the cost of services.

(20) If applicable, the caption "Reimbursement Provisions," followed by a description of the circumstances under which reimbursements are made under the plan contract, the extent of reimbursement, and the method of claim for reimbursement.

(21) The caption "Renewal Provisions," followed by a statement of the terms under which the plan contract may be renewed by the group or the plan member, as appropriate, including any reservation by the plan of any right to change premiums or other plan contract provisions.

(22) The caption "Facilities," followed by a statement of the principal facilities available under the plan contract, including their location and description of the services provided. The hours of availability of both emergency and non-emergency services should be indicated, either specifically or by general description. However, if the Director approves in advance, a plan may provide a telephone number from which information as to the identity and location of the provider facilities defined in subsection (i)(2) of Section 1300.45 of these rules may be obtained, in lieu of listing such provider facilities.

(23) In the case of group contracts, the caption "Individual Continuation of Benefits," followed by a statement of the terms and conditions under which subscribers and enrollees may remain in the plan, as provided pursuant to subdivision (g) of Section 1373 of the Act.

(24) The caption "Termination of Benefits," followed by a statement of the terms and conditions for cancellation or termination of benefits, including a statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon a member who is hospitalized or undergoing treatment for an ongoing condition.

(25) Any appropriate statement to fulfill the requirement of Section 1300.69(i)(1) of these rules, unless the plan undertakes to mail such information annually.

(26) In the event that receipt of benefits or reimbursements to subscribers or enrollees under the plan contract is subject to significant delays, based upon the current experience of the plan, the combined evidence of coverage and disclosure form may be required by the Director to disclose such facts.

(27) A statement which shall be set forth in boldface type not less than two points larger than the type required by subsection (b)(2): "This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage."

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1360, 1363 and 1368, Health and Safety Code.

History:

1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).
2. Change without regulatory effect amending subsections (b), (c)(7), (c)(22) and (c)(26) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.63.3. Experimental Disclosure.

Notwithstanding those provisions of Sections 1300.63, 1300.63.1, 1300.63.2, and 1300.67.4 which require the use of any particular type size, boldface type, caption, subcaption, heading, design, order, or format, the Director by order may approve, for experimental use, reasonable alternatives to such requirements for a disclosure form, evidence of coverage, combined evidence of coverage and disclosure form, or plan contract upon the written request of a plan, for such period and under such conditions as the Director may specify, subject to each of the following conditions:

(a) That the plan submits two draft copies of the document containing the proposed alternatives, one as proposed to be used and the other redlined to highlight the proposed changes, along with two copies of the related plan contract, at least 30 days prior to any use of the document, or such shorter period as the Director by order may allow.

(b) That the plan demonstrates to the satisfaction of the Director that the document containing the proposed alternatives furthers the purposes of the Act, otherwise complies with the Act and the rules thereunder, and will provide to actual or potential subscribers or enrollees (as the case may be) unobjectionable information at least as clear, concise, accurate, easily understood, and easily readable as could otherwise be achieved.

(c) That the plan submits a proof or final copy of the document at such time, not to exceed 30 days, prior to its initial use as may be specified by the Director.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1363, Health and Safety Code.

History:

1. New section filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

2. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.63.50. Medicare Supplement Additional Disclosure. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1363, Health and Safety Code.

HISTORY:
1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).
2. Repealer and new table, amendment of subsection (a)(5)(A)8., and new subsection (a)(5)(A)9. filed 11-26-91; operative 12-26-91 (Register 92, No. 10).
3. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

§ 1300.64.50. Medicare Supplement Application Information. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1364, Health and Safety Code.

History:
1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).
2. Amendment filed 11-26-91; operative 12-26-91 (Register 92, No. 10).
3. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

§ 1300.64.51. Medicare Supplement "Buyer's Guide." [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1364, Health and Safety Code.

History:
1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).
2. Amendment of subsections (a) and (b) filed 11-26-91; operative 12-26-91 (Register 92, No. 10).
3. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

§ 1300.64.52. Standards for Marketing Medicare Supplement Contracts. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1346, 1364 and 1367.15, Health and Safety Code; 42 U.S.C. 1395ss.

History:
1. New section filed 11-26-91; operative 12-26-91 (Register 92, No. 10).
2. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

§ 1300.64.53. Reporting of Multiple Coverage. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367.15 and 1384(d)(i), Health and Safety Code; 42 U.S.C. 1395ss.

History:
1. New section filed 11-26-91; operative 12-26-91 (Register 92, No. 10).
2. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

§ 1300.64.54. Replacement Contracts: Elimination of Waiting Periods. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1367.15 and 1384(d)(i), Health and Safety Code; 42 U.S.C. 1395ss.

History:
1. New section filed 1-8-92; operative 1-1-92 (Register 92, No. 10).
2. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

§ 1300.64.55. Permitted Compensation Arrangements for the Sale of Medicare Supplement Contracts. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1346(i), 1367(h) and 1367.15, Health and Safety Code; 42 U.S.C. 1395ss.

History:
1. New section filed 11-26-91; operative 12-26-91 (Register 92, No. 10).
2. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

ARTICLE 6
Appeals on Cancellation

Section
1300.65. Cancellations, Rescissions, and Nonrenewals of an Enrollment or Subscription.
1300.65.1. Cancellations, Rescissions, or Nonrenewals for Reasons Other than Nonpayment of Premiums.
1300.65.2. Cancellations or Nonrenewals for Nonpayment of Premiums.
1300.65.3. Cancellations or Nonrenewals for Nonpayment of Premiums: APTC Enrollee.
1300.65.4. Grievance Form for Cancellations, Rescissions, and Nonrenewals of an Enrollment or Subscription.
1300.65.5. Notice of Right of Enrollee to Submit a Grievance.
1300.66. Deceptive Plan Names.

§ 1300.65. Cancellations, Rescissions, and Nonrenewals of an Enrollment or Subscription.

(a) Definitions

The terms used in Health and Safety Code sections 1365 and 1389.21, as well as the terms used in this Article, are defined as follows:

(1) "APTC enrollee" means an individual, an enrollee or a subscriber in the individual market who is currently a recipient of advance payments of the premium tax credit ("APTC") pursuant to the federal Patient Protection and Affordable Care Act ("PPACA") at section 1401 (26 U.S.C. § 36B).

(2) "Billed for the charge" means the enrollee, subscriber, or group contract holder was sent a bill that provides, at a minimum, an accurate itemization of the premium amount(s) due, the due date(s), and the period(s) of time covered by the premium(s). The bill shall also include the following statement in at least 12-point font:

> Your health plan is billing you for the cost of your health coverage. You must pay all amounts listed in this bill by the due date. If you do not pay this amount by the due date, your health coverage can be cancelled. You will receive a grace period before your plan can cancel your coverage for not paying the amount due. You can file a complaint with your plan and with the California Department of Managed Health Care if you think there is a mistake. Learn more about your health care rights and responsibilities in your plan Evidence of Coverage.

(3) "Cancelled," "not renewed" or "nonrenewal" means termination of coverage initiated by the plan during or at the conclusion of the contract term, but does not include the following:

(A) Voluntary termination at the request of the enrollee or subscriber.

(B) Termination for failure to satisfy any statutory or regulatory eligibility requirements under federal or state law.

(C) Exhaustion of any time-limited coverage provided by federal or state law, including, but not limited to, continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (section 4980B of Title 26 of the United States Code, sections 1161 et seq. of Title 29 of the United

States Code, and section 300bb of Title 42 of the United States Code) or Cal-COBRA (Health and Safety Code sections 1366.20 through 1366.29).

(D) Prospective termination for failure to satisfy eligibility requirements under a group plan contract, as follows:

(i) Time-based employment requirements, including, but not limited to, a reduction in work hours;

(ii) Marital or registered domestic partner status;

(iii) Attainment of limiting age by dependent child;

(iv) Group participation requirements; or

(v) Service-area requirements.

(4) "Contractholder" or "contract holder" means the enrollee, subscriber, group, association or employer with which the plan has contracted to provide health services.

(5) "Enrollee" means a person who is enrolled in a plan and who is a recipient of services from the plan, as that term is defined in Health and Safety Code section 1345(c).

(6) "Enrollment," "subscription," or "contract" means "plan contract," as that term is defined in Health and Safety Code section 1345(r).

(7) "Exchange" or "Covered California" means the California Health Benefit Exchange established in Title 22 (commencing with section 100500) of the Government Code.

(8) "Federal grace period" means the period of three consecutive months a QHP Issuer must provide to an APTC enrollee, before terminating the APTC enrollee's health care coverage for nonpayment of premiums.

(9) "Grace period" means the period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated.

(10) "Grievance" means a written or oral expression of dissatisfaction to the plan or the Director regarding the plan and/or provider, including a written or oral expression of dissatisfaction by an enrollee, subscriber, or group contract holder who believes their plan contract, enrollment or subscription has been or will be improperly cancelled, rescinded or not renewed. The right to request a review by filing a complaint authorized under Health and Safety Code section 1365(b) shall be handled as an expedited grievance pursuant to the requirements of Health and Safety Code sections 1368 and 1368.01, and California Code of Regulations, title 28, sections 1300.68 and 1300.68.01.

(11) "Group contract holder" means a group, association, or employer that contracts with a plan to provide health care services to members or employees.

(12) "Individual" means enrollee or subscriber as defined in Health and Safety Code section 1345(c) and (p), respectively.

(13) "Non-Suspension QHP Issuer" means a health care service plan that does not pend claims for services given to the APTC enrollee in the second and third months of the federal grace period. A Non-Suspension QHP Issuer shall provide coverage to the APTC enrollee as required by the plan contract during the 3-month federal grace period.

(14) "Nonpayment of Premiums" means failure of the enrollee, subscriber, or group contract holder to pay any premium, or portion of premium, by the due date after having been billed for the charge.

(15) "Notice of Cancellation, Rescission or Nonrenewal" means notice sent by the plan to the enrollee, subscriber, or group contract holder that the plan contract will be cancelled, rescinded or not renewed for any reason other than nonpayment of premiums as permitted under California Code of Regulations, title 28, sections 1300.65.1 or 1300.89.21, or Health and Safety Code sections 1365 or 1389.21.

(16) "Notice of End of Coverage" means the notice sent to the enrollee, subscriber, or group contract holder notifying the recipient that the enrollee's coverage has been cancelled.

(17) "Notice of Start of Federal Grace Period" means notice sent by the plan to the enrollee or subscriber that the plan contract will be terminated unless the premium amount due is received by the plan no later than the last day of the Federal Grace Period.

(18) "Notice of Start of Grace Period" means the notice sent by the plan to the enrollee, subscriber, or group contract holder that the plan contract will be terminated unless the premium amount due is received by the plan no later than the last day of the Grace Period.

(19) "Outstanding premium" means the total premium amounts that have been billed to the enrollee, subscriber or group contract holder and are past due.

(20) "Plan" means a "health care service plan" or "specialized health care service plan," as those terms are defined in Health and Safety Code section 1345(f).

(21) "Premium payment threshold policy" means a plan's policy to consider an enrollee, subscriber, or group contract holder to have paid all amounts due if the enrollee, subscriber, or group contract holder pays an amount sufficient to maintain a percentage of total premium owed equal to or greater than a level prescribed by the plan, provided that the level is reasonable and that the level and policy are applied in a uniform manner to all enrollees, subscribers, contract holders, and group contract holders.

(22) "QHP Issuer" means, for the purposes of this Article, a plan licensed under the provisions of the Act and certified by the Exchange to market individual and/or small group products on the Exchange. Any of the requirements contained in California Code of Regulations, title 28, sections 1300.65, 1300.65.1, 1300.65.2, and 1300.65.3 that are delegated by a QHP Issuer to a delegated group shall also apply to that delegated group.

(23) "Qualified Health Plan" or "QHP" means a plan contract certified to be offered through the Exchange.

(24) "Rescission" or "rescind" means retroactive cancellation of coverage as defined in California Code of Regulations, title 28, section 1300.89.21.

(25) "Small employer" has the same meaning as defined in Health and Safety Code sections 1357(*l*), 1357.500(k) and 1357.600(k).

(26) "Suspension QHP Issuer" means a health care service plan that pends claims for services rendered to the enrollee in the second and third months of the federal grace period, pursuant to Title 45 of the Code of Federal Regulations, section 156.270.

(b) Grievance

(1) An enrollee, subscriber, or group contract holder who believes a plan contract, enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed shall have at least 180 days from the date of the notice that the enrollee, subscriber, or group contract holder alleges to be improper to submit a grievance to the plan. An enrollee, subscriber, or group contract holder may also submit a grievance to the Director. An enrollee, subscriber, or group contract holder's right to submit a grievance is pursuant to Health and Safety Code sections 1365, 1368, and 1368.01.

(2) A grievance of an enrollee, subscriber, or group contract holder to the plan shall be processed pursuant to California Code of Regulations, title 28, section 1300.68.01. If the enrollee, subscriber, or group contract holder submits a grievance to the plan regarding a cancellation, rescission, or nonrenewal, the plan shall provide the Department and the enrollee, subscriber, or group contract holder with a disposition or pending status on the grievance within

three (3) calendar days of receipt of the grievance by the plan pursuant to Health and Safety Code section 1368 and California Code of Regulations, title 28, section 1300.68.01(a)(2). Health and Safety Code section 1368(a)(4)(B)(i) and California Code of Regulations, title 28, section 1300.68(d)(8) shall not exempt a plan from complying with any requirement for written acknowledgement and response to an enrollee's grievance, as that term is defined in this Article.

(3) An enrollee, subscriber, or group contract holder's grievance to the Director shall be processed to determine if a proper complaint exists pursuant to Health and Safety Code section 1365(b)(2), including a determination if the grievance is timely, complete, and within the Director's jurisdiction. If a proper complaint does exist, the Director shall notify the enrollee, subscriber, or group contract holder, and the plan that the grievance has been accepted within 48 hours of the determination that the grievance is a proper complaint.

(4) Within 1 business day of receipt of the Director's notice of acceptance of proper complaint, the plan shall provide the Director with a copy of all information the plan used to make its determination and all other relevant information necessary for the Director's review pursuant to California Code of Regulations, title 28, section 1300.68(g)(1) through (g)(6).

(5) If an enrollee, subscriber, or group contract holder submits a grievance before the effective date of a cancellation, rescission, or nonrenewal, the plan shall continue to provide coverage as specified in California Code of Regulations, title 28, section 1300.65(c).

(6) Within 30 calendar days of the receipt of a grievance, or longer if the Director determines in his or her discretion that additional time is necessary to review the cancellation, rescission, or nonrenewal, the Director shall, pursuant to Health and Safety Code section 1368(b)(5), send written notice of the final determination and reasons for the determination to the enrollee, subscriber, or group contract holder, and to the plan.

(7) If the Director determines the cancellation, rescission, or nonrenewal fails to comply with all legal requirements, including, but not limited to, all notice and timing requirements in this Article, the Director shall order reinstatement, in accordance with California Code of Regulations, title 28, section 1300.65(d), or direct the plan not to cancel coverage.

(8) If the Director finds the cancellation, rescission, or nonrenewal was proper, but the effective date was in violation of the requirements of this Article, the Director may exercise his or her discretion and adjust the effective date of the cancellation, rescission, or nonrenewal accordingly and notify the enrollee, subscriber, or group contract holder, as well as the plan of the adjusted cancellation date.

(c) Continuation of Coverage

(1) If the enrollee, subscriber, or group contract holder files a grievance before the effective date of a cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, the plan shall continue to provide coverage to the enrollee, subscriber, or contract holder pursuant to the terms of the plan contract while the grievance is pending with the plan and/or Director.

(2) During the period of continued coverage, the enrollee, subscriber, or group contract holder remains responsible for paying premiums and any copayments, coinsurance, or deductible obligations as required under the plan contract.

(3) If the Director determines the cancellation or nonrenewal for nonpayment of premiums is consistent with existing law, and if the enrollee or subscriber is not entitled to the federal grace period, the cancellation date shall comply with California Code of Regulations, title 28, section 1300.65.2(a)(5). Under the federal grace period, if the Director determines the cancellation or nonrenewal is consistent with existing law, the cancellation date shall comply

with California Code of Regulations, title 28, section 1300.65.3(a)(5)(A). The enrollee, subscriber, or group contract holder shall be responsible only for the required premium and cost sharing obligations incurred during the continued coverage period.

(4) If the Director determines the rescission is consistent with existing law, the plan shall return all premiums paid by the enrollee, subscriber, or group contract holder. The enrollee, subscriber, or group contract holder is responsible for the cost of all medical services received after the effective date of the rescission as defined in California Code of Regulations, title 28, section 1300.89.21(a).

(d) Reinstatement of Coverage

(1) If the Director determines the cancellation, rescission, or nonrenewal, including a cancellation for nonpayment of premium, does not comply with existing law, and the enrollee, subscriber, or group contract holder submitted the grievance after the plan contract was cancelled, rescinded, or not renewed, the Director shall order the plan to reinstate the enrollee, subscriber, or contract holder, retroactive to the effective date of cancellation, rescission, or nonrenewal.

(2) Within 15 days after receipt of the order for reinstatement, the plan shall either request an administrative hearing from the Director or reinstate the enrollee, subscriber, or contract holder.

(3) If the Director orders reinstatement, the plan shall be liable for the expenses incurred by the enrollee, subscriber, or group contract holder for covered health care services, less any applicable deductibles, copayments, or coinsurance pursuant to the enrollee, subscriber, or group contract holder's Evidence of Coverage, from the effective date of cancellation, rescission, or nonrenewal through the date of reinstatement. The plan shall reimburse the enrollee, subscriber, or group contract holder for any medical expenses incurred by the enrollee, subscriber, or contract holder pursuant to this subdivision within 30 days of receipt of the complete claim, as defined in California Code of Regulations, title 28, section 1300.71(a)(2).

(4) The enrollee, subscriber, or group contract holder shall be responsible for any and all premium payments accrued from the effective date of cancellation, rescission, or nonrenewal. An enrollee, subscriber, or group contract holder must pay all outstanding premiums before reinstatement.

(e) Applicability

The provisions in California Code of Regulations, title 28, sections 1300.65, 1300.65.1, 1300.65.2, 1300.65.3, 1300.65.4, and 1300.65.5 shall not apply to a plan contract offered in the Medi-Cal program (Chapters 7 (commencing with section 14000) and 8 (commencing with section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code).

(f) Format and Transmission Requirements Under this Article

(1) Except for the notice required under Health and Safety Code section 1389.21, notices shall be sent by any reasonable method of transmission, including paper, electronic, or another method of transmission specifically agreed to by the enrollee, subscriber, or group contract holder.

(2) The enrollee, subscriber, or group contract holder may agree to the electronic transmission of all notices under this Article, but shall not be required to opt-in to receive paper notices. For any method of transmission other than paper, the plan shall maintain a copy of the specific agreement for the method of transmission.

(3) For any method of transmission other than paper, the plan shall have a tracking system to demonstrate notices were sent in compliance with the

agreement between the plan and enrollee, subscriber, or group contract holder, and applicable law.

(4) Except as otherwise required under this Article, notices shall appear in at least 12-point font.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1365, 1368, 1368.01 and 1389.21, Health and Safety Code.

History:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Change without regulatory effect amending subsections (a) and (c)(4) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
3. Repealer of subsection (a), subsection relettering and amendment of newly designated subsections (b)(3) and (c) filed 5-7-2014; operative 7-1-2014 (Register 2014, No. 19).
4. Repealer and new section and amendment of Note filed 12-22-2014; operative 1-1-2015 pursuant to Government Code section 11343.4(b)(3) (Register 2014, No. 52).
5. Repealer and new section filed 7-30-2019; operative 10-1-2019 (Register 2019, No. 31).

§ 1300.65.1. Cancellations, Rescissions, or Nonrenewals for Reasons Other than Nonpayment of Premiums.

(a) General Requirements

(1) Applicability. This section shall apply to all cancellations for reasons other than for nonpayment of premiums.

(2) The plan shall send a Notice of Cancellation, Rescission, or Nonrenewal for all cancellations other than cancellations due to the nonpayment of premium. At a minimum, this Notice shall contain the information set forth in California Code of Regulations, title 28, section 1300.65.1(b)(1). The Notice of Cancellation, Rescission, or Nonrenewal shall be sent to the enrollee, subscriber, or group contract holder:

(A) At least 30 days before the cancellation, rescission, or nonrenewal for fraud or intentional misrepresentation of material fact pursuant to Health and Safety Code sections 1365(a)(2) or 1389.21, subject to limitations imposed by Health and Safety Code section 1389.21.

(B) At least 30 days before the cancellation, rescission, or nonrenewal for a cancellation or nonrenewal pursuant to Health and Safety Code sections 1365(a)(3), (4) or (7).

(C) At least 180 days before the discontinuation or termination of a contract if the cancellation or nonrenewal is due to the plan ceasing to provide or arrange for the provision of health benefits for new plan contracts in the individual or group market in this state pursuant to Health and Safety Code section 1365(a)(5). A notice sent pursuant to this subdivision shall also be sent concurrently to the Director.

(D) At least 90 days before the withdrawal of a health benefit plan from the market pursuant to Health and Safety Code section 1365(a)(6). A notice sent pursuant to this subdivision shall also be sent concurrently to the Director.

(3) The plan shall send a Notice of Cancellation, Rescission, or Nonrenewal to each subscriber in a group contract unless:

(A) The plan contract requires the group contract holder to promptly send any such Notice to each subscriber; and

(B) The plan sends the Notice to the group contract holder designated in the plan contract.

(4) The plan shall send a Notice of End of Coverage for all cancellations. This Notice shall be sent to the enrollee, subscriber, or group contract holder after the date coverage ended, and no later than five (5) calendar days after the date coverage ended. At a minimum, this Notice shall contain the information set forth in California Code of Regulations, title 28, section 1300.65.1(b)(2).

(5) When required pursuant to Health and Safety Code section 1373.96(m), notice as to the availability of the right to request completion of covered services shall be part of, accompany, or be sent simultaneously with both the Notice of Cancellation, Rescission, or Nonrenewal and the Notice of End of Coverage.

(b) Elements of Notices:

(1) Notice of Cancellation, Rescission, or Nonrenewal

The Notice of Cancellation, Rescission, or Nonrenewal shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of Cancellation, Rescission, or Nonrenewal" displayed in 20-point bolded font at the top of the first page of the notice;

(B) The name and contact information for the enrollee, subscriber, or group contract holder;

(C) For all contracts issued in the individual market, the names of all enrollees affected by the notice;

(D) The date of the notice;

(E) Reason for the cancellation, rescission, or nonrenewal;

(F) Effective date of the cancellation, rescission, or nonrenewal, expressed as a month, day and year;

(G) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) as set forth in California Code of Regulations, title 28, section 1300.65.5; and

(H) Any notice required under Health and Safety Code section 1366.50.

(2) Notice of End of Coverage

The Notice of End of Coverage shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of End of Coverage" displayed in 20-point bolded font at the top of the first page of the notice;

(B) The name and contact information for the enrollee, subscriber, or group contract holder;

(C) For all contracts issued in the individual market, the names of all enrollees affected by the notice;

(D) The date of the notice;

(E) The effective date of cancellation, rescission, or nonrenewal, expressed as a month, day and year;

(F) The reason for cancellation, rescission, or nonrenewal;

(G) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) as set forth in California Code of Regulations, title 28, section 1300.65.5;

(H) Any notice required under Health and Safety Code section 1366.50; and

(I) The following statement: "To learn about new coverage or whether your coverage can be reinstated, contact [health plan] at [contact information]."

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1365, 1366.50, 1373.96 and 1389.21, Health and Safety Code.

History:

1. Amendment of subsection (a) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Change without regulatory effect amending form filed 5-24-99 pursuant to section 100, title 1, California Code of Regulations (Register 99, No. 22).
3. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
4. Change without regulatory effect amending subsection (a) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).
5. Amendment filed 12-22-2014; operative 1-1-2015 pursuant to Government Code section 11343.4(b)(3) (Register 2014, No. 52).
6. Repealer and new section filed 7-30-2019; operative 10-1-2019 (Register 2019, No. 31).

§ 1300.65.2. Cancellations or Nonrenewals for Nonpayment of Premiums.

(a) General Requirements

(1) Applicability. This section shall apply to all cancellations and nonrenewals for nonpayment of premiums pursuant to Health and Safety Code section 1365(a)(1)(A), unless an enrollee, subscriber, or group contract holder is entitled to a longer grace period pursuant to state or federal law.

(2) Grace Period

(A) The grace period may not begin sooner than the day after the last date of paid coverage. Grace period is defined in California Code of Regulations, title 28, section 1300.65(a)(9).

(B) A plan shall provide coverage pursuant to the terms of the contract during the entire grace period. The term "Grace Period" does not include the "Federal Grace Period," as defined in California Code of Regulations, title 28, section 1300.65(a)(8), which applies to individuals receiving APTC pursuant to the PPACA, section 1401 (26 U.S.C. § 36B).

(3) Notices

(A) Upon determining that an enrollee, subscriber, or group contract holder has failed to make a premium payment by the due date, the plan shall send a Notice of Start of Grace Period to the enrollee, subscriber, or group contract holder, notifying the recipient that a payment delinquency has triggered a grace period starting from the day the Notice of Start of Grace Period is dated. This Notice shall, at minimum, contain the information set forth in California Code of Regulations, title 28, section 1300.65.2(b)(1).

(B) The plan shall send a Notice of Start of Grace Period to each subscriber in a group contract unless:

(i) The plan contract requires the group contract holder to promptly send any such Notice to each subscriber; and

(ii) The plan sends the Notice to the group contract holder designated in the plan contract.

(C) A plan shall not delegate the responsibility for sending the Notice of Start of Grace Period to a group contract holder for each subscriber in the group unless the plan has complied with California Code of Regulations, title 28, section 1300.65.2(a)(3)(B).

(D) In the case where a plan has delegated the responsibility for sending the Notice of Start of Grace Period to a group contract holder, the Notice of Start of Grace Period to the group contract holder triggers the 30-day grace period. Any subsequent notice to the subscribers in the group does not restart the 30-day grace period.

(E) For the purposes of this section, all plans shall notify an enrollee, subscriber, or group contract holder when the plan has cancelled, rescinded, or not renewed health coverage in one of the following two ways:

(i) Send a written notice of termination to the enrollee, subscriber, or group contract holder, when required pursuant to California Code of Regulations, title 10, section 6506(e)(1). This notice shall include the notice of grievance rights set forth in California Code of Regulations, title 28, section 1300.65.5, and any notice required under Health and Safety Code section 1366.50; or

(ii) Send the Notice of End of Coverage. This Notice shall be sent after the date coverage ends, and no later than five calendar days after the date coverage ended. At a minimum, this Notice shall contain the information set forth in California Code of Regulations, title 28, section 1300.65.2(b)(2).

(4) Notwithstanding California Code of Regulations, title 28, section 1300.65(a)(14), a plan may implement a premium payment threshold policy, as defined in California Code of Regulations, title 28, section 1300.65(a)(21).

(5) In the event the plan, after compliance with all timing and notice requirements of this section, fails to receive all outstanding premium amounts from the enrollee, subscriber, or group contract holder on or before the last day of the grace period, as specified in the Notice of Start of Grace Period, coverage may be cancelled prospectively only after the expiration of the entire grace period.

(6) The plan shall continue the enrollee, subscriber, and/or group contract holder's coverage uninterrupted pursuant to the plan contract upon payment of all outstanding premium amounts at any time before the expiration of the grace period.

(7) The enrollee, subscriber, or group contract holder is financially responsible for any and all premiums and any copayments, coinsurance, or deductible amounts obligated under the plan contract, including those incurred for services received during the grace period.

(b) Elements of Notices

(1) Notice of Start of Grace Period

The Notice of Start of Grace Period shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of Start of Grace Period" displayed in 20-point bolded font at the top of the first page of the notice;

(B) The name and contact information for the enrollee, subscriber, or group contract holder;

(C) For all contracts issued in the individual market, the names of all enrollees affected by the notice;

(D) The date of the notice, expressed as a month, day and year;

(E) A statement indicating the specific date the grace period begins;

(F) The dollar amount past due. This amount shall indicate the amounts owed by month if more than one month is past due;

(G) The date of the last day of paid coverage, expressed as a month, day and year;

(H) The name of the plan;

(I) An explanation of the grace period and the specific date the grace period expires, expressed as a month, day and year;

(J) The telephone number for the plan's customer service; and

(K) A statement explaining the consequence of losing coverage, including, financial responsibility for the payment of claims incurred and the obligations of the subscriber.

(2) Notice of End of Coverage

The Notice of End of Coverage shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of End of Coverage" displayed in 20-point bolded font at the top of the first page of the notice;

(B) The name and contact information for the enrollee, subscriber, or group contract holder;

(C) For all contracts issued in the individual market, the names of all enrollees affected by the notice;

(D) The date of the notice;

(E) The effective date of cancellation, expressed as a month, day and year;

(F) The reason for cancellation;

(G) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) and California Code of Regulations, title 28, section 1300.65.5;

(H) Any notice required under Health and Safety Code section 1366.50; and

(I) The following statement: "To learn about new coverage or whether your coverage can be reinstated, contact [health plan] at [contact information]."

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1365 and 1366.50, Health and Safety Code.

History:

1. New section filed 12-22-2014; operative 1-1-2015 pursuant to Government Code section 11343.4(b)(3) (Register 2014, No. 52).
2. Repealer and new section filed 7-30-2019; operative 10-1-2019 (Register 2019, No. 31).

§ 1300.65.3. Cancellations or Nonrenewals for Nonpayment of Premiums: APTC Enrollee.

(a) General Requirements

(1) Applicability. This section shall apply to all cancellations and nonrenewals for nonpayment of premiums for an enrollee who is receiving the APTC through the PPACA, section 1401 (26 U.S.C. § 36B), pursuant to Health and Safety Code section 1365(a)(1)(A).

(2) Federal Grace Period

(A) To qualify for the federal grace period, as defined in California Code of Regulations, title 28, section 1300.65(a)(8), an APTC enrollee shall have paid at least one full month's premium before the nonpayment of premiums.

(B) The federal grace period begins the first day after the last day of paid coverage and lasts for three full consecutive months.

(C) Notwithstanding California Code of Regulations, title 28, section 1300.65(a)(14), a QHP Issuer may implement a premium payment threshold policy, as defined in California Code of Regulations, title 28, section 1300.65(a)(21).

(D) Upon determining that an APTC enrollee has failed to make a premium payment by the due date, the QHP Issuer shall send a "Notice of Start of Federal Grace Period" to the APTC enrollee, notifying the recipient that a payment delinquency has triggered a 3-month federal grace period starting from the first day after the last day of paid coverage.

(E) The Notice of Start of Federal Grace Period sent to the APTC enrollee shall not be mailed or dated on or before the premium due date for which the APTC enrollee is receiving the Notice. The Notice of Start of Federal Grace Period must be sent on or before the fifth (5th) business day after the start of the federal grace period. However, in the event a QHP Issuer learns of a payment delinquency between the last day of paid coverage and the fifteenth (15th) day of the first month of the federal grace period, due to the discovery of insufficient funds, a rejected credit card payment, or a similar event, the QHP Issuer shall send the Notice of Start of Federal Grace Period within five (5) calendar days of learning of the payment delinquency. A Suspension QHP Issuer that fails to send the Notice of Start of Federal Grace Period by the applicable deadline(s) shall not suspend the APTC enrollee's coverage during the second and third months of the federal grace period.

(3) Suspension of Coverage

(A) Suspension of coverage during months two and three of the federal grace period is optional for the plan.

(B) A Non-Suspension QHP Issuer shall not take or threaten action that causes or suggests that the APTC enrollee's coverage may be suspended. A Non-Suspension QHP Issuer shall:

(i) Provide its APTC enrollees with the 3-month federal grace period,

(ii) Provide coverage to the APTC enrollee as required by the plan contract during the 3-month federal grace period,

(iii) Pay all claims for covered health care services rendered during the 3-month federal grace period, notwithstanding California Code of Regulations, title 28, section 1300.65.3(a)(5)(A), and

(iv) Not hold an APTC enrollee financially responsible for the costs of claims for covered health care services rendered during the 3-month federal grace period, even if cancellation occurs for nonpayment of premium. An APTC enrollee remains responsible for payment of outstanding premiums and any applicable deductibles, copayments, and coinsurance, pursuant to the APTC enrollee's Evidence of Coverage, accrued during the 3-month federal grace period, even if cancellation occurs for nonpayment of premium.

(C) To suspend an enrollee during months two and three of the federal grace period, a Suspension QHP Issuer shall:

(i) Comply with any and all notice requirements to the enrollee related to suspension of coverage;

(ii) Make any necessary system adjustments by day 1 of the second month of the federal grace period to the QHP Issuer's real time eligibility and verification system to accurately reflect the APTC enrollee's suspension of coverage; and

(iii) Reinstate the APTC enrollee, retroactive to the last day of the first month, if the APTC enrollee pays all outstanding premium amounts before the end of the federal grace period.

(D) During the first month of the federal grace period, the Suspension QHP Issuer shall:

(i) Provide coverage to the APTC enrollee as required by the plan contract; and

(ii) If the APTC enrollee does not pay outstanding premium amounts by day 15 of the first month of the federal grace period, the Suspension QHP Issuer shall send a Notice of Suspension to the APTC enrollee, and shall send a separate Notice of Suspension to providers. Both notices shall be sent no earlier than day 16 of the first month of the federal grace period but no later than the end of the first month of the federal grace period.

(E) During months two and three of the federal grace period, the Suspension QHP Issuer shall:

(i) Suspend or pend claims for services rendered to the APTC enrollee; and

(ii) Make any necessary system adjustments by day 1 of the second month of the federal grace period to the Suspension QHP Issuer's real time eligibility and verification system to accurately reflect the APTC enrollee's suspension of coverage. For the purposes of this subdivision, the QHP Issuer shall use only the terms "coverage pending," "coverage suspended," or "inactive pending investigation" so as to clearly communicate the status of the APTC enrollee.

(F) During the suspension of coverage, the APTC enrollee:

(i) Remains responsible for making all delinquent and ongoing premium payments; and

(ii) May submit a grievance pursuant to Health and Safety Code section 1365(b).

(G) The Notice of Suspension shall be given to the APTC enrollee's assigned group, assigned network provider, any provider with an outstanding prior authorization to provide services to the APTC enrollee, and any network provider that submitted claims for the APTC enrollee in the two months prior to the start of the APTC enrollee's federal grace period.

(i) This notice requirement is in addition to the provider's ability to verify APTC enrollee eligibility for coverage with the QHP Issuer.

(ii) This notice requirement does not replace a provider's responsibility to verify eligibility for coverage of an APTC enrollee with the QHP Issuer before providing health care services.

(iii) In the event the Suspension QHP Issuer does not provide the notice to the APTC enrollee's providers or does not update its real time eligibility and verification system by day 1 of the second month of the federal grace period, and providers provide health care services to the APTC enrollee, the Suspension QHP Issuer shall be responsible for paying the claim costs of the APTC enrollee that would have been covered under the plan contract notwithstanding the Suspension of Coverage.

(4) Reinstatement of Coverage

(A) In the event that an APTC enrollee does not pay all outstanding premium amounts before the next premium due date, the QHP Issuer shall bill the APTC enrollee in the same form and manner of billing as if the APTC enrollee were not in the federal grace period, and include in the billing statement the total premium amounts owing at the end of the billing cycle.

(B) Upon payment of all outstanding premium amounts at any time before the expiration of the federal grace period, the QHP Issuer shall reinstate the APTC enrollee's coverage pursuant to the plan contract and immediately update its real time eligibility and verification system to reflect an "active" status.

(C) If an APTC enrollee with coverage through a Suspension QHP Issuer pays all outstanding premium amounts before the end of the federal grace period, the Suspension QHP Issuer shall be liable for the claims covered under the APTC enrollee's Evidence of Coverage less any applicable deductibles, copayments, or coinsurance, from the date of suspension of coverage through the date of reinstatement. The Suspension QHP Issuer shall reimburse the APTC enrollee for any medical expenses incurred pursuant to this subdivision within 30 days of receipt of the complete claim, as defined in California Code of Regulations, title 28, section 1300.71(a)(2).

(5) Cancellation or Nonrenewal Following Federal Grace Period

If the APTC enrollee fails to pay outstanding premium amounts on or before the last day of the federal grace period, the QHP Issuer shall cancel or not renew the APTC enrollee's health care coverage.

(A) The effective date of cancellation for an APTC enrollee canceled or not renewed by a Suspension QHP Issuer or by a Non-Suspension QHP Issuer shall be the day after the last day of the first month of the 3-month federal grace period pursuant to 45 Code of Federal Regulations part 155.430(d)(4).

(B) For the purposes of this section, all plans shall notify an enrollee, subscriber, or group contract holder when the plan has cancelled, rescinded, or not renewed health coverage in one of the following two ways:

(i) Send a written notice of termination to the enrollee, subscriber, or group contract holder, when required pursuant to California Code of Regulations, title 10, section 6506(e)(1). This notice shall include the notice of grievance rights set forth in California Code of Regulations, title 28, section 1300.65.5, and any notice required under Health and Safety Code section 1366.50, or

(ii) Send the Notice of End of Coverage. This Notice shall be sent after the date coverage ends, and no later than five calendar days after the date coverage ended. At a minimum, this Notice shall contain the information set forth in California Code of Regulations, title 28, section 1300.65.3(b)(4).

(b) Notice Requirements

(1) Notice of Start of Federal Grace Period to APTC Enrollee

The Notice of Start of Federal Grace Period to the APTC Enrollee shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of Start of Federal Grace Period" displayed in 20-point bolded font at the top of the notice;

(B) The name and contact information for the APTC enrollee;

(C) The names of all APTC enrollees affected by the notice;

(D) The date of the notice;

(E) The date of the first day of the federal grace period, expressed as a month, day and year;

(F) The dollar amount past due. This amount shall indicate the amounts owed by month if more than one month is past due;

(G) The date of the last day of paid coverage, expressed as a month, day and year;

(H) The name of the QHP Issuer;

(I) An explanation of the three-month federal grace period and the date the federal grace period expires;

(J) The telephone number for the QHP Issuer's customer service; and

(K) A statement explaining the consequence of losing coverage, including financial responsibility for the payment of claims incurred and the obligations of the subscriber.

(2) Notice of Suspension to APTC Enrollee

The Notice of Suspension to the APTC enrollee shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of Suspension" displayed in 20-point bolded font at the top of the first page of the notice;

(B) The name and contact information for the APTC enrollee;

(C) The names of all APTC enrollees affected by the notice;

(D) The date of the notice;

(E) A statement indicating the start date of the federal grace period;

(F) The dollar amount past due. This amount shall indicate the amounts owed by month if more than one month is past due;

(G) Date of the last day of paid coverage, expressed as a month, day and year;

(H) The name of the QHP Issuer;

(I) An explanation of the three-month federal grace period and the date the federal grace period expires;

(J) An explanation of the suspension of coverage during the second and third months of the federal grace period and the start and end dates of the suspension of coverage;

(K) An explanation that the APTC enrollee must pay the total outstanding premium in order to exit the federal grace period and prevent coverage from ending;

(L) The telephone number for the QHP Issuer's customer service;

(M) Consequence of losing coverage, including financial responsibility for the payment of claims incurred and the obligations of the APTC enrollee; and

(N) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) and California Code of Regulations, title 28, section 1300.65.5.

(3) Notice of Suspension to APTC Enrollee's Provider(s)

The Notice of Suspension to the APTC Enrollee's Provider(s) shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of Suspension to APTC Enrollee's Provider" displayed in 20-point bolded font at the top of the notice;

(B) The names of all APTC enrollees affected by the notice;

(C) The date of the notice;

(D) The name of the Suspension QHP Issuer for the APTC enrollee;

(E) An explanation of the suspension of coverage during the second and third months of the federal grace period, and the start and end dates of the suspension of coverage; and

(F) The Suspension QHP Issuer's customer service telephone number for providers.

(4) Notice of End of Coverage

The Notice of End of Coverage shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of End of Coverage" displayed in 20-point bolded font at the top of the notice;

(B) The name and contact information for the APTC enrollee;

(C) The names of all APTC enrollees affected by the notice;

(D) The date of the notice;

(E) The end of coverage effective date, expressed as a month, day and year;

(F) The reason for end of coverage;

(G) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) and California Code of Regulations, title 28, section 1300.65.5;

(H) Any notice required under Health and Safety Code section 1366.50; and

(I) The following statement: "To learn about new coverage or whether your coverage can be reinstated, contact [health plan] at [contact information]."

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1365, Health and Safety Code; and Code of Federal Regulations, title 45, part 156.270.

History:

1. New section filed 7-30-2019; operative 10-1-2019 (Register 2019, No. 31).

§ 1300.65.4. Grievance Form for Cancellations, Rescissions, and Non-renewals of an Enrollment or Subscription.

(a) Grievances to the Director pursuant to Health and Safety Code section 1365(b) may be made electronically, verbally, or in writing signed by the enrollee, subscriber, or group contract holder (or their legal representative).

(b) An enrollee, subscriber, or group contract holder is not required to use a specific form to submit a written grievance to the Director pursuant to Health and Safety Code section 1365(b)(1). An enrollee, subscriber, or group contract holder may submit a written grievance using any form that, at a minimum, contains the information enumerated in California Code of Regulations, title 28, section 1300.65.4(d), and addressed to:

DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
980 9TH STREET, SUITE 500
SACRAMENTO, CA 95814

(c) The plan shall make readily available to its members a form that, at a minimum, contains the information enumerated in California Code of Regulations, title 28, section 1300.65.4(d).

(d) An enrollee, subscriber, or group contract holder may submit a written grievance using a form that, at a minimum, contains fields for, or notice of, the following information:

(1) Full name of enrollee, subscriber, or group contract holder filing the grievance;

(2) Name and identification number(s) of all enrollees affected;

(3) Name of parent or guardian, if filing for minor child enrollee;

(4) Date of birth;

(5) Gender, as follows:

Gender: □ Male □ Female □ Other _____

(6) Mailing address;

(7) Daytime phone number;

(8) Evening phone number;

(9) Email address;
(10) Health plan name;
(11) Health plan membership number;
(12) Medical group name, if applicable;
(13) Employer, if applicable;
(14) Medi-Cal identification number, if applicable;
(15) Medicare or Medicare Advantage identification number, if applicable;
(16) Date enrollee received notice that coverage was or will end;
(17) Date enrollee filed a grievance with an entity other than the Department, if applicable;
(18) Copies of plan notice(s) and correspondence(s) received, if any;
(19) Copies of enrollee correspondence(s) sent, if any;
(20) Copies of proof of payment for the last paid coverage period;
(21) A Medical Release, if necessary, as follows:

MEDICAL RELEASE

I request that the Department of Managed Health Care (DMHC) make a decision about my problem with my plan. I request that the DMHC review my Cancellation of Health Coverage Grievance Form to determine if my grievance qualifies for the DMHC's Consumer Complaint process. I allow my providers, past and present, and my plan to release my medical records and information to review this issue. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my grievance. These records may also include non-medical records and any other information related to my grievance. I allow the DMHC to review these records and information and send them to my plan. My permission will end one year from the date below, except as allowed by law. For example, the law allows the DMHC to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

Enrollee, Legal Guardian, or Parent Signature: _____

Date: _____

Please see the instruction sheet for mailing or faxing information.

(22) An Authorized Assistant Form, if necessary, as follows:

AUTHORIZED ASSISTANT FORM

If you want to give another person permission to assist you with your grievance, complete Parts A and B below.

If you are a parent or legal guardian submitting this grievance for a child under the age of 18, you do not need to complete this form.

If you are filing this grievance for an enrollee who cannot complete this form because the enrollee is either incompetent or incapacitated, and you have legal authority to act for this enrollee, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the enrollee.

PART A: ENROLLEE

I allow the person named below in Part B to assist me in my grievance filed with the DMHC. I allow the DMHC staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my grievance will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Enrollee Signature:_____Date:_____

PART B: PERSON ASSISTING ENROLLEE

Name of Person Assisting (print): _____

Signature of Person Assisting: _____

Street Address: _____

City:_____State:_____Zip:_____

Relationship to Enrollee: _____

Daytime Phone Number: _____

Evening Phone Number: _____

Email Address (if available): _____

My power of attorney for health care decisions or other legal document is attached:_____(check if applicable)

(23) An Instruction Sheet, as follows:

GRIEVANCE/COMPLAINT FORM INSTRUCTION SHEET

If you have questions, call the Help Center at 1-888-466-2219 or TDD at 1-877-688-9891. This call is free.

How to File:

1. File online at www.HealthHelp.ca.gov. [This is the fastest way.]

   OR

   Fill out and sign the Cancellation of Health Care Coverage Grievance Form.

2. If you want someone to help you with your grievance, complete the Authorized Assistant Form.
3. Include documents requested on the Cancellation of Health Care Coverage Grievance Form, such as notices from your health plan, billing statements, and proof of payment.
4. If you are not submitting online, please mail or fax your form and any supporting documents to:

   DEPARTMENT OF MANAGED HEALTH CARE
   HELP CENTER
   980 9TH STREET, SUITE 500
   SACRAMENTO, CA 95814-2725
   FAX: 916-255-5241

What Happens Next?

The Help Center will send you a letter telling you if your grievance has been accepted. If your grievance is accepted, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.

(24) The Information Practices Act of 1977 Notice, as follows:

INFORMATION PRACTICES ACT OF 1977 NOTICE

The Information Practices Act of 1977 (California Civil Code section 1798.17) requires the following notice.

- California's Knox-Keene Act gives the DMHC the authority to regulate health plans and investigate the grievances of health plan members.
- The DMHC's Help Center uses your personal information to investigate your problem with your health plan.
- You provide the DMHC this information voluntarily. You do not have to provide this information. However, if you do not, the DMHC may not be able to investigate your grievance.
- The DMHC may share your personal information, as needed, with the plan and providers to investigate your grievance.
- The DMHC may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the DMHC Records Request Coordinator, DMHC, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call 916-322-6727.

(25) Explanation of reason for filing the grievance; and

(26) Signature of enrollee.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1365, Health and Safety Code.

History:

1. New section filed 7-30-2019; operative 10-1-2019 (Register 2019, No. 31).

§ 1300.65.5. Notice of Right of Enrollee to Submit a Grievance.

The following language regarding the right of an enrollee, subscriber, or group contract holder to submit a grievance to the Department of Managed Health Care must appear in at least 12-point font when required by a section in this Article:

RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR PLAN ENROLLMENT, SUBSCRIPTION, OR CONTRACT.

If you believe your health care coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a grievance with the plan and/or the Department of Managed Health Care.

OPTION (1) — YOU MAY SUBMIT A GRIEVANCE TO YOUR PLAN.

- You may submit a grievance to [plan] by calling [plan phone number], online at [plan website], or by mailing your written grievance to [plan address].
- You may want to submit your grievance to [plan] first if you believe your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.
- [Plan] will resolve your grievance or provide a pending status within three (3) calendar days. If you do not receive a response from the plan within three (3) calendar days, or if you are not satisfied in any way with

the plan's response, you may submit a grievance to the Department of Managed Health Care as detailed under Option 2 below.

OPTION (2) — YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DEPARTMENT OF MANAGED HEALTH CARE.

- You may submit a grievance to the Department of Managed Health Care without first submitting it to the plan or after you have received the plan's decision on your grievance.
- You may submit a grievance to the Department of Managed Health Care online at:

  WWW.HEALTHHELP.CA.GOV
- You may submit a grievance to the Department of Managed Health Care by mailing your written grievance to:

  HELP CENTER
  DEPARTMENT OF MANAGED HEALTH CARE
  980 NINTH STREET, SUITE 500
  SACRAMENTO, CALIFORNIA 95814-2725
- You may contact the Department of Managed Health Care for more information on filing a grievance at:

  PHONE: 1-888-466-2219
  TDD: 1-877-688-9891
  FAX: 1-916-255-5241

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1365 and 1368, Health and Safety Code.

History:
1. New section filed 7-30-2019; operative 10-1-2019 (Register 2019, No. 31).

§ 1300.66. Deceptive Plan Names.

(a) A change of plan name is a "material modification" of the plan within the meaning of subdivision (b) of Section 1352 of the Act.

(b) A plan name will be considered deceptive if it suggests the quality of care furnished by the plan, or that full benefits are provided for health care or a specialized area of health care, or that the cost of benefits to members of the plan is lower than the cost of similar benefits purchased elsewhere, and in any such case the express or implied representation contained in the plan name is demonstrably untrue or is not supported by substantial evidence, at all times while such name is used by the plan. Nothing in this subsection limits or restricts the Director from a determination that a plan or solicitor firm name is deceptive for reasons other than those stated herein.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1366, Health and Safety Code.

History:
1. Change without regulatory effect amending subsection (b) and adding Note filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

ARTICLE 7
Standards

Section
1300.67. Scope of Basic Health Care Services.
1300.67.003. State Medical Loss Ratio Annual Report.
1300.67.005. Essential Health Benefits.

1300.67.04. Language Assistance Programs.
1300.67.05. Acts of War Exclusions.
1300.67.1. Continuity of Care.
1300.67.1.3. Block Transfer Filings.
1300.67.2. Accessibility of Services.
1300.67.2.1. Geographic Accessibility Standards.
1300.67.2.2. Timely Access to Non-Emergency Health Care Services.
1300.67.3. Standards for Plan Organization.
1300.67.4. Subscriber and Group Contracts.
1300.67.8. Contracts with Providers.
1300.67.10. Discrimination Prohibited. [Repealed]
1300.67.11. Disclosure of Conflicts of Interest.
1300.67.12. Contracts with Solicitor Firms.
1300.67.13. Coordination of Benefits ("COB").
1300.67.205. Standard Prescription Drug Formulary Template.
1300.67.24. Outpatient Prescription Drug Copayments, Coinsurance, Deductibles, Limitations and Exclusions.
1300.67.241. Prescription Drug Prior Authorization or Step Therapy Exception Request Form Process.
1300.67.50. Certain Medicare Supplement Contracts: Presumption of Unfairness. [Repealed]
1300.67.51. Medicare Supplement Contract Provisions. [Repealed]
1300.67.52. Medicare Supplement Additional Benefit Requirements. [Repealed]
1300.67.53. Medicare Supplement Minimum Aggregate Benefits. [Repealed]
1300.67.55. Medicare Supplement Reporting Requirements. [Repealed]
1300.67.56. Transitional Requirements for the Conversion of Medicare Supplement Contracts to Conform to Medicare Program Revisions. [Repealed]
1300.67.57. Format For Notices of Changes in Coverage. [Repealed]
1300.67.58. Participating Physician or Supplier Claims Form Requirement. (Compliance with Section 4081 of the Omnibus Budget Reconciliation Act of 1987) [Repealed]
1300.67.59. Format for Reporting Loss Ratio Experience. [Repealed]

§ 1300.67. Scope of Basic Health Care Services.

The basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any copayment, deductible, or limitation of which the Director may approve:

(a) Physician services, which shall be provided by physicians licensed to practice medicine or osteopathy in accordance with applicable California law. There shall also be provided consultation with and referral by physicians to other physicians.

(1) The plan may also include, when provided by the plan, consultation and referral (physician or, if permitted by law, patient initiated) to other health professionals who are defined as dentists, nurses, podiatrists, optometrists, physician's assistants, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists and other professionals engaged in the delivery of health services who are licensed to practice, are certified, or practice under authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law.

(b) Inpatient hospital services, which shall mean short-term general hospital services, including room with customary furnishings and equipment, meals (including special diets as medically necessary), general nursing care, use of operating room and related facilities, intensive care unit and services, drugs, medications, biologicals, anesthesia and oxygen services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and other diagnostic, therapeutic and rehabilitative services as appropriate, and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early rehospitalization.

(c) Ambulatory care services, (outpatient hospital services) which shall include diagnostic and treatment services, physical therapy, speech therapy, occupational therapy services as appropriate, and those hospital services which can reasonably be provided on an ambulatory basis. Such services may be provided at a hospital, any other appropriate licensed facility, or any appropriate facility which is not required by law to be licensed, if the professionals delivering such services are licensed to practice, are certified, or practice under the authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law.

(d) Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services, which shall include, but not be limited to, electrocardiography and electroencephalography.

(e) Home health services, which shall include, where medically appropriate, health services provided at the home of an enrollee as prescribed or directed by a physician or osteopath licensed to practice in California. Such home health services shall include diagnostic and treatment services which can reasonably be provided in the home, including nursing care, performed by a registered nurse, public health nurse, licensed vocational nurse or licensed home health aide.

(1) Home health services may also include such rehabilitation, physical, occupational or other therapy, as the physician shall determine to be medically appropriate.

(f) Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a physician's supervision,

(1) reasonable health appraisal examinations on a periodic basis;

(2) a variety of voluntary family planning services;

(3) prenatal care;

(4) vision and hearing testing for persons through age 16;

(5) immunizations for children in accordance with the recommendations of the American Academy of Pediatrics and immunizations for adults as recommended by the U.S. Public Health Service;

(6) venereal disease tests;

(7) cytology examinations on a reasonable periodic basis;

(8) effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

(g)(1) Emergency health care services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health care service plan area. Emergency health care services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan.

(2) Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be provided on a reimbursement or fee-for-service basis and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits. Emergency services defined in section 1317.1 include active labor. "Urgently needed services" are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area. "Urgently needed services" includes maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that

she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area.

(h) Hospice services as set forth in Section 1300.68.2.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1317.1, 1345 and 1367, Health and Safety Code.

History:

1. Amendment of subsection (c) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Change without regulatory effect amending introductory paragraph filed 12-22-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 51).
3. New subsection (h) filed 6-26-2001; operative 7-26-2001 (Register 2001, No. 26).
4. Redesignation and amendment of former subsection (g) as new subsections (g)(1)-(2) filed 9-16-2003; operative 10-16-2003 (Register 2003, No. 38).

§ 1300.67.003. State Medical Loss Ratio Annual Report.

(a) Every health care service plan ("health plan") required to submit the Federal Medical Loss Ratio ("MLR") Annual Reporting Form (CMS form-10418) to the federal Department of Health and Human Services ("DHHS") shall also file the MLR Annual Reporting Form with the Department of Managed Health Care ("Department").

(b) The MLR Annual Report Form shall be filed with the Department no later than July 31 of the year following the end of the MLR reporting year. The MLR reporting year is the calendar year during which health coverage is provided by a health plan. All terms used in the MLR Annual Reporting Form instructions will have the same meaning as used in 45 CFR Part 158, the Public Health Service Act (42 U.S.C. Sec. 300g-18), and Health and Safety Code section 1367.003.

(c) If a financial examination pursuant to Health and Safety Code section 1382 and Title 28 California Code of Regulations section 1300.82 is necessary to verify the health plan's representations in the MLR Annual Report, the Department shall give the health plan a 30-day prior notification of the commencement of the financial examination.

(d) The health plan shall have 30 days from the date of notification to electronically submit all requested records, books and papers authorized in Health and Safety Code section 1381(a) to the Department.

(e) The Director may extend the time for a health plan to comply with subsection (d) upon a finding of good cause.

NOTE: Authority Cited: Section 1344, Health and Safety Code. Reference: Sections 1367.003 and 1381, Health and Safety Code.

History:

1. New section filed 10-7-2013; operative 1-1-2014 (Register 2013, No. 41).

§ 1300.67.005. Essential Health Benefits.

(a) All health plans that offer individual and small group contracts subject to Health and Safety Code Section 1367.005 shall comply with the requirements of this section.

(b) In addition to any other requirements set forth in the Knox-Keene Health Care Service Plan Act of 1975 (hereinafter the "Act'), to demonstrate compliance with Health and Safety Code Section 1367.005 and this section, health plans shall electronically file through the Department's Efile application the Essential Health Benefits Filing Worksheet (EHB Filing Worksheet) no later than the date that qualified health plan product filings are required to be submitted, and thereafter as necessary for new or amended plan contracts.

(c) The EHB Filing Worksheet shall include:

(1) The benefits specified in Health and Safety Code Section 1367.005 and the federal Patient Protection and Affordable Care Act (PPACA) at section

1302(b) (42 U.S.C. §18022) and 45 Code of Federal Regulations (CFR) parts 156.100 and 156.115;

(2) Pursuant to Health and Safety Code Section 1367.005(a)(2)(A)(v), any "other health benefits" covered by the base-benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, in the first quarter of 2014, which are not otherwise required to be covered under the Act;

(3) Required benefits for pediatric vision and dental care, for individuals until at least the end of the month in which the enrollee turns 19 years of age, consistent with benefits described in Health and Safety Code Section 1367.005(a)(4) - (5); and

(4) Prescription drug benefits required by Health and Safety Code Section 1367.005(d) and 45 CFR part 156.122, including the plan's prescription drug list and/or formulary. The EHB Filing Worksheet shall include a certification that the plan's drug list meets or exceeds the prescription drug formulary requirements specified in 45 CFR part 156.122, subparagraph (a)(1).

(d) "Other health benefits" are essential health benefits and are required to be covered as follows:

(1) Acupuncture services that are typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.

(2) Nonemergency ambulance and psychiatric transport services inside the service area if:

(A) The plan or plan-contracted physician determines the enrollee's condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide; and

(B) The use of other means of transportation would endanger the enrollee's health.

(C) These services must be covered only when the vehicle transports the enrollee to or from covered services.

(3) Chemical dependency services, which shall be in compliance with federal parity requirements set forth in the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), as follows:

(A) Inpatient detoxification - Hospitalization for medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education, and counseling.

(B) Outpatient evaluation and treatment for chemical dependency:

(i) Day-treatment programs;

(ii) Intensive outpatient programs;

(iii) Individual and group chemical dependency counseling; and

(iv) Medical treatment for withdrawal symptoms.

(C) Transitional residential recovery services - Chemical dependency treatment in a nonmedical transitional residential recovery setting. This setting provides counseling and support services in a structured environment.

(D) Chemical dependency services exclusion - Services in a specialized facility for alcoholism, drug abuse, or drug addiction are not required to be covered except as otherwise specified above.

(4) Special contact lenses to treat aniridia (missing iris) or aphakia,(absence of the crystalline lens of the eye) as follows:

(A) Aniridia: Up to two medically necessary contact lenses per eye (including fitting and dispensing) in any 12-month period, whether provided by the plan during the current or a previous 12-month contract period.

(B) Aphakia: Up to six medically necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year for enrollees, whether

provided by the plan under the current or a previous contract in the same calendar year.

(5) Durable medical equipment for home use.

(A) In addition to durable medical equipment otherwise required to be covered by the Act, the plan shall cover durable medical equipment for use in the enrollee's home (or another location used as the enrollee's home). Durable medical equipment for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

(B) The plan may limit coverage to the standard equipment or supplies that adequately meet the enrollee's medical needs. Coverage includes repair or replacement of covered equipment. The plan may decide whether to rent or purchase the equipment, and may select the vendor. The enrollee may be required to return the equipment to the plan or pay the fair market price of the equipment or any unused supplies when they are no longer medically necessary.

(C) The plan shall cover durable medical equipment for home use, substantially equal to the following:

(i) Standard curved handle or quad cane and replacement supplies

(ii) Standard or forearm crutches and replacement supplies

(iii) Dry pressure pad for a mattress

(iv) IV pole

(v) Enteral pump and supplies

(vi) Bone stimulator

(vii) Cervical traction (over door)

(viii) Phototherapy blankets for treatment of jaundice in newborns

(ix) Dialysis care equipment as follows:

a. The plan shall cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis.

b. The following dialysis care services are not required to be covered:

1. Comfort, convenience, or luxury equipment, supplies and features

2. Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

(6) Mental Health Services in addition to services required under the Act, as follows:

(A) Mental Health Services for Mental Disorders Other than SMI and SED. In addition to the coverage required under Health and Safety Code sections 1374.72 and 1374.73, the plan shall cover any mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV). All coverage of mental health services must comply with federal mental health parity requirements, as set forth in the MHPAEA:

(B) The plan is not required to cover services for conditions the DSM IV identifies as something other than a "mental disorder," such as relational problems (e.g. couples counseling or family counseling).

(C) Outpatient mental health services. The plan shall cover the following services when provided by licensed health care professionals acting within the scope of their license:

(i) Individual and group mental health evaluation and treatment;

(ii) Psychological testing when necessary to evaluate a mental disorder; and

(iii) Outpatient services for the purpose of monitoring drug therapy.

(D) Inpatient psychiatric hospitalization. Coverage shall include room and board, drugs, and services of physicians and other providers who are licensed health care professionals acting within the scope of their license.

(E) Intensive psychiatric treatment programs as follows:

(i) Short-term hospital-based intensive outpatient care (partial hospitalization);

(ii) Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program;

(iii) Short-term treatment in a crisis residential program in a licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis; and

(iv) Psychiatric observation for an acute psychiatric crisis.

(7) Organ Donation Services for actual or potential living donors, in addition to transplant services of organs, tissue, or bone marrow required under the Act, as follows:

(A) Coverage for donation-related services for a living donor, or an individual identified by the plan as a potential donor, whether or not the donor is an enrollee. Services must be directly related to a covered transplant for the enrollee, which shall include services for harvesting the organ, tissue, or bone marrow and for treatment of complications, pursuant to the following guidelines:

(i) Services are directly related to a covered transplant service for an enrollee or are required for evaluating potential donors, harvesting the organ, bone marrow, or stem cells, or treating complications resulting from the evaluation or donation, but not including blood transfusions or blood products.

(ii) Donor receives covered services no later than 90 days following the harvest or evaluation service;

(iii) Donor receives services inside the United States, with the exception that geographic limitations do not apply to treatment of stem cell harvesting;

(iv) Donor receives written authorization for evaluation and harvesting services;

(v) For services to treat complications, the donor either receives non-emergency services after written authorization, or receives emergency services the plan would have covered if the enrollee had received them; and

(vi) In the event the enrollee's plan membership terminates after the donation or harvest, but before the expiration of the 90 day time limit for services to treat complications, the plan shall continue to pay for medically necessary services for donor for 90 days following the harvest or evaluation service.

(B) The plan is not required to cover:

(i) Treatment of donor complications related to a stem cell registry donation;

(ii) HLA blood screening for stem cell donations, for anyone other than the enrollee's siblings, parents, or children;

(iii) Services related to post-harvest monitoring for the sole purpose of research or data collection; or

(iv) Services to treat complications caused by the donor failing to come to a scheduled appointment or leaving a hospital before being discharged by the treating physician.

(8) Ostomy and urological supplies substantially equal to the following:

(A) Ostomy supplies: adhesives; adhesive remover; ostomy belt; hernia belts; catheter; skin wash/cleaner; bedside drainage bag and bottle; urinary leg bags; gauze pads; irrigation faceplate; irrigation sleeve; irrigation bag; irrigation cone/catheter; lubricant; urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; gloves; stoma caps; colostomy plug; ostomy inserts; urinary and ostomy pouches; barriers; pouch closures; ostomy rings; ostomy face plates; skin barrier; skin sealant; and waterproof and non-waterproof tape.

(B) Urological supplies: adhesive catheter skin attachment; catheter insertion trays with and without catheter and bag; male and female external collecting devices; male external catheter with integral collection chamber; irrigation

tubing sets; indwelling catheters; foley catheters; intermittent catheters; cleaners; skin sealants; bedside and leg drainage bags; bedside bag drainage bottle; catheter leg straps; irrigation tray; irrigation syringe; lubricating gel; sterile individual packets; tubing and connectors; catheter clamp or plug; penile clamp; urethral clamp or compression device; waterproof and non-waterproof tape; and catheter anchoring device.

(C) Incontinence supplies for hospice patients: disposable incontinence underpads; adult incontinence garments.

(D) Ostomy and urological supplies required under this section do not include supplies that are comfort, convenience, or luxury equipment or features.

(9) Prosthetic-and orthotic services and devices in addition to those services and devices required to be covered under the Act.

(A) Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services to determine whether the enrollee needs a prosthetic or orthotic device. If the plan covers a replacement device, the enrollee pays the cost sharing the enrollee would pay for obtaining that device.

(B) The plan shall cover the prosthetic and orthotic services and devices substantially equal to the following:

(i) Enteral and Parenteral Nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; and supplies for self-administered injections;

(ii) Up to three brassieres required to hold a breast prosthesis every 12 months;

(iii) Compression burn garments and lymphedema wraps and garments; and

(iv) Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.

(10) Skilled nursing facility services as follows:

(A) For up to 100 days per benefit period (including any days covered under the prior subscriber contract issued by the plan to the enrollee or enrollee's group) of skilled inpatient services in a skilled nursing facility. The skilled inpatient services must be customarily provided by a skilled nursing facility, and above the level of custodial or intermediate care.

(B) A benefit period begins on the date the enrollee is admitted to a hospital or skilled nursing facility at a skilled level of care. A benefit period ends on the date the enrollee has not been an inpatient in a hospital or skilled nursing facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required to commence a benefit period.

(C) The following services are covered as part of the skilled nursing services:

(i) Physician and nursing services;

(ii) Room and board;

(iii) Drugs prescribed by a physician as part of the plan of care in the plan skilled nursing facility in accord with the plan's drug formulary guidelines if they are administered in the skilled nursing facility by medical personnel;

(iv) Durable medical equipment in accord with the plan's durable medical equipment formulary if skilled nursing facilities ordinarily furnish the equipment;

(v) Imaging and laboratory services that skilled nursing facilities ordinarily provide;

(vi) Medical social services;

(vii) Blood, blood products, and their administration;

(viii) Medical supplies;

(ix) Behavioral health treatment for pervasive developmental disorder or autism; and

(x) Respiratory therapy.

(11) Procedures for the prenatal diagnosis of fetal genetic disorders including tests for specific genetic disorders for which genetic counseling is available.

(12) Rehabilitative/habilitative health care services and devices.

(A) Coverage shall be in accordance with subdivisions (a)(3) and (p)(1) of section 1367.005, and as follows:

(i) Individual and group outpatient physical, occupational, and speech therapy related to pervasive developmental disorder or autism;

(ii) All other individual and group outpatient physical, occupational, and speech therapy;

(iii) Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation daytreatment program, a skilled nursing facility; and in an inpatient hospital (including treatment in an organized multidisciplinary rehabilitation program).

(B) The plan shall include in its Evidence of Coverage and Schedule of Benefits a disclaimer that limits for rehabilitative and habilitative service shall not be combined.

(13) Coverage in connection with a clinical trial in accordance with section 1370.6, and as follows:

(A) The plan would have covered the services if they were not related to a clinical trial.

(B) The enrollee is eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:

(i) a plan provider makes this determination;

(ii) the enrollee provides the plan with medical and scientific information establishing this determination;

(C) If any plan providers participate in the clinical trial and will accept the enrollee as a participant in the clinical trial, the enrollee must participate in the clinical trial through a plan provider unless the clinical trial is outside the state where the enrollee lives; or

(D) The clinical trial is an approved clinical trial, meaning it is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:

(i) The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;

(ii) The study or investigation is a drug trial that is exempt from having an investigational new drug application, or

(iii) The study or investigation is approved or funded by at least one of the following:

(I) The National Institutes of Health;

(II) The Centers for Disease Control and Prevention;

(III) The Agency for Health Care Research and Quality;

(IV) The Centers for Medicare & Medicaid Services;

(V) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

(e) In the event the list of "other health benefits" in subdivision (d) omits benefits otherwise required pursuant to Health and Safety Code Section 1367.005, the provisions of Health and Safety Code Section 1367.005 shall control.

(f) If a stand-alone dental plan described in the PPACA at section 1311(d)(2)(B)(ii) (42 U.S.C. §18031(d)(2)(B)(ii)) is offered on the California Health Benefit Exchange (Exchange), then, pursuant to the PPACA section 1302(b)((4)(F) (42 U.S.C. §18022(b)(4)(F)), health plan contracts offered in the Exchange may, but are not required to, omit coverage of pediatric dental care benefits described in Health and Safety Code Section 1367.005(a)(5). A health plan shall not omit coverage of the pediatric dental EHB for health plan contracts sold outside the Exchange.

(g) The worksheet shall be in the following form:

CALIFORNIA ESSENTIAL HEALTH BENEFITS FILING WORKSHEET

For Individual Plan Subscriber Contracts and Evidence of Coverage ("EOC"), Small Group Plan EOCs, or Combined Individual or Small Group EOC/Disclosure Forms ("DF")

This EHB Worksheet requires plans to record how their coverage, as disclosed in EOCs, Subscriber Contracts, and DFs, complies with EHB requirements set forth in Health and Safety Code section 1367.005. The alignment of certain provisions of the Act with federal EHB categories is not meant to be legally definitive, but is offered as a way to organize required benefits as plans frequently organize them within their EOCs. Note that some benefits may be listed under multiple federal EHB categories because benefits and categories overlap in many plan EOCs. The plans must utilize the boxes in the third column to identify where the required EHB is located in plan documents and supply the necessary information to describe the benefit. For the purposes of the EHB Worksheet, "Section" refers to a provision of the Health and Safety Code and "Rule" refers to a section of Title 28 of the California Code of Regulations.

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
#1: Ambulatory Patient Services	Section 1345(b)(2) Rule 1300.67(b-c) **Ambulatory Care Services** Section 1345(b)(1) Rule 1300.67(a) **Outpatient Physician Services** Section 1345(b)(4) Rule 1300.67(e) Section 1367.005(a)(2)(C) **Home Health Services** Section 1345(b)(2) Rule 1300.67(c) **Outpatient Physical, Occupational, and Speech Therapy** Section 1370.6 **Cancer Clinical Trials** Benchmark Plan EHB Rule 1300.67.005(d)(13) **Other Clinical Trials** Section 1373(b) **Sterilization Services** Benchmark Plan EHB Rule 1300.67.005(d)(1) **Acupuncture Services** Benchmark Plan EHB Rule 1300.67.005(d)(8) **Ostomy, Urinary Supplies**	
#2: Emergency Services	Section 1345(b)(6) Rule 1300.67(g)(1) **Emergency Services**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
	Section 1371.5 Rule 1300.67(g)(1) **Emergency Response Ambulance Services**	
	Section 1345(b)(6) Rule 1300.67(g)(2) **Out of Area Coverage and Urgently Needed Services**	
#3: Hospitalization	Section 1345(b)(2) Rule 1300.67(b-c) **Inpatient Hospital Services**	
	Section 1345(b)(7) Section 1368.2 Rule 1300.67(h) **Hospice Services**	
	Section 1367.635 **Mastectomies and Lymph Node Dissections**	
	Section 1367.63 **Reconstructive Surgery**	
	Section 1367.6 **Breast Cancer Coverage, Including Surgery**	
	Section 1367.68 **Jawbone Surgery**	
	Section 1367.71 **Dental Anesthesia**	
	Section 1373(b) **Sterilization Services**	
	Section 1374.17 **Organ Transplant Services for HIV**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
	Benchmark Plan EHB Rule 1300.67.005(d)(2) **Ambulance and Psychiatric Transport Services—Nonemergency**	
	Benchmark Plan EHB Rule 1300.67.005(d)(7) **Organ Donation Services**	
	Benchmark Plan EHB Rule 1300.67.005(d)(10) **Skilled Nursing Facility Services**	
#4: Maternity and Newborn Care	Section 1345(b)(1-2) Rule 1300.67(a-b) **Inpatient Maternity Care**	
	Section 1345(b)(5) Rule 1300.67(f)(3) **Prenatal Care**	
	Rule 1300.67(g)(2) **Urgently Needed Services, Including Maternity Services**	
	Section 1367.62 **Maternity Hospital Stay**	
	Section 1367.54 **Alpha-Fetoprotein Testing**	
	Section 1373.4 **Inpatient Hospital and Ambulatory Maternity Services**	
	45 CFR 147.130 HRSA Guidelines for Women's Preventive Services **Breastfeeding Support, Supplies, Counseling**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
	Benchmark Plan EHB Section 1367.7 Rule 1300.67.005(d)(11): **Prenatal Diagnosis of Genetic Disorders of the Fetus**	
5: Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment	Section 1345(b)(1) Rule 1300.67(a) Section 1374.72 Section 1367.005(a)(2)(D) **Mental Health Services**	
	Section 1374.73 Section 1367.005(a)(2)(D) Benchmark Plan EHB Rule 1300.67.005(d)(12)(A) **Behavioral Health Treatment ("BHT") for PDD or Autism**	
	Benchmark Plan EHB Section 1367.005(a)(2)(D) Rule 1300.67.005(d)(6) **Mental Health Services for Mental Disorders Other than SMI and SED**	
	Section 1367.005(a)(2)(D) Benchmark Plan EHB: Rule 1300.67.005(d)(3) **Chemical Dependency Services**	
#6: Prescription Drugs	Section 1367.25 **Coverage for Contraceptive Methods**	
	Section 1367.45 **Coverage for Approved AIDS Vaccine**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
	Section 1370.6 **Cancer Clinical Trials**	
	EHB Benchmark Plan Rule 1300.67.005(d)(13) **Other Clinical Trials**	
	Section 1367.21 **Off Label Drug Use**	
	Section 1367.002 Section 1367.06 **Pediatric Asthma Services**	
	Section 1374.56 **Phenylketonuria Services**	
	Section 1367.215 **Pain Management Medication for Terminally Ill**	
	Section 1367.22 **Coverage for Previously Approved Prescription**	
	Section 1367.24 **Prescription Authorization Process for Non Formulary Drugs**	
	Rule 1300.67.24 **Outpatient Prescription Drug Coverage, Limitations and Exclusions**	
#7: Rehabilitative and Habilitative Services and Devices	Section 1345(b)(2) Rule 1300.67(c) Benchmark Plan EHB Rule 1300.67.005(d)(12) **Outpatient Physical, Occupational, and Speech Therapy**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
	Section 1374.73 Section 1367.005(a)(3) Benchmark Plan EHB Rule 1300.67.005(d)(12)(A) **Behavioral Health Treatment ("BHT") for PDD or Autism**	
	Section 1345(b)(4) Rule 1300.67(e) Section 1367.005(a)(2)(C) **Home Health Services**	
	Section 1367.61 **Prosthetics for Laryngectomy**	
	Section 1367.18 **Orthotic and Prosthetic Devices and Services**	
	Section 1367.6 Section 1367.635 **Prosthetic Devices Incident to Mastectomy**	
	Benchmark Plan EHB Rule 1300.67.005(d)(4) **Contact Lenses to Treat Aniridia and Aphakia**	
	Benchmark Plan EHB Rule 1300.67.005(d)(5) **Additional Durable Medical Equipment Required to be Covered**	
	Benchmark Plan EHB Rule 1300.67.005(d)(9) **Additional Prosthetic-Orthotics Devices Required to be Covered**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
#8: Laboratory Services	Section 1345(b)(3) Rule 1300.67(d) **Diagnostic Laboratory and Therapeutic Radiologic Services** Section 1367.65 **Mammography Services** Section 1367.46 Rule 1300.67.24 **Coverage for HIV Testing** Section 1367.54 **Alpha-Fetoprotein Testing** Section 1367.6 **Breast Cancer Screening** Section 1367.64 **Prostate Cancer Screening** Section 1367.66 **Cervical Cancer Screening** Section 1367.665 **Cancer Screening Tests** Section 1367.67 **Osteoporosis Services** Section 1367.9 **Diethylstilbestrol Services** Benchmark Plan EHB Section 1367.7 Rule 1300.67.005(d)(11): **Prenatal Diagnosis of Genetic Disorders of the Fetus**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
#9: Preventive and Wellness Services and Chronic Disease Management	Section 1345(b)(5) Rule 1300.67(f) Section 1367.002 45 CFR 147.130 75 Fed Reg 41726, 41728 HRSA Guidelines for Women's Preventive Services **Preventive Health Services** Section 1367.06 **Pediatric Asthma Services** Section 1367.35 **Comprehensive Pediatric Preventive Services** Section 1367.6 **Breast Cancer Screening** Section 1367.64 **Prostate Cancer Screening** Section 1367.665 **General Cancer Screening** Section 1367.66 **Cervical Cancer Screening** Section 1367.51 **Diabetes Equipment and Supply Services** Section 1367.65 **Mammography Services** Section 1367.46 Rule 1300.67.24 **Coverage for HIV Testing** Section 1367.67 **Osteoporosis Services** Section 1367.9 **Diethylstilbestrol Services**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
#10: Pediatric Services, Including Oral and Vision Care	Section 1367.005(a)(5) Benefits for pediatric oral care covered under the dental benefit received by children under the Medi-Cal program as of 2014, pursuant to the Medi-Cal Dental Program Provider Handbook in effect during the first quarter of 2014, including coverage pursuant to the Early Periodic Screening, Diagnosis, and Treatment benefit pursuant to 42 U.S.C. Section 1396d(r), and provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. **Oral Care** Section 1367.005(a)(4) BCBS Association, 2014 FEP BlueVision — High Option, including but not limited to low vision benefits. **Vision Care** Section 1345(b)(5) Rule 1300.67(f)(4) **Pediatric Vision and Hearing Services** Section 1345(b)(5) Rule 1300.67(f)(5) **Pediatric Immunization Services** Section 1367.002 Section 1367.06 **Pediatric Asthma Services**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
	Section 1367.002 Section 1367.35 **Comprehensive Pediatric Preventive Services**	

PRESCRIPTION DRUG BENEFITS

Directions for Plan Completion of Prescription Drug EHB-Benchmark Plan Benefits Chart

To demonstrate compliance with the prescription drug essential health benefits required under the PPACA at section 1302(b) (42 U.S.C. §18022) and at 45 CFR §156.122, please complete the form below indicating the number of prescription drugs offered by the Plan in each class and category of prescription drugs listed below. Plans must make whatever modifications are necessary to their current formularies so that the number of prescription drugs they cover equal or exceed the number listed in the "EHB Submission Count" column. Please attach the Plan's prescription drug list and/or formulary to this worksheet.

The plan must demonstrate it provides at least the greater of one (1) drug per category and class or the same number of drugs provided by the base-benchmark plan as indicated in the EHB Submission Count column, pursuant to 45 Code of Federal Regulations part 156.122, subparagraph (a). (78 Fed. Reg. 12834, 12867, February 25, 2013.)

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	10	
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	3	
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	7	
ANESTHETICS	LOCAL ANESTHETICS	2	
ANTI-ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3	

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
ANTI-ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID DEPENDENCE TREATMENTS	1	
ANTI-ADDICITION/ SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID REVERSAL AGENTS	1	
ANTI-ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	0	
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	20	
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	9	
ANTIBACTERIALS	AMINOGLYCOSIDES	5	
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	14	
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	7	
ANTIBACTERIALS	BETA-LACTAM, OTHER	2	
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5	
ANTIBACTERIALS	MACROLIDES	3	
ANTIBACTERIALS	QUINOLONES	6	
ANTIBACTERIALS	SULFONAMIDES	4	
ANTIBACTERIALS	TETRACYCLINES	4	
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	3	
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	2	
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	3	
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3	
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	4	
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1	
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	2	
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1	
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	6	
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	2	
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9	
ANTIDEPRESSANTS	TRICYCLICS	9	
ANTIEMETICS	ANTIEMETICS, OTHER	9	
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	3	
ANTIFUNGALS	NO USP CLASS	9	
ANTIGOUT AGENTS	NO USP CLASS	5	
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2	
ANTIMIGRAINE AGENTS	PROPHYLACTIC	2	
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	3	

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3	
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2	
ANTIMYCOBACTERIALS	ANTITUBERCULARS	8	
ANTINEOPLASTICS	ALKYLATING AGENTS	4	
ANTINEOPLASTICS	ANTIANDROGENS	3	
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	3	
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	2	
ANTINEOPLASTICS	ANTIMETABOLITES	5	
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	4	
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3	
ANTINEOPLASTICS	ENZYME INHIBITORS	3	
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	13	
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0	
ANTINEOPLASTICS	RETINOIDS	2	
ANTIPARASITICS	ANTHELMINTICS	3	
ANTIPARASITICS	ANTIPROTOZOALS	10	
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	2	
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3	
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	2	
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4	
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2	
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	2	
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10	
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	5	
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1	
ANTISPASTICITY AGENTS	NO USP CLASS	3	
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	1	
ANTIVIRALS	ANTI-HEPATITIS B (HBV) AGENTS	5	
ANTIVIRALS	ANTI-HEPATITIS C (HBC) AGENTS	7	
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5	
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	12	
ANTIVIRALS	ANTI-HIV AGENTS, INTEGRASE INHIBITORS	2	
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3	
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9	
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4	
ANTIVIRALS	ANTIHERPETIC AGENTS	3	

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
ANXIOLYTICS	ANXIOLYTICS, OTHER	3	
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5	
ANXIOLYTICS	BENZODIASEPINES	0	
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6	
BIPOLAR AGENTS	MOOD STABILIZERS	5	
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	7	
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	1	
BLOOD GLUCOSE REGULATORS	INSULINS	6	
BLOOD PRODUCTS/ MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	3	
BLOOD PRODUCTS/ MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	4	
BLOOD PRODUCTS/ MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0	
BLOOD PRODUCTS/ MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	6	
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4	
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4	
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	1	
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	3	
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	9	
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	7	
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	5	
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	2	
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2	
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	3	
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	2	
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	4	
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2	
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	4	

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	3	
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	2	
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3	
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	3	
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	1	
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	2	
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	1	
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	3	
DENTAL AND ORAL AGENTS	NO USP CLASS	6	
DERMATOLOGICAL AGENTS	NO USP CLASS	50	
ENZYME REPLACEMENT/ MODIFIERS	NO USP CLASS	2	
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	2	
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6	
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	3	
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	1	
GASTROINTESTINAL AGENTS	LAXATIVES	1	
GASTROINTESTINAL AGENTS	PROTECTANTS	2	
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	2	
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	2	
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	5	
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	4	
GENITOURINARY AGENTS	PHOSPHATE BINDERS	2	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (ADRENAL)	NO USP CLASS	23	

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)	NO USP CLASS	4	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	1	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	2	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTERONE AGONISTS/ ANTAGONISTS	0	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	5	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (THYROID)	NO USP CLASS	2	
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1	
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	2	

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	5	
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	3	
IMMUNOLOGICAL AGENTS	ANDIOEDEMA (HAE) AGENTS	1	
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	14	
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0	
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	11	
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	2	
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5	
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1	
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	6	
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	2	
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	14	
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	2	
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	6	
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	12	
OTIC AGENTS	NO USP CLASS	5	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	5	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	ANTIHISTAMINES	5	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	ANTILEUKOTRIENES	1	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	PHOSPHDIESTERASE INHIBITORS, AIRWAYS DISEASE	3	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	5	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	CYCSTIC FIBROSIS AGENTS	3	

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	MAST CELL STABILIZERS	1	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	PULMONARY ANTIHYPERTENSIVES	5	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	RESPIRATORY TRACT AGENTS, OTHER	1	
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	2	
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	1	
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	1	
THERAPEUTIC NUTRIENTS/MINERALS/ ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	4	
THERAPEUTIC NUTRIENTS/MINERALS/ ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	3	
THERAPEUTIC NUTRIENTS/MINERALS/ ELECTROLYTES	VITAMINS	0	

NOTE: Authority cited: Sections 1341, 1344, 1346 and 1367.005, Health and Safety Code. Reference: Section 1367.005, Health and Safety Code.

HISTORY:

1. New section filed 7-5-2013 as an emergency; operative 7-5-2013 (Register 2013, No. 27). A Certificate of Compliance must be transmitted to OAL by 1-2-2014 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 12-16-2013 as an emergency, including amendment of subsection (c)(4) and subsection (g) — worksheet; operative 1-2-2014 (Register 2013, No. 51). A Certificate of Compliance must be transmitted to OAL by 4-2-2014 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction restoring inadvertently deleted portions of Filing Worksheet (Register 2014, No. 16).
4. Certificate of Compliance as to 12-16-2013 order transmitted to OAL 3-4-2014 and filed 4-14-2014 (Register 2014, No. 16).
5. Amendment filed 11-28-2016 as an emergency; operative 11-28-2016 (Register 2016, No. 49). A Certificate of Compliance must be transmitted to OAL by 5-30-2017 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 11-28-2016 order transmitted to OAL 5-16-2017 and filed 6-27-2017 (Register 2017, No. 26).

§ 1300.67.04. Language Assistance Programs.

(a) Application.

(1) Every health care service plan, including specialized health care service plans (plans), shall comply with the requirements of this section. The requirements of this section shall not apply to plan contracts for the provision of services to Medi-Cal enrollees or to contracts between plans and the federal government for the provision of services to Medicare enrollees.

(2) If a plan has both Medi-Cal and non-Medi-Cal lines of business, then the plan will be in compliance with the requirements of this section as to its non-Medi-Cal lines of business if:

(A) The Medi-Cal standards for providing language assistance services, including standards for timeliness and proficiency of interpreters, are equivalent to or exceed the standards set forth in Section 1367.04 of the Act and this section;

(B) The plan applies the Medi-Cal standards for language assistance programs to the plan's non-Medi-Cal lines of business; and

(C) The Department of Managed Health Care (Department) determines, as described in Section 1367.04(h)(3) of the Act, that the plan is in compliance with the Medi-Cal standards.

(3) A plan that seeks the Department's determination of compliance as provided in subsection (a)(2) shall request such determination as part of its filing pursuant to subsection (e)(2) and provide documentation sufficient to support and verify the request to the Department's satisfaction. The Department's determination pursuant to subsection (a)(2) shall apply only to the enrollees in a plan's non-Medi-Cal lines of business to which the plan actually applies the plan's Medi-Cal program standards.

(b) Definitions.

(1) Demographic profile means, at a minimum, identification of an enrollee's preferred spoken and written language, race and ethnicity.

(2) Interpretation: the act of listening to something spoken or reading something written in one language (source language) and orally expressing it accurately and with appropriate cultural relevance into another language (target language).

(3) Limited English Proficient or LEP Enrollee: an enrollee who has an inability or a limited ability to speak, read, write, or understand the English language at a level that permits that individual to interact effectively with health care providers or plan employees.

(4) Point of Contact: an instance in which an enrollee accesses the services covered under the plan contract, including administrative and clinical services, and telephonic and in-person contacts.

(5) Threshold Language(s): the language(s) identified by a plan pursuant to Section 1367.04(b)(1)(A) of the Act.

(6) Translation: replacement of a written text from one language (source language) with an equivalent written text in another language (target language).

(7) Vital Documents: the following documents, when produced by the plan (plan-produced documents) including when the production or distribution is delegated by a plan to a contracting health care service provider or administrative services provider:

(A) Applications;

(B) Consent forms, including any form by which an enrollee authorizes or consents to any action by the plan;

(C) Letters containing important information regarding eligibility and participation criteria;

(D) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal;

(E) Notices advising LEP enrollees of the availability of free language assistance and other outreach materials that are provided to enrollees;

(F) A plan's explanation of benefits or similar claim processing information that is sent to an enrollee if the document requires a response from the enrollee; and

(G) Subject to subsection (c)(2)(F)(ii), the enrollee disclosures required by Section 1363(a)(1), (2) and (4) of the Act.

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(1) Enrollee Assessment. Every health care service plan and specialized health care service plan shall assess its enrollee population to develop a demographic profile and to survey the linguistic needs of individual enrollees. In assessing its enrollee population each plan shall, at a minimum:

(A) Develop a demographic profile of the plan's enrollee population for the purposes of calculating threshold languages and reporting to the Department pursuant to Section 1367.07 of the Act. All plans shall apply statistically valid methods for population analysis in developing the demographic profile and plans may utilize a variety of methods for collecting demographic data for this purpose, including census data, client utilization data from third parties, data from community agencies and third party enrollment processes;

(B) Survey its enrollees in a manner designed to identify the linguistic needs of each of the plan's enrollees, and record the information provided by a responding enrollee in the enrollee's file. Plans may utilize existing processes and methods to distribute the linguistic needs survey, including but not limited to, existing enrollment and renewal processes, subscriber newsletters, mailings and other communication processes. A plan may demonstrate compliance with the survey requirement by distributing to all subscribers, including all individual subscribers under group contracts, a disclosure explaining, in English and in the plan's threshold languages, the availability of free language assistance services and how to inform the plan and relevant providers regarding the preferred spoken and written languages of the subscriber and other enrollees under the subscriber contract; and

(C) Collect, summarize and document enrollee demographic profile data in a manner that enables the plan to maintain confidentiality of personal information and to disclose the information to the Department on request for regulatory purposes and to contracting providers on request for lawful purposes, including language assistance purposes and health care quality improvement purposes. This section is not intended to limit or expand existing law regarding confidentiality of medical records.

(2) Providing Language Assistance Services. Every plan shall develop language assistance program policies and procedures, which shall describe, at a minimum, the information outlined below.

(A) All points of contact where the need for language assistance may be reasonably anticipated.

(B) The types of resources needed to provide effective language assistance to the plan's enrollees.

(C) The plan's processes for informing enrollees of the availability of language assistance services at no charge to enrollees, and how to access language assistance services. At a minimum, these processes shall include the following:

(i) Processes to promote effective identification of LEP enrollee language assistance needs at points of contact, to ensure that LEP enrollees are informed at points of contact that interpretation services are available at no cost to the

LEP enrollee, and to facilitate individual enrollee access to interpretation services at points of contact.

(ii) Processes for including the notice required by Section 1367.04(b)(1)(B)(i) with all vital documents, all enrollment materials and all correspondence, if any, from the plan confirming a new or renewed enrollment. If documents are distributed in an LEP enrollee's preferred written language the notice need not be included.

(iii) Processes for including statements, in English and in threshold languages, about the availability of free language assistance services and how to access them, in or with brochures, newsletters, outreach and marketing materials and other materials that are routinely disseminated to the plan's enrollees.

(D) Processes to ensure the plan's language assistance program conforms with the requirements of section 1300.68(b)(3) and (7) of these regulations, including standards to ensure that LEP enrollees receive information regarding their rights to file a grievance and seek an independent medical review in threshold languages and through oral interpretation.

(i) All plans shall ensure that grievance forms and procedures in threshold languages are made readily available to enrollees and to contracting providers for distribution to enrollees upon request.

(ii) All plans shall inform contracting providers that informational notices explaining how enrollees may contact their plan, file a complaint with their plan, obtain assistance from the Department and seek an independent medical review are available in non-English languages through the Department's web site. The notice and translations can be obtained online at www.hmohelp.ca.gov for downloading and printing. In addition, hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.

(E) Processes to ensure that contracting providers are informed regarding the plan's standards and mechanisms for providing language assistance services at no charge to enrollees, and to ensure that LEP language needs information collected by the plan is made available to contracting providers.

(F) Processes and standards for providing translation services, including, but not limited to:

(i) A list of the threshold languages identified by the plan;

(ii) A list of the types of standardized and enrollee-specific vital documents that must be translated and the applicable standards for making translated vital documents available to subscribers and enrollees. Plans need not translate subscriber contracts, evidences of coverage and other large disclosure forms and enrollee handbooks in their entirety, but may excerpt from large documents the disclosures specified at subsection (b)(7)(G) for translation in a format that permits cost-effective and timely production and distribution, so long as there is no loss of accuracy or meaning by doing so. A plan may demonstrate compliance regarding translation of the disclosures specified at subsection (b)(7)(G) if the plan provides a standardized matrix that lists the major categories of health care services covered under the plan's subscriber contracts, together with the corresponding copayments and coinsurance, and exclusions and limitations, and disclosing any applicable deductibles and lifetime maximums, using the same sequence as the uniform matrix described at Section 1363(b)(1) of the Act.

(iii) A description of how the plan will provide or arrange for the provision of translation of vital documents at no charge to enrollees in accordance with the requirements of Section 1367.04 of the Act and this section. This subsection is not intended to prohibit or discourage a plan from providing translation of vital documents into a greater number of languages than the threshold languages;

(iv) A requirement that non-English translations of vital documents must meet the same standards required for English language versions of those documents; and

(v) A requirement that, with respect to vital documents that are not standardized, but which contain enrollee-specific information, a plan shall provide the English version together with the Department-approved written notice of the availability of interpretation and translation services and, if a translation is requested, the plan shall provide the requested translation in accordance with the requirements of Section 1367.04 of the Act and this section.

(G) Processes and standards for providing individual enrollee access to interpretation services at points of contact at no charge, including, but not limited to:

(i) A list of the non-English languages likely to be encountered among the plan's enrollees.

(ii) A requirement that the plan shall provide LEP enrollees with interpretation services for information contained in plan-produced documents.

(iii) A requirement that qualified interpretation services be offered to LEP enrollees, at no cost to the enrollee, at all points of contact, including when an enrollee is accompanied by a family member or friend that can provide interpretation services. The offer of a qualified interpreter, and the enrollee's refusal if interpretation services are declined, shall be documented in the medical record or plan file, as applicable.

(iv) When an enrollee needs interpretation services at a point of contact that occurs in a hospital, facility or provider office subject to federal or state law that requires the hospital, facility or provider office to provide interpretation services, the plan is not relieved of its obligation to comply with the requirements of Section 1367.04 of the Act or this section. Full service plans shall have reasonable processes in place to ensure that LEP enrollees can obtain the plan's assistance in arranging for the provision of timely interpretation services at all points of contact as defined at subsection (b)(4). This subsection does not prohibit a plan from incorporating into its language assistance program a contracting hospital's language assistance program if: the hospital's language assistance program provides access to interpretation services consistent with the requirements of Section 1367.04 of the Act and this section; the plan monitors for deficiencies in delivery of interpretation services by the hospital; and the plan takes appropriate corrective action to address hospital deficiencies in delivery of interpretation services to the plan's enrollees. This subsection is not intended to limit or expand any existing state or federal law.

(v) A description of the arrangements the plan will make to provide or arrange for the provision of timely interpretation services at no charge to LEP enrollees at all points of contact where language assistance is needed. For purposes of this subsection "timely" means in a manner appropriate for the situation in which language assistance is needed. Interpretation services are not timely if delay results in the effective denial of the service, benefit, or right at issue. A plan's language assistance program shall specify quality assurance standards for timely delivery of language assistance services for emergency, urgent and routine health care services, and shall include standards for coordinating interpretation services with appointment scheduling.

(vi) The range of interpretation services that will be provided to enrollees as appropriate for the particular point of contact. The range of services may include, but is not limited to:

(aa) Arranging for the availability of bilingual plan or provider staff who are trained and competent in the skill of interpreting;

(bb) Hiring staff interpreters who are trained and competent in the skill of interpreting;

(cc) Contracting with an outside interpreter service for trained and competent interpreters;

(dd) Arranging formally for the services of voluntary community interpreters who are trained and competent in the skill of interpreting; and

(ee) Contracting for telephone, videoconferencing or other telecommunications supported language interpretation services.

(vii) As used in this section, "trained and competent in the skill of interpreting," "qualified interpretation services" and "qualified interpreter" means that the interpreter meets the plan's proficiency standards established pursuant to subsection (c)(2)((H).

(H) The plan's policies and standards for ensuring the proficiency of the individuals providing translation and interpretation services.A plan may develop and apply appropriate criteria for ensuring the proficiency of translation and interpretation services or may adopt certification by an association acceptable to the Department at the time of certification. A plan's language assistance proficiency standards shall require:

(i) A documented and demonstrated proficiency in both English and the other language;

(ii) A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems; and

(iii) Education and training in interpreting ethics, conduct and confidentiality. The Department will accept plan standards for interpreter ethics, conduct, and confidentiality that adopt and apply, in full, the standards promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare.

(3) Staff training.

Every plan shall implement a system to provide adequate training regarding the plan's language assistance program to all plan staff who have routine contact with LEP enrollees. The training shall include instruction on:

(A) Knowledge of the plan's policies and procedures for language assistance;

(B) Working effectively with LEP enrollees;

(C) Working effectively with interpreters in person and through video, telephone and other media, as may be applicable; and

(D) Understanding the cultural diversity of the plan's enrollee population and sensitivity to cultural differences relevant to delivery of health care interpretation services.

(4) Compliance Monitoring.

(A) Every plan shall monitor its language assistance program, including delegated programs, and make modifications as necessary to ensure compliance with Section 1367.04 of the Act and this section.

(d) In reviewing a plan's proposed language assistance program, the Department will evaluate the totality of the plan's language assistance program to determine whether the program as a whole provides meaningful access for LEP enrollees, and may consider relevant operational and demographic factors, including but not limited to:

(1) Whether the plan is a full service plan or specialized health care service plan;

(2) The nature of the points of contact;

(3) The frequency with which particular languages are encountered;

(4) The type of provider network and methods of health care service delivery;

(5) The variations and character of a plan's service area;

(6) The availability of translation and interpretation services and professionals;

(7) The variations in cost of language assistance services and the impact on affordability of health care coverage; and

(8) A plan's implementation of best practices and utilization of existing and emerging technologies to increase access to language assistance services, such as video interpreting programs, language translation software, collaborating with other plans to share a pool of interpreters, and other methods and technologies.

(9) Specialized dental, vision, chiropractic, acupuncture and employee assistance program plans that demonstrate adequate availability and accessibility of qualified bilingual contracted providers and office staff to provide meaningful access to LEP enrollees, will be in compliance with the requirements of subsection (c)(2)(G)(iii) and (v). For the purposes of this subsection, specialized dental, vision, chiropractic, acupuncture and employee assistance program plans may demonstrate adequate availability and accessibility of competent and qualified bilingual providers and office staff if:

(A) The plan identifies within its provider directories those contracting providers who are themselves bilingual or who employ other bilingual providers and/or office staff, based on language capability disclosure forms signed by the bilingual providers and/or office staff, attesting to their fluency in languages other than English;

(B) The plan requires all contracting providers to provide quarterly updates regarding any changes in the language capabilities of currently employed providers and/or office staff by submitting new language capability disclosure forms, and the plan updates its provider directories accordingly, and consistent with Section 1367.26 of the Act; and

(C) The plan's quality assurance audits of contracting providers confirm and document the accuracy of provider language capability disclosure forms and attestations.

(e) Implementation.

(1) Within one year of the effective date of this section, every plan shall complete the initial enrollee assessment required by Section 1367.04 of the Act and this section. Every plan shall update its assessment of enrollee language needs and enrollee demographic profile at least once every three years following the initial assessment.

(2) By July 1, 2008, every plan shall file, in accordance with Section 1352 of the Act, an amendment to its quality assurance program providing its written language assistance program policies and procedures, together with information and documents sufficient to demonstrate compliance with the requirements and standards of Section 1367.04 of the Act and this section. The filing shall include the plan's Section 1367.04(b)(1)(B)(v) notices. All materials filed with the Department that contain documents in non-English languages shall include the following minimum supporting documentation:

(i) The English version of each non-English document

(ii) An attestation by the translator or, if applicable, by an authorized officer of the organization providing translator services, outlining the qualifications of the translator making the translation and affirming that the non-English translation is an accurate translation of the English version.

(3) By January 1, 2009 every plan shall have established and implemented a language assistance program in compliance with the requirements of Section 1367.04 of the Act and this section.

(4) Every contract between a health care provider and a plan, including a specialized plan, that is issued, amended, delivered or renewed on or after January 1, 2009, shall require compliance with the plan's language assistance

program standards developed pursuant to Section 1367.04 of the Act and this section.

(A) A plan shall retain financial responsibility for the implementation of the language assistance program required by Section 1367.04 of the Act and this section, except to the extent that delegated financial responsibility has been separately negotiated and specifically documented in written contracts. This subsection does not create an exception to Section 1367 of the Act and delegation shall not constitute a waiver of the plan's obligation to provide language assistance services required by Section 1367.04 of the Act and this section.

(B) Delegation to contracting providers of any part of the plan's obligation to provide language assistance services required by Section 1367.04 of the Act and this section constitutes a material change to a provider contract subject to the requirements of Section 1375.7 of the Act.

(f) The Department will periodically review plan compliance with the standards and requirements of Section 1367.04 of the Act and this section by methods that may include, but are not limited to, the medical survey process, reviews of consumer grievances and complaints to the Department's HMO Help Center, and provider complaints submitted to the Department's provider complaint line. The Department may also periodically request that plans submit information and data regarding enrollee language needs and demographic profile.

NOTE: Authority cited: Sections 1344 and 1367.04, Health and Safety Code. Reference: Sections 1259, 1342, 1363, 1365.5, 1367, 1367.04, 1367.07, 1368, 1368.01, 1370 and 1375.7, Health and Safety Code.

History:

1. New section filed 1-24-2007; operative 2-23-2007 (Register 2007, No. 4).

§ 1300.67.05. Acts of War Exclusions.

(a) No health care service plan contract executed or amended on or after the effective date of this regulation shall limit or exclude health care services based on a determination that the need for the health care service arose as a result of an Act of War.

(1) The term "contract" includes but is not limited to health care service plan contracts with subscribers and health care service providers.

(2) The term "Act of War" includes any act or conduct, or the prevention of an act or conduct, resulting from war, declared or undeclared, terrorism, or warlike action by any individual, government, military, sovereign group, terrorist or other organization.

(b) This regulation does not preclude a health plan from coordinating coverage of benefits with other entities.

(c) Nothing in this section shall prevent the Director from finding any exclusion or limitation of health care service or other services covered by the contract objectionable on grounds other than those set forth herein.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345 and 1367, Health and Safety Code.

History:

1. New section filed 2-14-2002 as an emergency; operative 2-14-2002 (Register 2002, No. 7). A Certificate of Compliance must be transmitted to OAL by 6-14-2002 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2-14-2002 order, including amendment of subsection (a), transmitted to OAL 6-6-2002 and filed 7-17-2002 (Register 2002, No. 29).
3. Editorial correction of subsection (a) (Register 2002, No. 35).

§ 1300.67.1. Continuity of Care.

Within each service area of a plan, basic health care services shall be provided in a manner which provides continuity of care, including but not limited to:

(a) The availability of primary care physicians, who will be responsible for coordinating the provision of health care services to each enrollee;

(b) The encouragement of each enrollee to select a primary physician;

(c) The maintenance and ready availability of medical records, with sharing within the plan of all pertinent information relating to the health care of each enrollee;

(d) The maintenance of staff, including health professionals, administrative and other supporting staff, directly or through an adequate referral system, sufficient to assure that health care services will be provided on a timely and appropriate basis to enrollees;

(e) An adequate system of documentation of referrals to physicians or other health professionals. The monitoring of the follow up of enrollees' health care documentation shall be the responsibility of the health care service plan and associated health professionals.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367, Health and Safety Code.

History:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.67.1.3. Block Transfer Filings.

(a) Definitions. As used in this section:

(1) "Affected Enrollee" means enrollees of the plan who are assigned to a Terminated Provider Group or a Terminated Hospital.

(2) "Alternate Hospital" means a hospital that will provide services to plan enrollees in place of a Terminated Hospital.

(3) "Block Transfer" means a transfer or redirection of two thousand (2,000) or more enrollees by a plan from a Terminated Provider Group or Terminated Hospital to one or more contracting providers that takes place as a result of the termination or non-renewal of a Provider Contract.

(4) "Enrollee Transfer Notice" means a written notice that is sent to enrollees who are assigned to a Terminated Provider group or Terminated Hospital.

(5) "Provider Contract" means a contract between a plan and one or more health care providers, through which the plan arranges to provide health care services for its enrollees.

(6) "Provider Group" means a medical group, an independent practice association, or any other similar organization providing services to enrollees of a plan who are assigned to that provider group.

(7) "Receiving Provider Group" means a provider group that will provide services to Affected Enrollees in place of the current Provider Group.

(8) "Terminated Hospital" means a general acute care hospital that will no longer maintain a Provider Contract with the plan following the termination or non-renewal of a Provider Contract.

(9) "Terminated Provider" means either a Terminated Provider Group or a Terminated Hospital.

(10) "Terminated Provider Group" means a Provider Group that will no longer maintain a Provider Contract with the plan following the termination or non-renewal of a Provider Contract.

(b) For any proposed Block Transfer, a plan shall file with the Department a Block Transfer filing that includes, at minimum, all the items of information described in this subsection (b). The Block Transfer filing must be submitted to the Department at least seventy-five (75) days prior to the termination or

non-renewal of any Provider Contract with a Terminated Provider Group or a Terminated Hospital. The Block Transfer filing must be submitted in an electronic format developed by the Department and made available at the Department's website at www.hmohelp.ca.gov and must include, at minimum, all of the following information as appropriate for the type of provider involved:

(1) A form of the written notice that the plan intends to send to Affected Enrollees. The Enrollee Transfer Notice must include:

(A) The name of the Terminated Provider Group or Terminated Hospital. The plan may also add the name of the assigned physician, where appropriate.

(B) A brief explanation of why the transfer is necessary due to the termination of the contract between the plan and the Terminated Provider.

(C) The date of the pending contract termination and transfer.

(D) An explanation to the Affected Enrollee outlining the Affected Enrollee's assignment to a new Provider Group, options for selecting a physician within a new Provider Group, and applicable timeframes to make a new Provider Group selection. The explanation must include a notification to the Affected Enrollee that he or she may select a different network provider by contacting the plan as outlined in the plan's written continuity of care policy and evidence of coverage or disclosure form.

(E) A statement that the plan will send the Affected Enrollee a new member information card with the name, address and telephone number of the Receiving Provider Group and assigned physician by a specified later date, which will occur prior to the date of the contract termination. Alternatively, the plan may notify the Affected Enrollee of the name, address and telephone number of the new Provider Group and assigned physician, or Alternate Hospital, to which the Affected Enrollee will be assigned in the absence of a selection made by the enrollee.

(F) A statement that the Affected Enrollee may contact the plan's customer service department to request completion of care for an ongoing course of treatment from a Terminated Provider. This statement may include either a statement outlining the specific conditions set forth in California Health and Safety Code section 1373.96(c), or an explanation to the Affected Enrollee that his or her eligibility is conditioned upon certain factors as outlined in the plan's written continuity of care policy and evidence of coverage or disclosure form.

(G) The telephone number through which the Affected Enrollee may contact the plan for a further explanation of his or her rights to completion of care, including the plan's written continuity of care policy; and a link that an Affected Enrollee may use to obtain of a downloadable copy of the policy from the plan's website.

(H) A statement informing any enrollee of a point of service product that the Affected Enrollee may be required to pay a larger portion of costs if he or she continues to use his or her current providers, if applicable to the particular Block Transfer.

(I) The following statement in at least 8-point font:

> "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. Please contact your HMO's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov."

The statement may be modified to include the health care service plan's name in place of the phrase "your HMO's."

(J) The plan shall require all contracted providers to include the statutory language required by California Health and Safety Code section 1373.65(f) in all communications to Affected Enrollees that concern the termination of a provider or a Block Transfer.

(K) Compliance with all applicable language assistance statues and regulations, including Section 1367.04 and any regulations based upon Section 1367.04.

(2) For a Terminated Hospital contract the plan shall also submit the following information:

(A) A brief explanation of the cause of the hospital redirection including whether the contract termination or non-renewal was initiated by the plan, the hospital, or by a contracting Provider Group.

(B) A copy of the notice of termination sent or received by the plan.

(C) If the contract termination will affect 50,000 or more enrollees, the relevant portions of the Provider Contract(s) that relate to continuity of care and transition of care.

(D) Either of the following two options:

1. a list of counties in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each county, or

2. a list of the zip codes in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each zip code.

(E) The number of Affected Enrollees assigned to the Terminated Hospital, and the number to be reassigned to each Alternate Hospital, classified by type of product (for example, commercial, Medi-Cal, Healthy Families, etc.)

(F) The number of Affected Enrollees within a 15-mile radius of the Terminated Hospital.

(G) The date that the plan anticipates it will mail the Enrollee Transfer Notification.

(H) The proposed date or dates of transfer of Affected Enrollees. If the plan intends to transfer Affected Enrollees on various dates, please explain the reason for the different transfer dates.

(I) If additional governmental departments or agencies require approval of enrollee notices regarding the transfer, provide copies of each proposed notice as well as an explanation of the status of each required approval.

(J) The identity of the Terminated Hospital and Alternate Hospital including the contract renewal or termination date for each Alternate Hospital.

(K) A listing identifying any services that are available at the Terminated Hospital that are not available at an Alternate Hospital. The plan must discuss the arrangements it has made to ensure that enrollees have an opportunity to receive those services.

(L) Based upon the data made public on the Office of Statewide Health Planning and Development's website, for each of the proposed Alternate Hospitals, provide the available bed occupancy rate for the most recently completed calendar year. If the rate is at 80% or higher, please provide justification as to the sufficiency of the Alternate Hospital's capacity to serve additional plan enrollees.

(M) The number of bed days utilized by plan enrollees at the Terminated Hospital for the most recently completed calendar year.

(N) An analysis showing the driving distance between the proposed Alternate Hospital and the Terminated Hospital.

(O) Of the primary care providers to whom Affected enrollees are currently assigned, the number and percentage of primary care providers with active admitting privileges at the Alternate Hospital(s) and the number of Affected Enrollees assigned to these primary; care providers and the number and

percentage of primary care providers without active admitting privileges at the Alternate Hospital(s) and the number of Affected Enrollees assigned to these primary care providers.

(P) Explain the procedure by which an Affected Enrollee who is assigned to a primary care provider who does not have active admitting privileges to the Alternate Hospital(s) will receive needed hospital care.

(Q) Of the specialists available to Affected Enrollees with active admitting privileges at the Terminated Hospital, the number and percentage with active admitting privileges at the Alternate Hospital(s). If any of these specialists will be unable to admit to the Alternate Hospital(s), disclose the specialty involved, how many specialists of that specialty, if any, will still be available to admit the Alternate Hospital(s) and explain how Affected Enrollees will receive care for that specialty at a proposed Alternate Hospital if there are an insufficient number of remaining specialists with active admitting privileges.

(R) A disclosure of any anticipated increase in costs that will be incurred by Affected Enrollees of the plan's point of service products resulting from termination of the current hospital's contract if they continue to use the Terminated Provider.

(S) Confirmation that the plan's continuity of care program, as filed with the Department, will be implemented for any Affected Enrollees.

(3) For a Provider Group contract termination, the plan shall also submit the following information:

(A) A brief explanation of the cause or circumstances of the Provider Contract termination or non-renewal, including whether the contract termination or non-renewal was initiated by the plan or the Provider Group. If the Provider Contract termination is due to a provider closure, specify whether the provider closure is due to a bankruptcy, an insolvency, a sale, ceasing business operations or the closure of a specific office site.

(B) A copy of the notice of termination sent or received by the plan.

(C) If the contract termination will affect 50,000 or more enrollees, the relevant portions of the Provider Contract(s) that relate to continuity of care and transition of care.

(D) Either of the following two options:

(i) a list of counties in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each county, or

(ii) a list of the zip codes in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each zip code.

(E) A listing, classified by type of product (for example, commercial, Medi-Cal, Healthy Families, etc.) that specifies the number of Affected Enrollees assigned to the Terminated Provider.

(F) The date that the plan anticipates it will mail the Enrollee Transfer Notice.

(G) The proposed date or dates of transfer. If the plan intends to transfer Affected Enrollees on various dates, please explain the reason for the different transfer dates.

(H) The plan's estimate of the percentage of Affected Enrollees who will remain with the same primary care provider after the transfer to a Receiving Provider Group.

(I) If additional governmental departments or agencies require approval of enrollee notices regarding the transfer, please provide copies of each proposed notice as well as an explanation of the status of each required approval.

(J) A matrix of proposed Receiving Provider Groups that includes the following information:

1. the identity of the Receiving Provider Group(s), including its Risk Bearing Organization (RBO) number as assigned by the Department,

2. the number of Affected Enrollees being transferred to each Receiving Provider Group listed by type of product. If the plan gives the Affected Enrollees the choice of selecting a new provider, then the plan must provide the number of Affected Enrollees to be transferred to each receiving Provider Group by default if no selections are made by the Affected Enrollees,

3. a listing of all hospitals to which Receiving Provider Groups refer Affected Enrollees, if different from the Terminated Provider Group.

(K) Confirmation that the plan's continuity of care program, as filed with the Department, will be implemented for any Affected Enrollees.

(c) Timing of Notice Requirements. For any termination or non-renewal of a Provider Contract, a plan shall mail to all Affected Enrollees an Enrollee Transfer Notice that has been approved by the Department.

(1) The Enrollee Transfer Notice must be mailed to each Affected Enrollee at least sixty (60) days prior to the date of termination or non-renewal.

(d) Notice Mailing Requirements. The plan shall send an Enrollee Transfer Notice to Affected Enrollees as follows:

(1) For Affected Enrollees enrollees who are Block Transferred from a Terminated Provider Group — the plan shall send the notice to all Affected Enrollees assigned to the Terminated Provider Group.

(2) For Affected Enrollees who are block transferred from a Terminated Hospital — the plan shall send the notice to all Affected Enrollees who reside within 15 miles of the Terminated Hospital.

(e) If, for any reason, a plan is unable to send all Enrollee Transfer Notice required pursuant to subsection 1300.67.1.3(c) of Title 28, California Code of Regulations, at least sixty (60) days prior to the termination or non-renewal of a Provider Contract, the plan shall submit to the Department an application for a waiver of the 60-day requirement. The application for waiver must include an explanation of the plan's reasons for being unable to meet the 60-day notice requirement and its proposal to minimize any disruption that may be caused to Affected Enrollees by the reduced notice. A waiver application may be based upon the sudden closure of a contracted provider, a notice-timing conflict with another jurisdictional agency, or other circumstances for which good-cause exists. If the Department does not approve or disapprove the waiver request within seven (7) days of its receipt of the request, the waiver will be deemed to have been approved by the Department.

(f) If, after sending Enrollee Transfer Notices a plan reaches an agreement to renew or enter into a new Provider Contract or to not terminate their Provider Contract with a Terminated Provider to which the plan had assigned enrollees, then the plan shall promptly inform the Department and convey an additional enrollee notification, either by telephone or in writing, to each Affected Enrollee. The additional enrollee notification must include:

(1) A brief explanation of the fact that the plan has reached an agreement with the Affected Enrollee's previously assigned provider.

(2) An explanation to the enrollee regarding options for either returning to the previously assigned provider, keeping the newly assigned provider, or select another participating provider from the plan's contracting provider list.

(3) An explanation to the Affected Enrollee of the procedure by which the enrollee may contact the plan to express his or her desire to return to the previously assigned provider.

(4) If the additional enrollee notice is given in writing, then the notice must include the following statement in at least 8-point font:

"If you have any questions regarding this notice please contact [Plan Name] customer service department. If you have further concerns about your provider network, you are encouraged to contact the Department of Managed Health Care by telephone at its toll-free number 1-888-HMO-2219, or at TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov."

(5) Compliance with all applicable language assistance statutes and regulations, including Section 1367.04 and any regulations based upon Section 1367.04.

NOTE: Authority cited: Sections 1342, 1344 and 1346, Health and Safety Code. Reference: Sections 1367.04 and 1373.65, Health and Safety Code.

History:

1. New section filed 8-22-2005; operative 9-21-2005 (Register 2005, No. 34).

§ 1300.67.2. Accessibility of Services.

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

(a) The location of facilities providing the primary health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility.

(b) Hours of operation and provision for after-hour services shall be reasonable;

(c) Emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week;

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;

(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral;

(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments;

(g) A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that plan or area.

Subject to subsections (a) and (b) of this section, a plan may rely on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.

§ 1300.67.2.1. Geographic Accessibility Standards.

Subject to subsections (a) and (b) of this section, a plan may rely, for the purposes of satisfying the requirements for geographic accessibility, on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.

(a) If, given the facts and circumstances with regard to any portion of its service area, a plan's standards of accessibility adopted pursuant to Item H of Section 1300.51 and/or Section 1300.67.2 are unreasonably restrictive, or the service area is within a county with a population of 500,000 or fewer, and is within a county that, as of January 1, 2002, has two or fewer full service health care service plans in the commercial market, the plan may propose alternative standards of accessibility for that portion of its service area. The plan shall do so by including such alternative standards in writing in its plan license application or in a notice of material modification. The plan shall also include a description of the reasons justifying the less restrictive standards based on those facts and circumstances. If the Department rejects the plan's proposal, the Department shall inform the plan of the Department's reason for doing so.

(b) If, in its review of a plan license application or a notice of material modification, the Department believes the accessibility standards set forth in Item H of Section 1300.51 and/or Section 1300.67.2 are insufficiently prescribed or articulated or are inappropriate given the facts and circumstances with regard to a portion of a plan's service area, the Department shall inform the plan that the Department will not allow application of those standards to that portion of the plan's service area. The Department shall also inform the plan of the Department's reasons for rejecting the application of those standards.

(c) The facts and circumstances to be included in a discussion of the reasons justifying the standards of accessibility proposed by the plan pursuant to subsection (a) or (b) of this section shall include, to the extent relevant, but shall not necessarily be limited to the following:

(1) whether the plan contract involved is a group health care service plan contract or an individual health care service plan contract;

(2) whether the plan contract is a full-service health care service plan contract or a specialized health care service plan contract, and if the latter, whether emergency services need not be covered;

(3) the uniqueness of the services to be offered;

(4) whether the portion of the service area involved is urban or rural;

(5) population density in the portion of the service area, including whether the service area is within a county with a population of 500,000 or fewer;

(6) whether, as of January 1, 2002, the county containing the service area had two or fewer full service health care service plans providing coverage to the entire county in the commercial market;

(7) the distribution of enrollees in the portion of the service area;

(8) the availability and distribution of primary care physicians;

(9) the availability and distribution of other types of providers;

(10) the existence of exclusive contracts in the provider community or other barriers to entry;

(11) patterns of practice in the portion of the service area;

(12) driving times;

(13) waiting times for appointments;

(14) whether the plan or any other health care service plan currently has significant operations in that portion of the service area; and

(15) other standards of accessibility that the Director deems necessary or appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.

(d) At least 30 days before a health care service plan files a notice of material modification of its license with the department in order to withdraw from a county with a population of 500,000 or fewer, the health care service plan shall hold a public meeting at a time and place reasonably calculated to

facilitate attendance by affected enrollees in the county from which it intends to withdraw, and shall do all of the following:

(1) Provide notice announcing the public meeting at least 30 days prior to the public meeting to all affected enrollees, health care providers with which it contracts, the members of the board of supervisors of the affected county, the members of the city councils of cities in the affected county, and the members of the Legislature who represent the affected county.

(2) Provide notice announcing the public meeting at least 15 days prior to the public meeting in a newspaper of general circulation within the affected county.

(3) At the public meeting, allow testimony, which may be limited to a certain length of time by the health care service plan, of all interested parties.

(4) File with the department for review, no less than 30 days prior to the date of mailing or publication, the notices required under subparagraphs (1) and (2).

(e) The department may require a health care service plan that has filed to withdraw from a portion of a county with a population of fewer than 500,000 to hold a hearing for affected enrollees.

(f) A representative of the department shall attend the public meeting described in this section.

NOTE: Authority cited: Sections 1344, 1351 and 1366.1, Health and Safety Code. Reference: Sections 1366.1, 1367 and 1367.2, Health and Safety Code.

History:

1. New section filed 11-30-98; operative 11-30-98 pursuant to Government Code section 11343.4(d) (Register 98, No. 49).
2. Change without regulatory effect amending subsection (a) filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
3. Change without regulatory effect amending subsection (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
4. Amendment of section heading, section and Note filed 6-10-2004; operative 7-10-2004 (Register 2004, No. 24).

§ 1300.67.2.2. Timely Access to Non–Emergency Health Care Services.

(a) Application

(1) All health care service plans that provide or arrange for the provision of hospital or physician services, including specialized mental health plans that provide physician or hospital services, or that provide mental health services pursuant to a contract with a full service plan, shall comply with the requirements of this section.

(2) Dental, vision, chiropractic, and acupuncture plans shall comply with subsections (c)(1), (3), (4), (7), (9) and (10), and subsections (d)(1) and (g)(1). Dental plans shall also comply with subsection (c)(6).

(3) The obligation of a plan to comply with this section shall not be waived when the plan delegates to its medical groups, independent practice associations, or other contracting entities any services or activities that the plan is required to perform. A plan's implementation of this section shall be consistent with the requirements of the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's contracting providers shall be considered a material change to the provider contract, within the meaning of subsections (b) and (g)(2) of Section 1375.7 of the Act.

(4) This section confirms requirements for plans to provide or arrange for the provision of access to health care services in a timely manner, and establishes additional metrics for measuring and monitoring the adequacy of a plan's contracted provider network to provide enrollees with timely access to needed health care services. This section does not:

(A) Establish professional standards of practice for health care providers;

(B) Establish requirements for the provision of emergency services; or

(C) Create a new cause of action or a new defense to liability for any person.

(b) Definitions. For purposes of this section, the following definitions apply.

(1) "Advanced access" means the provision, by an individual provider, or by the medical group or independent practice association to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day.

(2) "Appointment waiting time" means the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.

(3) "Preventive care" means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full service plan includes but is not limited to all of the basic health care services required by subsection (b)(5) of Section 1345 of the Act, and Section 1300.67(f) of Title 28.

(4) "Provider group" has the meaning set forth in subsection (g) of Section 1373.65 of the Act.

(5) "Triage" or "screening" means the assessment of an enrollee's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.

(6) "Triage or screening waiting time" means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care.

(7) "Urgent care" means health care for a condition which requires prompt attention, consistent with subsection (h)(2) of Section 1367.01 of the Act.

(c) Standards for Timely Access to Care.

(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

(2) Plans shall ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of this section.

(3) When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of Section 1367.03 of the Act and the requirements of this section.

(4) Interpreter services required by Section 1367.04 of the Act and Section 1300.67.04 of Title 28 shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter

services at the time of the appointment. This subsection does not modify the requirements established in Section 1300.67.04, or approved by the Department pursuant to Section 1300.67.04 for a plan's language assistance program.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (G);

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (G);

(C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in (G) and (H);

(D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in (G) and (H);

(E) Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment, except as provided in (G) and (H);

(F) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment, except as provided in (G) and (H);

(G) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee;

(H) Preventive care services, as defined at subsection (b)(3), and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice; and

(I) A plan may demonstrate compliance with the primary care time-elapsed standards established by this subsection through implementation of standards, processes and systems providing advanced access to primary care appointments, as defined at subsection (b)(1).

(6) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each dental plan, and each full service plan offering coverage for dental services, shall ensure that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:

(A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;

(B) Non-urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subsection (c)(6)(C); and

(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

(7) Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.

(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

(8) Plans shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone as defined at subsection (b)(5).

(A) Plans shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage or screening waiting time does not exceed 30 minutes.

(B) A plan may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: plan-operated telephone triage or screening services consistent with subsection (b)(5); telephone medical advice services pursuant to Section 1348.8 of the Act; the plan's contracted primary care and mental health care provider network; or other method that provides triage or screening services consistent with the requirements of this subsection.

1. A plan that arranges for the provision of telephone triage or screening services through contracted primary care and mental health care providers shall require those providers to maintain a procedure for triaging or screening enrollee telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine and/or an answering service and/or office staff, that will inform the caller:

a. Regarding the length of wait for a return call from the provider; and

b. How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

2. A plan that arranges for the provision of triage or screening services through contracted primary care and mental health care providers who are unable to meet the time-elapsed standards established in paragraph (8)(A) shall also provide or arrange for the provision of plan-contracted or operated triage or screening services, which shall, at a minimum, be made available to enrollees affected by that portion of the plan's network.

3. Unlicensed staff persons handling enrollee calls may ask questions on behalf of a licensed staff person in order to help ascertain the condition of an enrollee so that the enrollee can be referred to licensed staff. However, under no circumstances shall unlicensed staff persons use the answers to those questions in an attempt to assess, evaluate, advise, or make any decision regarding the

condition of an enrollee or determine when an enrollee needs to be seen by a licensed medical professional.

(9) Dental, vision, chiropractic, and acupuncture plans shall ensure that contracted providers employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

(10) Plans shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes.

(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:

(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.

(2) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of contracted providers, which shall include:

(A) Tracking and documenting network capacity and availability with respect to the standards set forth in subsection (c);

(B) Conducting an annual enrollee experience survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to ascertain compliance with the standards set forth at subsection (c);

(C) Conducting an annual provider survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to solicit, from physicians and non-physician mental health providers, perspective and concerns regarding compliance with the standards set forth at subsection (c);

(D) Reviewing and evaluating, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of care, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services; and

(E) Verifying the advanced access programs reported by contracted providers, medical groups and independent practice associations to confirm that appointments are scheduled consistent with the definition of advanced access in subsection (b)(1).

(F) A plan that provides services through a preferred provider organization network may, for that portion of its network, demonstrate compliance with subsections (d)(2)(A) and (D) by monitoring, on not less than an annual basis: the number of PPO primary care and specialty physicians under contract with the plan in each county of the plan's service area; enrollee grievances and appeals regarding timely access; and the rates of compliance with the time-elapsed standards established in subsection (c)(5).

(3) A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Plans shall give advance written notice to all contracted providers

affected by a corrective action, and shall include: a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the plan's corrective action.

(e) Enrollee Disclosure and Education

(1) Plans shall disclose in all evidences of coverage the availability of triage or screening services and how to obtain those services. Plans shall disclose annually, in plan newsletters or comparable enrollee communications, the plan's standards for timely access.

(2) The telephone number at which enrollees can access triage and screening services shall be included on enrollee membership cards. A plan or its delegated provider group may comply with this requirement through an additional selection in its automated customer service telephone answering system, where applicable, so long as the customer service number is included on the enrollee's membership card.

(f) Plans may file, by notice of material modification, a request for the Department's approval of alternative time-elapsed standards or alternatives to time-elapsed standards. A request for an alternative standard shall include:

(1) An explanation of the plan's clinical and operational reasons for requesting the alternative standard, together with information and documentation, including scientifically valid evidence (based on reliable and verifiable data), demonstrating that the proposed alternative standard is consistent with professionally recognized standards of practice and a description of the expected impact of the alternative standard on clinical outcomes, on access for enrollees, and on contracted health care providers;

(2) The burden shall be on the plan to demonstrate and substantiate why a proposed alternative standard is more appropriate than time elapsed standards. Plans that have received approval for an alternative standard shall file, on an annual basis, an amendment requesting approval for continued use of the alternative standard, and providing updated information and documentation to substantiate the continued need for the alternative standard; and

(3) In approving or disapproving a plan's proposed alternative standards the Department may consider all relevant factors, including but not limited to the factors set forth in subsections (d) and (e) of Section 1367.03 of the Act and subsection (c) of Section 1300.67.2.1 of Title 28.

(g) Filing, Implementation and Reporting Requirements.

(1) Not later than twelve months after the effective date of this section, plans shall implement the policies, procedures and systems necessary for compliance with the requirements of Section 1367.03 of the Act and this section. Not later than nine months after the effective date of this section, each plan shall file an amendment pursuant to Section 1352 of the Act disclosing how it will achieve compliance with the requirements of this section, which shall include substantiating documentation, including but not limited to, quality assurance policies and procedures, survey forms, subscriber and enrollee disclosures, and amendments to provider contracts. The amendment shall also include documentation sufficient to confirm the plan's compliance, as of the date of filing, with existing requirements regarding physician-to-enrollee ratios, including but not limited to updated Exhibits I-1 and I-4 to the plan's license application. If a plan asserts prior Department approval of alternative physician-to-enrollee ratios or an alternative method of demonstrating network adequacy, the filing shall contain confirming documentation. A plan may concurrently request approval of alternative physician-to-enrollee ratios or an alternative method of demonstrating network adequacy by filing a notice of material modification pursuant to section 1300.67.2.1 of Title 28.

(2) By March 31, 2012, and by March 31 of each year thereafter, plans shall file with the Department a report, pursuant to subsection (f)(2) of Section 1367.03 of the Act, regarding compliance during the immediately preceding year. The first reporting period shall be the calendar year ending December 31, 2011. The reports shall document the following information:

(A) The timely access standards set forth in the plan's policies and procedures including, as may be applicable, any alternative time-elapsed standards and alternatives to time-elapsed standards for which the plan obtained the Department's prior approval by Order;

(B) The rate of compliance, during the reporting period, with the time elapsed standards set forth in subsection (c)(5), separately reported for each of the plan's contracted provider groups located in each county of the plan's service area. A plan may develop data regarding rates of compliance through statistically reliable sampling methodology, including but not limited to provider and enrollee survey processes, or through provider reporting required pursuant to subsection (f)(2) of Section 1367.03 of the Act;

(C) Whether the plan identified, during the reporting period, (1) any incidents of noncompliance resulting in substantial harm to an enrollee or (2) any patterns of non-compliance and, if so, a description of the identified non-compliance and the plan's responsive investigation, determination and corrective action;

(D) A list of all provider groups and individual providers utilizing advanced access appointment scheduling;

(E) A description of the implementation and use by the plan and its contracting providers of triage, telemedicine, and health information technology to provide timely access to care;

(F) The results of the most recent annual enrollee and provider surveys and a comparison with the results of the prior year's survey, including a discussion of the relative change in survey results; and

(G) Information confirming the status of the plan's provider network and enrollment at the time of the report, which shall include, on a county-by-county basis, in a format approved by the Department:

1. The plan's enrollment in each product line; and

2. A complete list of the plan's contracted physicians, hospitals, and other contracted providers, including location, specialty and subspecialty qualifications, California license number and National Provider Identification Number, as applicable. Physician specialty designation shall specify board certification or eligibility consistent with the specialty designations recognized by the American Board of Medical Specialties.

3. The information required by paragraphs (g)(2)(G)(1) and (2) shall be included with the annual report until the Department implements a web-based application that provides for electronic submission via a web portal designated for the collection of plan network data. Upon the Department's implementation of the designated network data collection web portal, the information required by paragraphs (G)(1) and (2), shall be submitted directly to the web portal.

(3) In determining a plan's compliance or non-compliance with the requirements of this section, the Department will focus more upon patterns of non-compliance than isolated episodes of non-compliance and may consider all relevant factors, including but not limited to:

(A) The efforts by a plan to evade the standards, such as referring enrollees to providers who are not appropriate for an enrollee's condition;

(B) The nature and extent of a plan's efforts to avoid or correct non-compliance, including whether a plan has taken all necessary and appropriate

action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance;

(C) The nature of physician practices, including group and individual practices, the nature of a plan's network, and the nature of the health care services offered;

(D) The nature and extent to which a single instance of non-compliance results in, or contributes to, serious injury or damages to an enrollee; and

(E) Other factors established in relevant provisions of law, and other factors that the Director deems appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.

NOTE: Authority cited: Sections 1344, 1346 and 1367.03, Health and Safety Code. Reference: Sections 1342, 1367, 1367.01, 1367.03, 1370, 1375.7 and 1380, Health and Safety Code.

History:

1. New section filed 12-18-2009; operative 1-17-2010 (Register 2009, No. 51).

§ 1300.67.3. Standards for Plan Organization.

(a) The organization of each plan shall provide the capability to furnish in a reasonable and efficient manner the health care services for which subscribers and enrollees have contracted. Such organization shall include:

(1) separation of medical services from fiscal and administrative management sufficient to assure the Director that medical decisions will not be unduly influenced by fiscal and administrative management,

(2) staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business, and

(3) written procedures for the conduct of the business of the plan, including the provision of health care services, so as to provide effective controls.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367, Health and Safety Code.

History:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Change without regulatory effect amending subsection (a)(1) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.67.4. Subscriber and Group Contracts.

(a) All subscriber and group contracts and endorsements and amendments shall be printed legibly in not less than 8-point type and shall include at least the following:

(1) The information required to be included on disclosure forms by Section 1363(a) of the Code and

(A) the information required to be included on disclosure forms by Section 1300.63 (except subsections (2), (3), (4) and (11) of subsection (b) thereof), and required to be included on evidences of coverage by subsections (b)(2) and (c) (except subsection (16) thereof) of Section 1300.63.1, or

(B) if the plan complies with the provisions of Section 1300.63.2, the information required to be included on combined evidences of coverage and disclosure forms by Section 1300.63.2 (except subsections (1) and (4) of subsection (b) and subsections (2), (25), and (27) of subsection (c) thereof).

(2) Definitions of all terms contained in the contract.

(A) Which are defined by the Act or Chapter 1 of Title 28 of the California Code of Regulations,

(B) Which are any of the following: "pre-existing condition," "guaranteed renewable," or "non-cancellable," or,

(C) Which require definition in order to be understood by a reasonable person not possessing special knowledge of law, medicine, or plans;

(D) Which specifically describes the eligibility of persons as subscribers or enrollees.

(3) Appropriate captions, in boldface type, for the following provisions: limitations, exclusions, exceptions, reductions, deductibles, copayments and other provisions which may decrease or limit benefits to, or increase costs of, any subscriber or enrollee;

(A) A benefit afforded by the contract shall not be subject to any limitation, exclusion, exception, reduction, deductible, or copayment which renders the benefit illusory.

(4) In the same section describing any particular benefit(s), any provisions described in (3) above which are applicable only to any such particular benefit(s);

(5) Provisions relating to cancellation under an appropriate caption, in boldface type, which provisions shall include:

(A) A statement of the bases for cancellation, which shall conform to Section 1365(a) of the Act and these rules;

(B) A statement of the opportunity for review of certain cancellations by the Director as provided in Section 1365(b) of the Code;

(C) A statement that, in the event of cancellation by either the plan (except in the case of fraud or deception in the use of services or facilities of the plan or knowingly permitting such fraud or deception by another) or the other party, the plan shall within 30 days return to the other part the pro rata portion of the money paid to plan which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due the plan;

(D) A statement of the time when a notice of cancellation becomes effective;

(E) A statement that receipt by the plan of the proper prepaid or periodic payment after cancellation of the contract for nonpayment shall reinstate the contract as though it had never been cancelled if such payment is received on or before the due date of the succeeding prepaid or periodic payment, provided, however, that the contract may specify one or more of the following methods by which the plan may avoid such reinstatement:

1. In the notice of cancellation, the plan notifies the other party that if payment is not received within 15 days of issuance of the notice of cancellation, a new application is required and the conditions under which a new contract will be issued or the original contract reinstated; or

2. If such payment is received more than 15 days after issuance of the notice of cancellation, the plan refunds such payment within 20 business days; or

3. If such payment is received more than 15 days after issuance of the notice of cancellation, the plan issues to the other party, within 20 business days of receipt of such payment, a new contract accompanied by written notice stating clearly those respects in which the new contract differs from the cancelled contract in benefits, coverage or otherwise;

(6) A provision prohibiting the plan from increasing the amount paid by the other party, except after a period of at least 30 days from and after the postage paid mailing to the other party at the other party's most current address of record with the plan;

(7) A provision prohibiting the plan from decreasing in any manner the benefits stated in the contract, except after a period of at least 30 days from and after the postage paid mailing to the other party at the other party's most current address of record with the plan;

(8) A provision requiring the plan to provide written notice within a reasonable time to the other party of any termination or breach of contract by, or inability to perform of, any contracting provider if the other party may be materially and adversely affected thereby;

(9) A provision that (i) the plan is subject to the requirements of Chapter 2.2 of Division 2 of the Code and of Chapter 1 of Title 28 of the California Code of Regulations, and (ii) any provision required to be in the contract by either of the above shall bind the plan whether or not provided in the contract.

(10) A provision that, upon termination of a provider contract, the plan shall be liable for covered services rendered by such provider (other than for copayments as defined in subdivision (g) of Section 1345) to a subscriber or enrollee who retains eligibility under the applicable plan contract or by operation of law under the care of such provider at the time of such termination until the services being rendered to the subscriber or enrollee by such provider are completed, unless the plan makes reasonable and medically appropriate provision for the assumption of such services by a contracting provider.

(11) In the case of a group contract, a reasonable provision requiring the group contract holder to mail promptly to each subscriber a legible, true copy of any notice of cancellation of the plan contract which may be received from the plan and to provide promptly to the plan proof of such mailing and the date thereof, if the plan wishes to obligate the group contract holder in connection with the obligations imposed on the plan by Section 1300.65.

(b) For the purposes of this section:

(1) "Other party" means (i) in the case of a group contract, the group representative designated in the contract, and (ii) in the case of an individual contract, the subscriber.

(2) Any express or implied requirement of notice to the other party, in the context of a group contact, requires notice to the group representative designated in the contract and, with respect to material matters, to subscribers and enrollees under the group contract; however, a plan may fulfill any obligation imposed by this section to notify subscribers and enrollees under a group contract if it provides notice to the group representative designated in the contract, and the group contract requires the group representative to disseminate such notice to subscribers and enrollees in the group by the next regular communication to the group but in no event later than 30 days after the receipt thereof.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1367 and 1379, Health and Safety Code.

History:

1. New subsection (a)(10) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment of subsection (a)(5) filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).
3. Amendment of subsection (a) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
4. Amendment of subsections (a)(2)(A), (a)(6), (a)(7) and (a)(9) filed 12-26-91; operative 1-27-92 (Register 92, No. 12).
5. Change without regulatory effect amending subsection (a)(5)(B) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
6. Change without regulatory effect amending subsections (a)(2)(A) and (a)(9) filed 12-22-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 51).

§ 1300.67.8. Contracts with Providers.

Written contracts must be executed between the plan and each provider of health care services which regularly furnishes services under the plan. All contracts with providers shall be subject to the following requirements:

(a) A written contract shall be prepared or arranged in a manner which permits confidential treatment by the Director of payment rendered or to be rendered to the provider without concealment or misunderstanding of other terms and provisions of the contract.

(b) The contract shall require that the provider maintain such records and provide such information to the plan or to the Director as may be necessary for

compliance by the plan with the provisions of the Act and the rules thereunder, that such records will be retained by the provider for at least two years, and that such obligation is not terminated upon a termination of the agreement, whether by rescission or otherwise. (See Section 1300.75.1)

(c) That the plan shall have access at reasonable times upon demand to the books, records and papers of the provider relating to the health care services provided to subscribers and enrollees, to the cost thereof, to payments received by the provider from subscribers and enrollees of the plan (or from others on their behalf), and, unless the provider is compensated on a fee-for-service basis, to the financial condition of the provider.

(d) The contract shall prohibit surcharges for covered services and shall provide that whenever the plan receives notice of any such surcharge it shall take appropriate action.

(e) The contract shall contain provisions complying with Section 1379 of the Act and requiring that, upon termination of the contract of the provider for any cause, such provider shall comply with the provisions of subdivision (a)(10) of Section 1300.67.4.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1367, 1381 and 1385, Health and Safety Code.

History:

1. Amendment filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment of subsection (b) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
3. Change without regulatory effect amending subsections (a)-(b) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
4. New subsections (f)-(f)(5) filed 10-20-2003; operative 11-19-2003 (Register 2003, No. 43).
5. Repealer of subsections (f)-(f)(5) filed 1-24-2007; operative 2-23-2007 (Register 2007, No. 4).

§ 1300.67.10. Discrimination Prohibited. [Repealed]

History:

1. Repealer filed 12-26-91; operative 1-27-92 (Register 92, No. 12).

§ 1300.67.11. Disclosure of Conflicts of Interest.

(a) A plan shall not enter into any transaction with a person currently named in Item F of its application under Section 1300.51 (or currently named pursuant to Items 7, 8, or 9 of that application as in effect prior to the effective date of Section 1300.51.3) unless, prior thereto, each of the following conditions is met:

(1) The material facts concerning the transaction and the person's interest therein are disclosed to the governing body of the plan.

(2) The transaction is approved by a disinterested majority of the governing body.

(3) Such facts and such approval are made a part of the minutes of such governing body or, if no minutes are required of such governing body, otherwise retained as a record of the plan.

(b) A plan shall promptly give written notice to the Director if a transaction is entered into otherwise than in conformity with the terms of this section.

(c) For the purposes of this section, "governing body" means the board of directors, all general partners, the sole proprietor, the board of trustees, and any other persons occupying a similar position or performing similar functions.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1351 and 1367(h), Health and Safety Code.

History:

1. Amendment of subsection (a) filed 12-17-85; effective thirtieth day thereafter (Register 85, No. 51.
2. Change without regulatory effect amending subsection (b) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.67.12. Contracts with Solicitor Firms.

A plan shall not permit a solicitor firm to solicit enrollments or subscriptions on its behalf except pursuant to a written contract which meets all of the following minimum requirements:

(a) All funds received by the solicitor firm for the account of the plan shall at all times be segregated from the assets of the solicitor firm and shall be promptly deposited to a trust account in a state or federal bank authorized to do business in this state and insured by an appropriate federal insuring agency. "Promptly deposited" means deposited no later than the business day following receipt by the solicitor firm.

(b) All funds received by the solicitor firm for the account of the plan shall be transmitted to the plan, or to a person designated in the contract, net of actual commissions earned under the particular contract within (5) five business days after such funds are received by the solicitor firm.

(c) The solicitor firm shall comply and shall cause its principal persons and employees to comply with all applicable provisions of the Act and the rules thereunder.

(d) The solicitor firm shall promptly notify the plan of the institution of any disciplinary proceedings against it or against any of its principal persons or employees relating to any license issued to any such person by the California Insurance Commissioner.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367, Health and Safety Code.

History:

1. Amendment filed 12-20-77 as an emergency; effective upon filing (Register 77, No. 52).
2. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.67.13. Coordination of Benefits ("COB").

(a)(1) This rule does not require the use of COB provisions in plan contracts. If a contract contains a COB provision, the provision must be consistent with the standard provision set forth in subdivision (b), as interpreted by the "Instructions" set forth in that subdivision. COB provisions, or provisions for the reduction of benefits otherwise payable because of other coverage by whatever name designated, which are not consistent with the standard provision set forth in subdivision (b), may not be used, except that plans of coverage designed to be supplementary over the subscriber's or enrollee's underlying basic plan of coverage may provide that coverage shall be excess to that specific subscriber's or enrollee's plan of basic coverage from whatever source provided.

(2) A COB provision may not relieve a plan of a duty otherwise arising from a plan contract to deliver any health care service to any subscriber or enrollee because the subscriber or enrollee may be or is entitled to coverage for the service by any other plan or insurer.

(3) A COB provision may not result in a delay in furnishing any reasonably necessary health care service to any subscriber or enrollee pursuant to a plan contract.

(b) Standard COB Provision:

(1) Benefits Subject to This Provision

All of the benefits provided under this Plan contract are subject to this provision.

Instructions

When the contract provides both integrated Major Medical Expense Benefits and the Basic Benefits, but the COB provision applies to all or some of the

benefits, use appropriate alternate wording such as: "Only the Major Medical Expense Benefits provided under this contract are subject to this provision."

(2) Definitions

(A) "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by (i) group, blanket or franchise insurance coverage, (ii) service plan contracts, group practice, individual practice and other prepayment coverage, (iii) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (iv) any coverage under governmental programs, and any coverage required or provided by any statute.

The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

(B) "This Plan" means that portion of this contract which provides the benefits that are subject to this provision.

(C) "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

(D) "Claim Determination Period" means a calendar year.

Instructions

The definition of a "Plan" within the COB provision of group contracts enumerates the types of coverage which the Plan may consider in determining whether other coverage exists with respect to a specific claim. The definition:

1. May not include individual or family policies, or individual or family subscriber contracts, except as otherwise provided in this special instruction.

2. May include all group policies, group subscriber contracts, selected group disability insurance contracts issued pursuant to section 10270.97 of the Insurance Code and blanket insurance contracts, except blanket insurance contracts issued pursuant to section 10270.2(b) or (e) which contain nonduplication of benefits or excess policy provisions.

3. May not include any entitlements to Medi-Cal benefits under chapter 7 (commencing with section 14000) or chapter 8 (commencing with section 14500) of part 3 of division 9 of the Welfare and Institutions Code, or benefits under the California Crippled Children Services program under section 10020 of the Welfare and Institutions Code or any other coverage provided for or required by law when, by law, its benefits are excess to any private insurance or other non-governmental program.

4. May not include the medical payment benefits customarily included in the traditional automobile contracts.

5. May include "Medicare" or any other similar governmental benefits so long as it does not expand the definition of "Allowable Expenses" beyond the hospital, medical and surgical benefits as may be provided by the government program and so long as such benefits are not by law excess to this Plan.

(3) Effect on Benefits

(A) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of:

(i) the value of the benefits that would be provided by this Plan in the absence of this provision, and

(ii) the benefits that would be payable under all other plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

(B) As to any Claim Determination Period to which this provision is applicable, the benefits that would be provided under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in paragraph (3)C., shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been made therefor.

(C) If

(i) another Plan which is involved in paragraph (3)B. and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and

(ii) the rules set forth in paragraph (4) would require this Plan to determine its benefits before such other Plan, then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

(4) For the purposes of paragraph (3), use the first of the following rules establishing the order of determination which applies:

(A) The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent, except that, if the person is also a Medicare beneficiary and as a result of the rules established by Title XVIII of the Social Security Act (42 USC 1395 et seq.) and implementing regulations, Medicare is (i) secondary to the Plan covering the person as a dependent and (ii) primary to the Plan covering the person as other than a dependent (e.g., a retired employee), then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent.

(B) Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this subparagraph regarding dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this subparagraph shall not apply, and the rule set forth in the Plan which does not have the provisions of this subparagraph shall determine the order of the benefits.

(C) Except as provided in subparagraph (E), in the case of a person for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the

child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

(D) Except as provided in subparagraph (E), in the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

(E) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding subparagraphs (C) and (D), the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

(F) Except as provided in subparagraph (G), the benefits of a Plan covering the person for whose expenses claim is based as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other Plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person;

(G) If either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining its benefits after the other, then the rule under subparagraph (F) shall not apply;

(H) If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

(1) First, the benefits of a Plan covering the person as an employee, member, or subscriber, or as that person's dependent;

(2) Second, the benefits under continuation coverage. If the other Plan does not have the rules described above, and if, as a result, the Plans do not agree on the order of benefits, the rule under this subparagraph is ignored.

(I) When subparagraphs (A) through (H) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.

(5) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

Instructions

1. When a claim under a Plan with a COB provision involves another Plan which also has a COB provision, the carriers involved shall use the above rules to decide the order in which the benefits payable under the respective Plans will be determined.

2. In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within 24 hours after the prior Plan terminated. Thus, neither a change in the

amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another (e.g., single employer to multiple employer Plan, or vice versa, or single employer to a Taft-Hartley Welfare Plan) would constitute the start of a new Plan for purposes of this instruction.

3. If a claimant's effective date of coverage under a given Plan is subsequent to the date the carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this instruction, that the claimant's length of time covered under that Plan shall be measured from claimant's effective date coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall require the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time his coverage under that Plan has been in force.

4. It is recognized that there may be existing group plans containing provisions under which the coverage is declared to be "excess" to all other coverages, or other COB provisions not consistent with this rule. In such cases, plans are urged to use the following claims administration procedures: A group plan should pay first if it would be primary under the COB order of benefits determination. In those cases where a group plan would normally be considered secondary, the plan should make every effort to coordinate in a secondary position with benefits available through any such "excess" plans. The plan should try to secure the necessary information from the "excess" plan.

(6) Right to Receive and Release Necessary Information. For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, the Plan may release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish such information as may be necessary to implement this provision.

(7) Facility of Payment. Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Plan shall be fully discharged from liability under this Plan.

(8) Right of Recovery. Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as the Plan shall determine: any persons to or for or with respect to whom such payments were made, any insurers, service plans or any other organizations.

(c) Contracts in force on the effective date of this rule which contain an "excess" clause, "anti-duplication" provision, or any other provision by whatever name designated under which benefits would be reduced because of other existing coverages, shall be brought into compliance with this rule by the later of the next anniversary or renewal date of the group policy or contract, or the

expiration of the applicable collectively bargained contract pursuant to which they are written, if any.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 10270.98, Insurance Code.

History:

1. New section filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).
2. Repealer of former COB regulation section 1300.67.13 and adoption of new COB regulation section 1300.67.13 filed 3-9-87; effective upon filing pursuant to Government Code section 11346.2(d). Regulation approved for consistency with CCR, title 10, sections 2232.50 through 2232.59, as required by Insurance Code section 10270.98 (Register 87, No. 11).
3. Editorial correction of printing error restoring correct wording of subsection (8) of Instructions (Register 91, No. 33).
4. Amendment of subsections (b)(4)-(b)(4)(E), new subsections (b)(4)(F)-(b)(4)(H)(2), subsection relettering, and amendment of newly designated subsection (b)(4)(I) filed 8-6-93; operative 9-7-93 (Register 93, No. 32).
5. Editorial correction of printing error in History 2 (Register 93, No. 32).

§ 1300.67.205. Standard Prescription Drug Formulary Template.

The following standards are minimum standards, and unless otherwise noted, apply to all health plan formularies subject to section 1367.205 of the Health and Safety Code. A health plan may implement additional provisions exceeding these requirements.

(a) Definitions.

(1) "Coverage document" is a health plan contract, evidence of coverage, certificate of coverage, schedule of benefits, or any other contract for health coverage between an enrollee or subscriber and health plan.

(2) "Dosage form" is the physical form in which a prescription drug is produced and dispensed, such as a tablet, a capsule, or an injectable.

(3) "Established name" is the official nonproprietary name for a prescription drug, as defined in section 111225 of the Health and Safety Code, which must appear on the label pursuant to section 111355 of the Health and Safety Code.

(4) "Exception request" is the process by which an enrollee requests and gains access to clinically appropriate nonformulary drugs as set forth in sections 1367.24, 1367.241, and 1367.244 of the Health and Safety Code.

(5) "Exigent circumstances" is when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

(6) "Formulary" is the complete list of prescription drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product.

(7) "Nonformulary drug" is any prescription drug where an enrollee's copayment or out-of-pocket costs are different than the copayment or out-of-pocket costs for a formulary prescription drug, except as otherwise provided by law or regulation.

(8) "Prescription drug" or "drug" is a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug" or "prescription drug" includes: (A) disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs; (B) syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes; (C) drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs,

devices, and FDA-approved products; and (D) at the option of the health plan, any vaccines or other health care benefits covered under the prescription drug benefit of the health plan product.

(9) "Product" is a discrete package of health care coverage benefits that a health plan offers for a particular policy with a specific network service area.

(10) "Quantity Limit" is a restriction on the number of doses or any other limitations on the quantity of a prescription drug a health plan will cover during a specific time period.

(11) "Strength" is the amount of active ingredient or ingredients present in each dose of a prescription drug.

(b) Format of the formulary. The formulary shall be in a searchable format and shall include the following sections in the order listed:

(1) Cover page;

(2) Table of contents;

(3) Informational section;

(4) Categorical list of prescription drugs; and

(5) Index of prescription drugs.

(c) Cover page. The cover page of the formulary shall include all of the following:

(1) The title of the document.

(2) The name of the health plan offering the formulary.

(3) The name of each health plan product to which the formulary applies.

(4) The date the formulary was last updated.

(5) A notice that the formulary is subject to change and all previous versions of the formulary are no longer in effect.

(6) A direct website link/URL for the location of the electronic version of the formulary posted on the health plan's public website. The formulary shall be accessible to potential enrollees, enrollees, providers, and the general public. The formulary is accessible if it can be viewed on the website through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number, and if the health plan offers more than one health plan product, when an individual can easily discern which formulary applies to which health plan product.

(7) A direct website link/URL for the location of, or specific instructions for locating, plan-specific coverage documents that include cost sharing applicable to prescription drugs for each health plan product to which the formulary applies.

(d) Informational section. The informational section of the formulary shall include all of the following:

(1) Instructions for contacting the health plan's customer service department. A health plan shall have customer service representatives readily available during normal business hours to provide accurate, specific information concerning prescription drug benefits, including but not limited to:

(A) information concerning drugs covered under the medical benefit of the enrollee's contract;

(B) the actual dollar amount of cost sharing under the enrollee's contract for drugs subject to a copayment or coinsurance; and

(C) the process for submitting an exception request and requesting prior authorization and step therapy exceptions.

(2) Definitions. The informational section of the formulary shall have a definition section as prescribed below. A health plan may request an omission, deviation, or substitutions of the stated definitions to the Director for review and approval.

(A) "Brand name drug" is a drug that is marketed under a proprietary, trademark protected name. The brand name drug shall be listed in all CAPITAL letters.

(B) "Coinsurance" is a percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

(C) "Copayment" is a fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

(D) "Deductible" is the amount an enrollee pays for covered health care benefits before the enrollee's health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.

(E) "Drug Tier" is a group of prescription drugs that corresponds to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee's portion of the cost for the drug.

(F) "Enrollee" is a person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this formulary template shall also include subscribers as defined in this section below.

(G) "Exception request" is a request for coverage of a prescription drug. If an enrollee, his or her designee, or prescribing health care provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.

(H) "Exigent circumstances" are when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

(I) "Formulary" is the complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list,

(J) "Generic drug" is the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in ***bold and italicized lowercase*** letters.

(K) "Nonformulary drug" is a prescription drug that is not listed on the health plan's formulary.

(L) "Out-of-pocket cost" are copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.

(M) "Prescribing provider" is a health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.

(N) "Prescription" is an oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.

(O) "Prescription drug" is a drug that is prescribed by the enrollee's prescribing provider and requires a prescription under applicable law.

(P) "Prior Authorization" is a health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan

shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.

(Q) "Step therapy" is a process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee's medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee's prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.

(R) "Subscriber" means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

(3) Definitions of any additional or different terms used in the formulary that are necessary to understand the outpatient prescription drug benefit. The health plan must request review and approval from the Department for all additional or different terms used in the formulary, pursuant to section 1352 of the Health and Safety Code.

(4) Instructions for locating a prescription drug in the categorical list of prescription drugs. The instructions shall explain: (A) if a prescription drug may be located by looking up the therapeutic category and class of the drug or the brand or generic name of the drug in the alphabetical index; and (B) if a generic equivalent for a brand name drug is not available or is not covered, the drug will not be separately listed by its generic name.

(5) A description of how drugs are listed in the categorical list of prescription drugs. At minimum, the description shall explain: (A) a drug is listed alphabetically by its brand and generic names in the therapeutic category and class to which it belongs; (B) the generic name of a brand name drug is included after the brand name in parenthesis and all ***bold and italicized lowercase*** letters; (C) if a generic equivalent for a brand name drug is available, and both the brand name and generic equivalents are covered, the generic drug will be listed separately from the brand name drug in all ***bold and italicized lowercase*** letters; and (D) in the event a generic drug is marketed under a proprietary, trademark protected brand name, the brand name will be listed in all CAPITAL letters after the generic name in parentheses and regular typeface with first letter of each word capitalized. The description shall include an example of a drug available both as a brand name drug and a generic equivalent to illustrate how such a drug is listed.

(6) A description of the drug tiers in the formulary, if the drugs are grouped into tiers. The description shall include tier numbers designating the tiers and shall accurately describe the types of prescription drugs placed in each tier. The same description shall be used in the corresponding coverage documents. The description shall explain how to determine the following: (A) which prescription drugs on the formulary are preferred drugs; and (B) the cost sharing for each drug tier, including any applicable dollar maximum amounts for products subject to sections 1342.71 and 1342.73 of the Health and Safety Code. If the formulary has four tiers and is subject to sections 1342.71 and 1342.73 of the Health and Safety Code, drugs shall be placed in tiers consistent with the drug tier definitions in those sections of the Knox-Keene Act.

(7) A description of all utilization management restrictions the health plan imposes on prescription drug coverage, including but not limited to, prior authorization requirements, step therapy requirements, quantity limits, and network limitations on access including specialty pharmacy restrictions.

(8) Information about the differences between drugs covered under the medical benefit and drugs covered under the outpatient prescription drug benefit of the health plan product and instructions on how to obtain coverage information concerning drugs covered under the medical benefit.

(9) Notice that the health plan will update the formulary with any changes on a monthly basis. The notice shall include a description of the types of changes a health plan may make to the formulary during the policy year, the dates on which such changes shall be effective, and may include a description of any prior notification a health plan will provide an affected enrollee of a formulary change. At minimum, the notice shall include, but not be limited to, the following information: (A) change in drug or dosage form; (B) changes in tier placement of a drug that results in an increase in cost sharing; and (C) any changes of utilization management restrictions, including any additions of these restrictions.

(10) An explanation that the presence of a prescription drug on the formulary does not guarantee an enrollee will be prescribed that prescription drug by his or her prescribing provider for a particular medical condition.

(11) Notice that the health plan shall cover nonformulary drugs when medically necessary and a detailed description of the process for requesting coverage of a nonformulary drug. Subject to the exception in subdivision (k) of section 1367.24 of the Health and Safety Code, the description shall state that: (A) the health plan shall notify the enrollee or his or her designee and the enrollee's prescribing provider of its coverage determination within 24 hours of receipt of a request based on exigent circumstances and within 72 hours of receipt of all other requests; (B) the health plan shall provide coverage pursuant to a non-urgent request for the duration of the prescription, including refills; and (C) the health plan shall provide coverage, including refills, pursuant to a request based on exigent circumstances for the duration of the exigency. The description shall also state an enrollee may file a grievance or complaint, pursuant to section 1368 of the Health and Safety Code, relating to denial of a coverage request and that the coverage documents provide information on appeal rights and procedures.

(12) Instructions on how to locate and fill a prescription through a network retail pharmacy, mail order pharmacy, and specialty pharmacy, as applicable.

(13) A detailed description of the process for requesting prior authorization or a step therapy exception. Subject to the exceptions in subdivision (b) of section 1367.241 of the Health and Safety Code, the description shall state that if a health plan fails to respond to a completed prior authorization or step therapy request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request is deemed granted.

(14) Notice of an enrollee's rights to step therapy as provided in subdivision (d)(2) of Rule 1300.67.24.

(15) Notice pursuant to section 1367.22 of the Health and Safety Code that a health plan may not limit or exclude coverage for a drug if the health plan previously approved coverage of the drug for the enrollee's medical condition and the prescribing provider continues to prescribe the drug for the medical condition, provided the drug is appropriately prescribed and safe and effective for treating the enrollee's medical condition.

(16) A description of the coverage provided under the outpatient prescription drug benefit for drugs, devices, and FDA-approved products pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code. The description shall include a detailed explanation of the requirements and process to acquire

those drugs, devices, and FDA-approved products through the outpatient prescription drug benefit.

(17) A description of the limit on cost sharing for orally administered anti-cancer drugs required by section 1367.656 of the Health and Safety Code.

(18) If applicable to any drugs listed on the formulary, a detailed description of the process for requesting coverage and obtaining drugs that are subject to specialty pharmacy restrictions or other network limitations on coverage.

(19) An annotated legend or key to all abbreviations, symbols, and notations used in the formulary.

(e) Categorical list of prescription drugs.

(1) The categorical list of prescription drugs shall be organized by drug category and class based on a commonly used and widely accepted drug classification system such as the most current version of the U.S. Pharmacopeial Convention (USP) Medicare Model Guidelines or the American Hospital Formulary Service (AHFS) Pharmacologic-Therapeutic Classification. The formulary shall identify the drug classification system that is used. Prescription drugs shall be listed in drug classes consistent with the drug classification system. Prescription drugs belonging to multiple drug classes shall be listed in each applicable class. Category names shall appear alphabetically, and class names shall appear alphabetically within those categories. Brand name and generic prescription drugs shall be alphabetically listed by respective brand or established name within classes. In addition to a category and class name provided by the drug classification system, the categorical list shall include, where possible, a plain language description of the category and class.

(2) The categorical list shall include a complete list of all covered prescription drugs, including both generic and brand name drugs, and shall include, where possible, a plain language description of a prescription drug. A health plan may include prescription drugs covered only under the medical benefit of the product, provided that each such drug is clearly identified as a drug covered only under the medical benefit. A health plan may include nonformulary prescription drugs provided that each such drug is clearly identified as a nonformulary drug.

(3) The categorical list shall include columns in the following order from left to right: (A) Prescription Drug Name; (B) Drug Tier; and (C) Coverage Requirements and Limits. The column headings shall appear on the top of each page of the categorical list.

(4) In the "Prescription Drug Name" column, the proprietary name for a brand name drug shall appear in all CAPITAL letters. The established name for the brand name drug shall be placed in parentheses after the brand name in all ***bold and italicized lowercase*** letters. The established name for a generic drug shall appear in all ***bold and italicized lowercase*** letters. If a generic drug is sold under a brand name, the brand name shall be placed in parentheses after the established name in regular typeface with the first letter of each word capitalized.

(5) The "Prescription Drug Name" column shall include all covered dosage forms and strengths for each prescription drug. If there are differences in tier placement, quantity limit, prior authorization, step therapy, or other utilization restrictions or plan benefit offerings for a prescription drug based on its differing dosage forms or strengths, the categorical list of prescription drugs shall include separate rows for the dosage forms and/or strengths of the prescription drug to clearly identify the differences.

(6) The "Drug Tier" column shall identify the cost sharing tier where the prescription drug is placed, if applicable. A health plan shall use a unique tier number, abbreviation, or symbol for the following: (A) prescription drugs, devices, and FDA-approved products covered under the outpatient prescription

drug benefit of the product pursuant to sections 1367.002, 1367.25 and 1367.51 of the Health and Safety Code; (B) orally administered anti-cancer drugs that are subject to the cost sharing limit in section 1367.656 of the Health and Safety Code; (C) nonformulary drugs; and (D) drugs covered only under the medical benefit. The tier abbreviations, notations or symbols shall be explained in the annotated legend or key of the formulary.

(7) The "Coverage Requirements and Limits" column shall include abbreviations, notations, or symbols for all utilization management restrictions that the health plan imposes on prescription drug coverage, including but not limited to, prior authorization, step therapy, quantity limits, and network limitations on access including specialty pharmacy restrictions, in addition to any other requirements, limits, or other relevant information applicable to the coverage provided for a prescription drug. For each prescription drug subject to quantity limits, the applicable quantity limits shall be described with specificity. Each abbreviation, symbol, or notation used in the "Coverage Requirements and Limits" column shall be explained in the annotated legend or key of the formulary.

(8) The annotated legend or key to all abbreviations, symbols, and notations used in the formulary shall appear on each page of the categorical list.

(f) Index. The index shall list each covered brand name and generic drug by respective brand name or established name in alphabetical order and include the page number for the location of the drug in the categorical list of prescription drugs.

NOTE: Authority cited: Sections 1344 and 1367.205, Health and Safety Code. Reference: Sections 1342.71, 1367.002, 1367.205, 1367.24, 1367.241, 1367.25 and 1367.656, Health and Safety Code.

History:

1. New section filed 6-25-2019; operative 10-1-2019 (Register 2019, No. 26).

§ 1300.67.24. Outpatient Prescription Drug Copayments, Coinsurance, Deductibles, Limitations and Exclusions.

(a) Every health care service plan that provides coverage for outpatient prescription drug benefits shall provide coverage for all medically necessary outpatient prescription drugs except as described in this section, subject to the requirements of Health and Safety Code section 1342.7(g).

(1) Outpatient prescription drugs are self-administered drugs approved by the Federal Food and Drug Administration for sale to the public through retail or mail-order pharmacies that require prescriptions and are not provided for use on an inpatient basis. For purposes of this section "inpatient basis" has the meaning indicated in Section 1300.67(b), and "self-administered" means those drugs that need not be administered in a clinical setting or by a licensed health care provider.

(2) Coverage for outpatient prescription drugs shall also include coverage for disposable devices that are medically necessary for the administration of a covered outpatient prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs, and syringes for self-injectible outpatient prescription drugs that are not dispensed in pre-filled syringes. For purposes of this section, the term "disposable" includes devices that may be used more than once before disposal. This section does not create an obligation for a plan to provide coverage for a durable medical equipment benefit.

(b) Standards for outpatient prescription drug benefit plans

(1) A prescription drug benefit offered by a plan shall comply with the requirements of the Knox-Keene Act and the regulations promulgated by the

Director of the Department of Managed Health Care, including but not limited to Sections 1342, 1343.5, 1342.7, 1363, 1363.01, 1363.03, 1363.5, 1367(e), 1367(g), 1367(h), 1367.01, 1367.20, 1367.21, 1367.22 and 1367.24 of the Act and Section 1300.67.4(a)(3)(A) of these rules.

(2) All clinical aspects of a plan's prescription drug benefit shall be developed by qualified medical and pharmacy professionals in accordance with good professional practice. The plan shall establish and document an internal process for ongoing review by qualified medical and pharmacy professionals of the clinical aspects of the prescription drug benefit, including review of limitations and exclusions, and the safety, efficacy, and utilization of outpatient prescription drugs.

(3) Plans seeking to establish limitations or exclusions on outpatient prescription drug benefits shall do so consistent with up-to-date evidence-based outcomes and current published, peer-reviewed medical and pharmaceutical literature.

(4) A plan that provides coverage for prescription drugs through a mail order pharmacy shall have written policies and procedures documenting that the plan's mail order arrangements are in compliance with the requirements of the Act and this section, and applicable California and federal laws regarding pharmacists and pharmacy services. The mail order pharmacy process shall conform effectively and efficiently with a plan's processes for prior authorization for coverage of medically necessary drugs as required by the Act, and shall include standards for timely delivery and a contingency mechanism for providing the drug if a mail order provider fails to meet the delivery standards.

(5) In reviewing copayments, coinsurance, deductibles, limitations, or exclusions for compliance with Section 1367(e) and (h) of the Act, and Section 1300.67.4(a)(3)(A) of these rules, the Department's approval or disapproval may be based upon all relevant factors, including but not limited to:

(A) The type and number of enrollees affected;

(B) The clinical efficacy of the drug(s) proposed to be limited or excluded;

(C) The availability of therapeutic equivalents or other drugs medically necessary for treatment of health conditions;

(D) The specific health plan products to which the copayment, coinsurance, deductible, limitation, or exclusion will apply;

(E) The duration of the limitation or exclusion;

(F) The rationale for the copayment, coinsurance, deductible, limitation or exclusion;

(G) The projected effect of the copayment, coinsurance, deductible, limitation, or exclusion on the affordability and accessibility of coverage;

(H) The projected comparative clinical effect, including any potential risk of adverse health outcomes, based upon utilization data and review of peer-reviewed professional literature;

(I) The overall copayment structure of the product, including whether the copayment, coinsurance, or deductible contributes to the overall out-of-pocket maximum for the product;

(J) Information regarding similar copayments, coinsurance levels, deductibles, limitations, or exclusions previously approved by the Department;

(K) Evidence-based clinical studies and professional literature;

(L) The description of the copayment, coinsurance, deductible, limitation or exclusion as compared to other benefits and products in the marketplace;

(M) Any other historical, statistical, or other information that the submitting plan considers pertinent to the request for approval of the copayments, coinsurance level, deductibles, limitation, or exclusion.

(c) Copayments, Coinsurance and Deductibles

(1) A plan's prescription drug benefit shall provide that if the pharmacy's retail price for a prescription drug is less than the applicable copayment amount, the enrollee shall not be required to pay any more than the retail price.

(2) Proposed copayment structures or ranges, coinsurance, or deductibles submitted to the Director for approval shall be based upon a methodology that is fully described and documented, and that complies with the standards set forth in this Section. A plan may use actual cost data on prescription drugs or, for contracted services or products, nationally recognized data sources used by the plan in developing the contract rates.

(3) A copayment or percentage coinsurance shall not exceed 50 percent of the cost to the plan as described in subsection (c)(5) and (6). A percentage coinsurance shall meet one of the following additional requirements:

(A) Have a maximum dollar amount cap on the percentage coinsurance that will be charged for an individual prescription;

(B) Apply towards an annual out-of-pocket maximum for the product; or

(C) Apply towards an annual out-of-pocket maximum for the prescription drug benefit.

(4) In addition to compliance with this subsection (c), copayments and coinsurances shall comply with the standards identified at subsection (b), including that they shall be reasonable so as to allow access to medically necessary outpatient prescription drugs, and the Department's determination may be based on all relevant factors as provided in subsection (b)(5).

(5) The "cost to the plan" means the actual cost incurred by the plan or its contracting provider to acquire and dispense a covered outpatient prescription drug, without subtracting or otherwise considering any copayment or coinsurance amount to be paid by enrollees. The cost to the plan may include average cost calculations as described in this section, and shall include all discounts and other prospective cost and pricing arrangements, as applicable. Plans shall account for any rebates and other retrospective cost and pricing arrangements for outpatient prescription drugs by verifying that the rebates and other retrospective cost and pricing arrangements for outpatient prescription drugs are applied by the plan to reduce costs for the plan's subscribers.

(6) Compliance with the requirement not to exceed 50 percent of the actual cost to the plan may be met by various methods including the three methods described below. A plan may propose a different method, which shall be filed with the Department prior to implementation by the plan and supported by information and documentation sufficient to satisfy the Department as to the validity of the calculation methodology.

(A) Average Cost in Each Tier. This copayment represents the average plan cost per drug in a tier and is calculated in the following manner:

1. The copayment is for one tier in a multi-tier prescription drug benefit. (EXAMPLE: the Name Brand tier.)

2. Add together the plan's cost for all the drugs in that tier. (EXAMPLE: the Name Brand tier covers X drug which costs the plan $50 per prescription, Y drug which costs $100 per prescription, and Z drug which costs the plan $75 per prescription-added together for a total cost of $225.)

3. Divide the cost determined according to 2 above by the total number of drugs in that same tier. (EXAMPLE: there are 3 drugs in the Name Brand tier which cost the plan $225, $225/3 = $75.)

4. The copayment may not exceed 50 percent of the average cost of drugs in the tier to which it applies. (EXAMPLE: 50% of $75 = $37.50. The copayment for the Name Brand tier may not exceed $37.50.)

(B) Weighted Average Cost in Each Tier. This copayment is the same as the average per tier except that the prescriptions actually covered by the plan are used in the calculation.

1. The copayment is for one tier in a multi-tier prescription benefit. (EXAMPLE: the Name Brand tier.)

2. Calculate the number of prescriptions for drugs in that tier actually covered by the plan. (EXAMPLE: the plan covered the cost of 10 prescriptions in the Name Brand tier.)

3. Add together the cost for all the drugs covered in 2 above. (EXAMPLE: the plan covered three prescriptions for X drug (3 x $50= $150), three for Y drug (3 x $100 = $300) and four for Z drug (4 x $75 = $300). $150 + $300 + $300 = $750 total cost for prescriptions in that tier covered by the plan.)

4. Divide the total cost determined according to 3 above by the number of prescriptions from step 2. (EXAMPLE: $750/10 = $75.)

5. The copayment may not exceed 50 percent of the weighted average cost of drugs in the tier to which it applies. (EXAMPLE: 50% of $75 = $37.50. The copayment for the Name Brand tier may not exceed $37.50.)

(C) Weighted Average Cost Across All Tiers. This copayment is the same as the weighted average per tier except that there is one copayment calculated using the number of prescriptions for all tiers covered by the plan.

1. The copayment is for all tiers in a multi-tier prescription benefit. (EXAMPLE: the Name Brand tier and the Generic tier.)

2. Calculate the number of prescriptions for drugs in that tier actually covered by the plan. (EXAMPLE: Ten prescriptions under the Name Brand tier (three for X drug, three for Y drug and four for Z drug, ten prescriptions under the Generic tier (three for drug A, three for drug B and four for Drug C for a total of twenty drugs.)

3. Add together the cost for all the drugs covered in 2 above. (EXAMPLE: the ten Name Brand drugs cost $750 (from previous example) plus the Generic drugs, three for A drug (3 x $5 = $15), three for B drug (3 x $10 = $30) and four for C drug (4 x $15 = $60) (Generic total = $105) ($750 + $105 = $855 cost for all the drugs covered in the Name Brand and Generic tiers.)

4. Divide the total cost across tiers determined according to 3 above by the number of prescriptions from step 2. (EXAMPLE: $855/20 = $42.75)

5. The copayment may not exceed 50 percent of the weighted average cost of drugs in all the tiers in the prescription drug benefit to which it applies. (EXAMPLE: 50% of $42.75 = $21.38. The copayment for all tiers may not exceed $21.38.)

(d) Limitations

Plans that provide coverage for outpatient prescription drug benefits may apply the following limitations:

(1) A plan may impose prior authorization requirements on prescription drug benefits, consistent with the requirements of the Act and regulations.

(2) When there is more than one drug that is appropriate for the treatment of a medical condition, a plan may require step therapy. A plan that requires step therapy shall have an expeditious process in place to authorize exceptions to step therapy when medically necessary and to conform effectively and efficiently with continuity of care requirements of the Act and regulations. In circumstances where an enrollee is changing plans, the new plan may not require the enrollee to repeat step therapy when that enrollee is already being treated for a medical condition by a prescription drug provided that the drug is appropriately prescribed and is considered safe and effective for the enrollee's condition. Nothing in this section shall preclude the new plan from imposing a prior authorization requirement pursuant to Section 1367.24 for the continued

coverage of a prescription drug prescribed pursuant to step therapy imposed by the former plan, or preclude the prescribing provider from prescribing another drug covered by the new plan that is medically appropriate for the enrollee. For purposes of this section, "step therapy" means a type of protocol that specifies the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are to be prescribed.

(3) A plan shall provide coverage for the medically necessary dosage and quantity of the drug prescribed for the treatment of a medical condition consistent with professionally recognized standards of practice.

(A) A plan may limit the amount of the drug dispensed at any one time to a 30-day supply or, if the treatment is for less than 30 days, for the medically necessary amount of the drug.

(B) A plan may impose a requirement that maintenance drugs be dispensed in a two months or greater supply.

(C) A plan may establish a mandatory mail order process for maintenance drugs when dispensed in a three months supply or greater quantities, but shall not impose any fees or costs for mandatory mail order prescriptions other than the applicable copayment or coinsurance. A plan shall not require an enrollee to fill a prescription by mail if the prescribed drug is not available to be filled in that manner.

(D) For purposes of this section,"maintenance drugs" means those outpatient prescription drugs that are prescribed for the enrollee on a continual basis to treat a chronic condition.

(4) Plans may require enrollees who are prescribed drugs for smoking cessation to be enrolled in or to have completed a smoking cessation program, if covered by the plan prior to or concurrent with receiving the prescription drug.

(5) Other limitations that the Department may approve pursuant to Section 1342.7 of the Act and this section.

(e) Exclusions

Plans that provide coverage for outpatient prescription drug benefits are not required to provide coverage for prescription drugs that meet the following conditions:

(1) When prescribed for cosmetic purposes. For purposes of this section "cosmetic" means drugs solely prescribed for the purpose of altering or affecting normal structures of the body to improve appearance rather than function.

(2) When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. Drugs for mental performance shall not be excluded from coverage when they are used to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.

(3) When prescribed solely for the purposes of losing weight, except when medically necessary for the treatment of morbid obesity. Plans may require enrollees who are prescribed drugs for morbid obesity to be enrolled in a comprehensive weight loss program, if covered by the plan, for a reasonable period of time prior to or concurrent with receiving the prescription drug.

(4) When prescribed solely for the purpose of shortening the duration of the common cold.

(5) Drugs that are available over the counter. A plan shall not exclude coverage of an entire class of prescription drugs when one drug within that class becomes available over the counter. A plan that seeks to exclude coverage for an entire class of drugs when more than one drug within that class become available over the counter, shall first file a notice of material modification and

obtain the Department's prior approval in accordance with Section 1342.7 of the Act and this regulation.

(6) Replacement of lost or stolen drugs.

(7) Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider except when coverage is otherwise required in the context of emergency services.

(8) Other categories of prescription drugs approved by the Department pursuant to Section 1342.7 of the Act and this section.

(f) Oversight of Plan and Provider Compliance

A plan shall have written policies and procedures for its outpatient prescription drug benefits, and quality assurance systems in place for the early identification and swift correction of problems in the accessibility and availability of outpatient prescription drug benefits. A contract between a health care service plan and a prescription drug benefit provider shall include provisions, terms and conditions sufficient to ensure that the standards and requirements of this regulation are met.

(g) Implementation

(1) Any exclusion or limitation on a prescription drug benefit that is not described at subsections (d) or (e) may not be applied to any plan's prescription drug benefit unless a plan has filed a notice of material modification with the Department and received approval by Order to apply the exclusion or limitation. The Order of approval may be issued subject to specified terms and conditions, or for specified periods, as the Department may determine are necessary and appropriate. Following issuance of an Order approving an exclusion or limitation, any other licensed plan may apply the same exclusion or limitation to its prescription drug benefit if it files an amendment with the Department not less than 30 days prior to implementation of the exclusion or limitation, and represents that it is exactly the same as that previously approved by Order, provides specific reference to the Order number and date issued, and addresses any specified terms and conditions upon such Order, as applicable.

(2) A plan may meet the material modification filing requirements of subsection (g)(1) with respect to exclusions and limitations contained in contracts issued, renewed or amended on or before January 1, 2007, by filing within six months of the effective date of this regulation a report disclosing and describing all such exclusions and limitations on prescription drug benefits covered under all subscriber contracts subject to the requirements of Section 1342.7 of the Act. The Department will provide an expeditious review of the exclusions and limitations disclosed in the report.

NOTE: Authority cited: Sections 1342.7, 1344 and 1346, Health and Safety Code. Reference: Sections 1342, 1342.7, 1343.5, 1363, 1363.01, 1363.03, 1363.5, 1367, 1367.01, 1367.215, 1367.24, 1367.25, 1367.45, 1367.51, 1374.72 and 1375.1, Health and Safety Code; see also SB 842. ch.791, Stats. 2002.

History:

1. New section filed 11-3-2000 as an emergency; operative 11-3-2000 (Register 2000, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-5-2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 11-3-2000 order transmitted to OAL 3-5-2001 and filed 4-16-2001 (Register 2001, No. 16).
3. Amendment of section heading and repealer and new section and Note filed 6-26-2006; operative 7-26-2006 (Register 2006, No. 26).

§ 1300.67.241. Prescription Drug Prior Authorization or Step Therapy Exception Request Form Process.

(a) Health plans that utilize a prescription drug prior authorization or step therapy exception process shall use and accept only the Prescription Drug Prior

Authorization or Step Therapy Exception Request Form, numbered 61-211 (Revised 12/16), which is incorporated by reference and referred to hereafter in this section as "Form 61-211." This section does not apply to the following except as further specified in this regulation:

(1) Contracted physician groups described in Section 1367.241, subdivision (f)(1)-(3) of the Act.

(2) Health plans or their affiliated providers if the health plan owns or operates its pharmacies and does not utilize prescription prior authorizations for prescription drugs.

(3) Physicians or physician groups that have been delegated the financial risk for prescription drugs by a health care service plan and that do not use a prior authorization process.

(b) Contracted physician groups specified in subdivision (a)(1) shall comply with the following provisions of this regulation: subdivisions (e)(3), (e)(4), (k), (*l*), (m)(1), (m)(2) and (m)(3).

(c)(1) A prescribing provider may use an electronic prior authorization system compliant with the SCRIPT standard as described in Health and Safety Code Section 1367.241, subdivision (e), in place of Form 61-211.

(2) A prescribing provider may submit prescription drug prior authorization or step-therapy exception requests using the contracted physician group's process for those groups described in section 1367.241, subdivision (f)(1)-(3) of the Act.

(d) A health plan that contracts with a pharmacy benefit manager to conduct prescription drug prior authorization or step therapy exception request services shall require their pharmacy benefit manager to use and accept only Form 61-211, except as specified in subdivision (c) of this regulation.

(e) Beginning January 1, 2018, a health plan that maintains the financial risk for prescription drug or step therapy exception benefits and its contracted pharmacy benefit managers shall do the following:

(1) Make Form 61-211 electronically available on their websites.

(2) Accept Form 61-211 or a form or a process compliant with subdivision (c) of this regulation through any reasonable means of transmission, including, but not limited to, paper, electronic transmission, telephone, web portal, or another mutually agreeable accessible method of transmission.

(3) Request from the prescribing provider only the minimum amount of material information necessary to approve or disapprove the prescription drug prior authorization or step therapy exception request. If state or federal law requires additional information for dispensing restricted prescription drugs, that information shall be submitted as part of section 3. of Form 61-211 or as specified in subdivision (c) of this regulation.

(4) Notify the prescribing provider and the enrollee or the enrollee's designee within 24 hours for exigent circumstances or 72 hours for non-urgent requests of receipt of a prescription drug prior authorization or step therapy exception request, including requests submitted pursuant to subdivision (c) of this regulation, that either:

(A) The prescribing provider's request is approved; or

(B) The prescribing provider's request is disapproved as not medically necessary or not a covered benefit; or

(C) The prescribing provider's request is disapproved as missing material information necessary to approve or disapprove the prescription drug prior authorization or step therapy exception request; or

(D) The patient is no longer eligible for coverage; or

(E) The prescription drug prior authorization or step therapy exception request was not submitted on the required form. Please resubmit your request

on the attached Form 61-211 or on a form or process compliant with subdivision (c) of this regulation;

(F) This subdivision (e)(4) shall not apply to Medi-Cal managed care contracts or any contracts entered into pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(f) Definitions. The following definitions are applicable for this regulation:

(1) Exigent circumstances shall mean the circumstances described in section 1367.241, subdivision (h) of the Act.

(2) Step therapy exception is the exception to the step therapy process and the determination of whether the exception shall be granted, taking into consideration the enrollee's needs and medical circumstances, along with the professional judgment of the enrollee's provider.

(3) Electronic I.D. Verification shall mean a unique identification number that clearly identifies the prescribing provider on the prescription drug prior authorization or step therapy exception request to allow verification by the health plan or pharmacy benefit manager.

(g) For nonformulary prescription drug exception requests and subsequent coverage, the health plan or its contracted pharmacy benefits manager shall comply with 45 C.F.R. 156.122(c). This subdivision (g) shall not apply to Medi-Cal managed care contracts or any contracts entered into pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(h) A health plan that offers a prescription drug prior authorization or step therapy exception process telephonically or through a web portal shall not require the prescribing provider to provide more information than is required by Form 61-211 or a form or process compliant with subdivision (c) of this regulation.

(i) Notices to the prescribing provider required under this regulation shall be delivered in the same manner as the prescription drug prior authorization or step therapy exception request was submitted, or another mutually agreeable accessible method of notification.

(j) "Minimum Amount of Material Information" means the information generated by or in the possession of the prescribing provider related to the patient's clinical condition that enables an individual with the appropriate training, experience, and competence in prescription drug prior authorization processing to determine if the prescription drug prior authorization or step therapy exception request should be approved or disapproved.

(k) In the event the prescribing provider's prescription drug prior authorization or step therapy exception request is disapproved pursuant to (e)(4)(B), the notice of disapproval shall contain an accurate and clear written explanation of the specific reason(s) for disapproving the prescription drug prior authorization or step therapy exception request. In the event the prescribing provider's prescription drug prior authorization or step therapy exception request is disapproved pursuant to (e)(4)(C), the notice of disapproval shall contain an accurate and clear written explanation of the specific material information that is necessary to approve the request.

(l)) In the event the health plan or contracted physician group fails to send the notice of disapproval, consistent with the requirements of subdivisions (e) and (c), to the prescribing provider 24 hours for exigent circumstances or 72 hours for non-urgent requests, the prescription drug prior authorization or step therapy exception request shall be deemed approved. This subdivision (*l*)

shall not apply to Medi-Cal managed care contracts or any contracts entered into pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(m) Review and Enforcement.

(1) A health plan or physician group that contracts with a pharmacy benefit manager to conduct prescription drug prior authorization or step therapy exception services shall include a provision in the contract requiring the pharmacy benefit manager to comply with section 1367.241 of the Act and this regulation.

(2) A health plan or contracted physician group that contracts with a pharmacy benefit manager to conduct prescription drug prior authorization or step therapy exception services shall have written policies and procedures in place to ensure that the contracted pharmacy benefit managers comply with section 1367.241 of the Act and this regulation.

(3) The obligation of the health plan or contracted physician group to comply with section 1367.241 of the Act and this regulation shall not be deemed to be waived when the health plan or contracted physician group contracts with a pharmacy benefit manager to conduct prescription drug prior authorization or step therapy exception services except as otherwise specified under this regulation.

(4) A health plan or contracted pharmacy benefit manager that requires a prescribing provider to utilize a prescription drug prior authorization or step therapy exception form or process in violation of this regulation shall subject the health plan to all civil, criminal, and administrative remedies available under the Act.

(5) Failure of a health plan or a contracted pharmacy benefit manager to comply with the requirements of section 1367.241 of the Act and this regulation may constitute a basis for disciplinary action against the health plan. The Director shall have the civil, criminal, and administrative remedies available under the Act, including section 1394.

NOTE: Authority cited: Sections 1341.9, 1344, 1367.24, 1367.241 and 1367.244, Health and Safety Code. Reference: Sections 1367.24, 1367.241 and 1367.244, Health and Safety Code.

HISTORY:

1. New section filed 4-28-2014; operative 7-1-2014 (Register 2014, No. 18).
2. Amendment of section and Note filed 3-21-2017; operative 7-1-2017 (Register 2017, No. 12).

§ 1300.67.50. Certain Medicare Supplement Contracts: Presumption of Unfairness.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1367 and 1384(d), Health and Safety Code.

History:

1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).
2. Amendment of subsections (a) and (c), new subsection (d)(4), renumbering with amendment to subsections (d)(5) and (d)(6) and amendment of NOTE filed 11-26-91; operative 12-26-91 (Register 92, No. 10).
3. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

§ 1300.67.51. Medicare Supplement Contract Provisions. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367, Health and Safety Code.

History:

1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).
2. Amendment of subsections (a), (b)(1), (b)(10)(A), (b)(10)(N), (c)(2), (c)(4)-(6), (d)(2) and new (d)(3.1)-(vii) filed 11-26-91; operative 12-26-91 (Register 92, No. 10).

3. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

§ 1300.67.52. Medicare Supplement Additional Benefit Requirements. [Repealed]

NOTE: Authority cited: Sections 1344, 1367 and 1367.15, Health and Safety Code. Reference: Sections 1344, 1367 and 1367.15, Health and Safety Code.

History:
1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).
2. New subsection (b) and subsection renumbering, repealer of subsection (e) and new subsections (f)-(h) filed 1-8-92; operative 1-1-92 (Register 92, No. 12).
3. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

§ 1300.67.53. Medicare Supplement Minimum Aggregate Benefits. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367, Health and Safety Code.

History:
1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).
2. Amendment of subsections (a), (c), (d), new subsection (e) and relettering filed 11-26-91; operative 12-26-91 (Register 92, No. 10).
3. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

§ 1300.67.55. Medicare Supplement Reporting Requirements. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1346(c),1352.1 and 1367.15, Health and Safety Code; 42 U.S.C. 1395u(h)(3)(B) and 42 U.S.C. 1395ss.

History:
1. New section filed 11-26-91; operative 12-26-91 (Register 92, No. 10).
2. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

§ 1300.67.56. Transitional Requirements for the Conversion of Medicare Supplement Contracts to Conform to Medicare Program Revisions. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1346(c) and 1367.15, Health and Safety Code; 42 U.S.C. 1395ss.

History:
1. New section filed 11-26-91; operative 12-26-91 (Register 92, No. 10).
2. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

§ 1300.67.57. Format For Notices of Changes in Coverage. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367.15, Health and Safety Code; 42 U.S.C. 1395ss.

History:
1. New section filed 11-26-91; operative 12-26-91 (Register 92, No. 10).
2. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

§ 1300.67.58. Participating Physician or Supplier Claims Form Requirement. (Compliance with Section 4081 of the Omnibus Budget Reconciliation Act of 1987) [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1367(h) and 1367.15, Health and Safety Code; 42 U.S.C. 1395u(h)(3)(B) and 42 U.S.C. 1395ss.

History:
1. New section filed 11-26-91; operative 12-26-91 (Register 92, No. 10).
2. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

§ 1300.67.59. Format for Reporting Loss Ratio Experience. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1367.15 and 1384(d), Health and Safety Code; 42 U.S.C. 1395ss.

History:
1. New section filed 11-26-91; operative 12-26-91 (Register 92, No. 10).
2. Change without regulatory effect repealing section filed 9-14-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 38).

ARTICLE 8
Self-Policing Procedures

Section
1300.67.60. Standing Referral to HIV/AIDS Specialist. [Renumbered]
1300.68. Grievance System.
1300.68.01. Expedited Review of Grievances.
1300.68.2. Hospice Services.
1300.69. Public Policy Participation by Subscribers.
1300.70. Health Care Service Plan Quality Assurance Program.
1300.70.4. Independent Medical Reviews Experimental and Investigational Therapies.
1300.71. Claims Settlement Practices.
1300.71.4. Emergency Medical Condition and Post-Stabilization Responsibilities for Medically Necessary Health Care Services.
1300.71.31. Methodology for Determining Average Contracted Rate; Default Reimbursement Rate.
1300.71.38. Fast, Fair and Cost-Effective Dispute Resolution Mechanism.
1300.71.39. Unfair Billing Patterns.
1300.73.21. Arbitration and Settlement Agreements.
1300.74.16. Standing Referral to HIV/AIDS Specialist.
1300.74.30. Independent Medical Review System.
1300.74.72. Mental Health Parity.
1300.74.73. Pervasive Developmental Disorder and Autism Coverage.

§ 1300.67.60. Standing Referral to HIV/AIDS Specialist. [Renumbered]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1344 and 1374.16, Health and Safety Code.

History:
1. New section filed 12-17-2002; operative 1-16-2003 (Register 2002, No. 51).
2. Renumbering of former section 1300.67.60 to new section 1300.74.16 filed 1-10-2008; operative 2-9-2008 (Register 2008, No. 2).

§ 1300.68. Grievance System.

Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.

(a) The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems:

(1) "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a' grievance and an inquiry, it shall be considered a grievance.

(2) "Complaint" is the same as "grievance."

(3) "Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

(4) "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.

(A) If the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the plan's receipt of the grievance.

(B) Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances pursuant to subsection (f) below. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the plan resulting from the review is completed.

(b) The plan's grievance system shall include the following:

(1) An officer of the plan shall be designated as having primary responsibility for the plan's grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures.

(2) Each plan's obligation for notifying subscribers and enrollees about the plan's grievance system shall include information on the plan's procedures for filing and resolving grievances, and the telephone number and address for presenting a grievance. The notice shall also include information regarding the Department's review process, the independent medical review system, and the Department's toll-free telephone number and website address.

(3) The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Plans shall develop and file with the Department a policy describing how they ensure that their grievance system complies with this subsection within 90 days of the effective date of this regulation.

(4) The plan shall maintain a toll-free number, or a local telephone number in each service area, for the filing of grievances.

(5) A written record shall be made for each grievance received by the plan, including the date received, the plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to section 1300.69, and by an officer of the plan or his designee. This review shall be thoroughly documented.

(6) The plan grievance system shall ensure that assistance in filing grievances shall be provided at each location where grievances may be submitted. A "patient advocate" or ombudsperson may be used.

(7) Grievance forms and a description of the grievance procedure shall be readily available at each facility of the plan, on the plan's website, and from each contracting provider's office or facility. Grievance forms shall be provided promptly upon request.

(8) The plan shall assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance.

(9) The grievance system shall allow enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of the enrollee's dissatisfaction.

(c) Through periodic medical surveys under Section 1380 of the Act, the Department shall periodically review the plan's grievance system, including the records of grievances received by the plan, and assess the effectiveness of the plan policies and actions taken in response to grievances.

(d) The plan shall respond to grievances as follows:

(1) A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance.

(2) The grievance system shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance.

(3) The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.

(4) For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

(5) Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee. In addition to the notice set forth at Section 1368.02(b) of the Act, the response shall also include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.

(6) Copies of grievances and responses shall be maintained by the Plan for five years, and shall include a copy of all medical records, documents, evidence of coverage and other relevant information upon which the plan relied in reaching its decision.

(7) The Department's telephone number, the California Relay Service's telephone numbers, the plan's telephone number and the Department's Internet address shall be displayed in all of the plan's acknowledgments and responses to grievances in 12-point boldface type with the statement contained in subsection (b) of Section 1368.02 of the Act.

(8) Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in subsection (b).

(e) The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The system shall:

(1) Monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the enrollee or plan; and the number of grievances pending over 30 calendar days. The system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other contracts. The system shall indicate whether an enrollee grievance is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) an action filed or before a trial or appellate court; or (5) other dispute resolution process. Additionally, the system shall indicate whether an enrollee grievance has been submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration.

(2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the quality of care and (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues.

(f) Quarterly Reports

(1) All plans shall submit a quarterly report to the Department describing grievances that were or are pending and unresolved for 30 days or more. The report shall be prepared for the quarters ending March 31st, June 30th, September 30th and December 31st of each calendar year. The report shall also contain the number of grievances referred to external review processes, such as reconsiderations of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, the Medi-Cal fair hearing process, the Department's complaint or Independent Medical Review system, or other external dispute resolution systems, known to the plan as of the last day of each quarter.

(2) The quarterly report shall include:

(A) The licensee's name, quarter and date of the report;

(B) The total number of grievances filed by enrollees that were or are pending and unresolved for more than 30 calendar days at any time during

the quarter under the categories of Commercial, Medicare, and Medi-Cal/other products offered by the plan;

(C) A brief explanation of why the grievance was not resolved in 30 days, and indicate whether the grievance was or is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) court; or (5) other dispute resolution processes. Alternatively, the plan shall indicate whether the grievance was or is submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration.

(D) The nature of the unresolved grievances as (1) coverage disputes; (2) disputes involving medical necessity; (3) complaints about the quality of care; (4) complaints about access to care (including complaints about the waiting time for appointments); (5) complaints about the quality of service; and (6) other issues. All issues reasonably described in the grievance shall be separately categorized.

(E) The; quarterly report shall not contain personal or confidential information with respect to any enrollee.

(3) The quarterly report shall be verified by an officer authorized to act on behalf of the plan. The report shall be submitted in writing or through electronic filing to the Department's Sacramento Office to the attention of the Filing Clerk no later than 30 days after each quarter. The quarterly report shall not be filed as an amendment to the plan application.

(4) The quarterly report shall be filed in the format specified in subsection (i).

(g) An enrollee may submit a grievance to the Department. The Department shall notify the plan, and within five (5) calendar days after notification, the plan shall provide the following information to the Department:

(1) A written response to the issues raised by the grievance.

(2) A copy of the plan's original response sent to the enrollee regarding the grievance.

(3) A complete and legible copy of all medical records related to the grievance. The plan shall inform the Department if medical records were not used by the plan in resolving the grievance.

(4) A copy of the cover page and all relevant pages of the enrollee's Evidence of Coverage (EOC), with the specific applicable sections underlined. If the plan relied solely on the EOC, the plan shall notify the Department of that fact.

(5) All other information used by the plan or relevant to the resolution of the grievance.

(6) The Department may request additional information or medical records from the plan. Within five (5) calendar days of receipt of the Department's request, the plan shall forward information and records that are maintained by the plan or any contracting provider. If requested information cannot be timely forwarded to the Department, the plan's response will describe the actions being taken to obtain the information or records and when receipt is expected.

(h) Nothing in this section shall preclude an enrollee from seeking assistance directly from the Department in cases involving an imminent or serious threat to the health of the enrollee or where the Department determines an earlier review is warranted. In such cases, the Department may require the plan and contracting providers to expedite the delivery of information.

The Department may consider the failure of a plan to timely provide the requested information as evidence in favor of the enrollee's position in the Department's review of grievances submitted under subsection (b) of Section 1368 of the Act.

(i)

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE
QUARTERLY REPORT OF
PENDING AND UNRESOLVED GRIEVANCES
PURSUANT TO HEALTH AND SAFETY CODE SECTION 1368(c)

Name of Licensed Health Plan (as appearing on license):
_____

DMHC Plan File No.: _____ _____

Report for_____Quarter 200 _

Categories of Grievances Included in this Report: (Check and list current enrollment)

[ ] Commercial
[ ] Medicare
[ ] Medi-Cal
[ ] Healthy Families

Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues that are not available to other enrollees. Therefore, grievances pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights.

I. Total Number of Grievances Unresolved Within 30 Days During the Quarter

NOTE: These include all grievances received by the plan or any entity to which the plan has delegated grievance resolution.

	Total	*Comm*	*Medicare*	*MediCal*
A. Total number of grievances pending or submitted over 30 days at the beginning of the quarter				
B. Total number of additional grievances which exceeded the 30 days timeframe for resolution during this quarter				
C. Total number of grievances that were unresolved within 30 days at any time during quarter (A + B)				
D. Total number of grievances pending or submitted over 30 days at the end of the quarter				

II. Commercial Members

Number of Commercial Member Grievances Unresolved Within 30 Days During the Quarter by Type of Grievance

Reason Why Pending Over 30 Days	*Total, all grievance types*	*Coverage Disputes*	*Disputes Involving Medical Necessity*	*Quality of Care*	*Access to Care (including appointments)*	*Quality of Service*
1. Pending in Plan's Internal Grievance System						
2. Pending in Department's consumer complaint process						
3. Pending in Department's Independent Medical Review system						
4. Submitted to Arbitration						
5. Pending in Court						
6. Pending, other dispute resolution						
Total						

III. Medicare Members (complete if Medicare + Choice products provided by Plan)

Number of Medicare Member Grievances Unresolved Within 30 Days During the Quarter by Type of Grievance

Reason Why Pending Over 30 Days	*Total, all grievance types*	*Coverage Disputes*	*Disputes Involving Medical Necessity*	*Quality of Care*	*Access to Care (including appointments)*	*Quality of Service*
1. Pending in Plan's Internal Grievance System						
2. Submitted to Medicare Appeals System						

Reason Why Pending Over 30 Days	*Total, all grievance types*	*Coverage Disputes*	*Disputes Involving Medical Necessity*	*Quality of Care*	*Access to Care (including appointments)*	*Quality of Service*
3. Pending in Department's consumer complaint process						
4. Pending in Department's Independent Medical Review system						
5. Submitted to Arbitration						
6. Pending in Court						
7. Pending other dispute resolution						
Total						

IV. Medi-Cal Members (Complete if Medi-Cal Managed Care products offered by Plan)

Number of Medi-Cal Member Grievances Unresolved Within 30 Days During the Quarter by Type of Grievance

Reason Why Pending Over 30 Days	*Total, all grievance types*	*Coverage Disputes*	*Disputes Involving Medical Necessity*	*Quality of Care*	*Access to Care (including appointments)*	*Quality of Service*
1. Pending in Plan's Internal Grievance System						
2. Submitted to Medi-Cal fair hearing process						
3. Pending in Department's consumer complaint process						
4. Pending in Department's Independent Medical Review system						

Reason Why Pending Over 30 Days	*Total, all grievance types*	*Coverage Disputes*	*Disputes Involving Medical Necessity*	*Quality of Care*	*Access to Care (including appointments)*	*Quality of Service*
5. Submitted to Arbitration						
6. Pending in Court						
7. Pending, other dispute resolution						
Total						

VERIFICATION

I, the undersigned, have read and signed this report and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this report is true.

BY:_____
(Signature of Individual Authorized to Sign on Behalf of Plan)

_____
(Typed Name, Title, Phone)

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1368, Health and Safety Code.

History:

1. Change without regulatory effect amending subsections (d), (f) and (g) filed 2-23-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 8).
2. Editorial correction of subsection (e) (Register 97, No. 19).
3. Amendment of section and new Note filed 9-18-98; operative 10-18-98 (Register 98, No. 38).
4. Amendment filed 5-30-2000 as an emergency; operative 5-30-2000 (Register 2000, No. 22). A Certificate of Compliance must be transmitted to OAL by 9-27-2000 or emergency language will be repealed by operation of law on the following day.
5. Amendment filed 8-14-2000 (Regulatory Action No. 00-0807-01E) as an emergency; operative 8-14-2000 (Register 2000, No. 33). A Certificate of Compliance must be transmitted to OAL by 12-12-2000 or emergency language will be repealed by operation of law on the following day.
6. Amendment filed 8-14-2000 (Regulatory Action No. 00-0807-02E) as an emergency; operative 8-14-2000 (Register 2000, No. 33). A Certificate of Compliance must be transmitted to OAL by 12-12-2000 or emergency language will be repealed by operation of law on the following day.
7. Editorial correction of History 5 and History 6 (Register 2001, No. 2).
8. Certificate of Compliance as to 8-14-2000 order (Regulatory Action No. 00-0807-01E) transmitted to OAL 11-29-2000 and filed 1-10-2001 (Register 2001, No. 2).
9. Certificate of Compliance as to 8-14-2000 order (Regulatory Action No. 00-0807-02E), including amendments, transmitted to OAL 11-29-2000 and filed 1-10-2001 (Register 2001, No. 2).
10. Repealer and new section filed 11-12-2002; operative 12-12-2002 (Register 2002, No. 46).

§ 1300.68.01. Expedited Review of Grievances.

(a) Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include:

(1) Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the

grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.

(2) A written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance by the Plan.

(3) Consideration by the plan of the enrollee's medical condition when determining the response time.

(4) No requirement that the enrollee participate in the plan's grievance process prior to applying to the Department for review of the urgent grievance.

(b) Each plan's grievance system shall allow for the Department to contact the plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the plan shall respond to the Department within 30 minutes after initial contact from the Department. During non-work hours, the plan shall respond to the Department within 1 hour after initial contact from the Department.

(1) The system established by the plan shall provide for the availability of a plan representative with authority on the plan's behalf to resolve urgent grievances and authorize the provision of health care services covered under the enrollee's plan contract in a medically appropriate and timely manner. Such authority shall include making financial decisions for expenditure of funds on behalf of the plan without first having to obtain approval from supervisors or other superiors within the plan. Nothing in this subsection shall restrict the plan representative from consulting with other plan staff on urgent grievances.

(2) Plans shall provide the Department with the following information concerning urgent grievances:

(A) A description of the system established by the plan to resolve urgent grievances. The description shall include the system's provisions for scheduling qualified plan representatives, including back-up plan representatives as necessary, to be available twenty-four (24) hours a day, seven days a week to respond to Department contacts regarding urgent grievances. Provisions for scheduling shall include the names and titles of those plan representatives who will be available under the system, their telephone numbers, and, as applicable, pager numbers, answer service numbers, voice-mail numbers, e-mail addresses, or other means for contact.

(B) A description of how the Department may access the grievance system established by the plan.

(3) If the plan revises the system established pursuant to subsection (b), the plan shall notify the Department at least thirty (30) days in advance of implementing the revisions.

(c) The plan shall notify the Department before changing or modifying any benefit or services that relates to the urgent grievance submitted to the Department pursuant to subsection (b)(1)(A) of section 1368 of the Act if the enrollee or the enrollee's representative objects to the change or modification.

NOTE: Authority cited: Section 1344, Health and Safety Code; Reference: Sections 1368 and 1368.01, Health and Safety Code.

History:

1. New section filed 5-30-2000 as an emergency; operative 5-30-2000 (Register 2000, No. 22). A Certificate of Compliance must be transmitted to OAL by 9-27-2000 or emergency language will be repealed by operation of law on the following day.
2. Repealer filed 8-14-2000 (Regulatory Action No. 00-0807-01E) as an emergency; operative 8-14-2000 (Register 2000, No. 33). A Certificate of Compliance must be transmitted to OAL by 12-12-2000 or emergency language will be repealed by operation of law on the following day.
3. New section filed 8-14-2000 (Regulatory Action No. 00-0807-02E) as an emergency; operative 8-14-2000 (Register 2000, No. 33). A Certificate of Compliance must be transmitted to OAL by 12-

12-2000 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of History 2 and History 3 (Register 2001, No. 2).
5. Certificate of Compliance as to 8-14-2000 order (Regulatory Action No. 00-0807-01E) transmitted to OAL 11-29-2000 and filed 1-10-2001 (Register 2001, No. 2).
6. Certificate of Compliance as to 8-14-2000 order (Regulatory Action No. 00-0807-02E), including amendment, transmitted to OAL 11-29-2000 and filed 1-10-2001 (Register 2001, No. 2).
7. Repealer and new section filed 11-12-2002; operative 12-12-2002 (Register 2002, No. 46).

§ 1300.68.2. Hospice Services.

(a) For purposes of this section, the following definitions shall apply:

(1) "Bereavement services" means those services available to the surviving family members for a period of at least one year after the death of the enrollee. These services shall include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to, and following the death of the enrollee.

(2) "Hospice service" or "hospice program" means a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of an enrollee who is experiencing the last phases of life due to the existence of a terminal disease, to provide supportive care to the primary care giver and the family of the hospice patient, and which meets all of the following criteria;

(A) Considers the enrollee and the enrollee's family, in addition to the enrollee, as the unit of care.

(B) Utilizes an interdisciplinary team to assess the physical, medical, psychological, social and spiritual needs of the enrollee and the enrollee's family.

(C) Requires the interdisciplinary team to develop an overall plan of care and to provide coordinated care which emphasizes supportive services, including, but not limited to, home care, pain control, and short-term inpatient services. Short-term inpatient services are intended to ensure both continuity of care and appropriateness of services for those enrollees who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

(D) Provides for the palliative medical treatment of pain and other symptoms associated with a terminal disease, but does not provide for efforts to cure the disease.

(E) Provides for bereavement services following the enrollee's death to assist the family to cope with social and emotional needs associated with the death of the enrollee.

(F) Actively utilizes volunteers in the delivery of hospice services.

(G) To the extent appropriate based on the medical needs of the enrollee, provides services in the enrollee's home or primary place of residence.

(3) "Hospice" or "Hospice Agency" means an entity which provides hospice services to terminally ill persons and holds a license, currently in effect, as a hospice pursuant to Health and Safety Code section 1747 or a home health agency with federal medicare certification pursuant to Health and Safety Code sections 1726 and 1747.1.

(4) "Home health aide services" means those services providing for the personal care of the terminally ill patient and the performance of related tasks in the patient's home in accordance with the plan of care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient. Home health aide services shall be provided by a person who is certified by the state Department of Health Services as a home health aide pursuant to Chapter 8 of Division 2 (Section 1725 et seq.) of the Health and Safety Code.

(5) "Homemaker services" means services that assist in the maintenance of a safe and healthy environment and services to enable the enrollee to carry out the treatment plan.

(6) "Interdisciplinary team" means the hospice care team that includes, but is not limited to, the enrollee and the patient's family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.

(7) "Medical direction" means those services provided by a licensed physician and surgeon who is charged with the responsibility of acting as a consultant to the interdisciplinary team, a consultant to the enrollee's attending physician and surgeon, as requested, with regard to pain and symptom management, and liaison with physicians and surgeons in the community. For purposes of this section, the person providing these services shall be referred to as the "medical director."

(8) "Plan of care" means a written plan developed by the attending physician and surgeon, the medical director or physician and surgeon designee, and the interdisciplinary team that addresses the needs of an enrollee and family admitted to the hospice program. The hospice shall retain overall responsibility for the development and maintenance of the plan of care and quality of services delivered. However, nothing in this section shall be construed to limit a health care service plan's obligations with respect to its QA program as required under Section 1300.70.

(9) "Skilled nursing services" means nursing services provided by or under the supervision of a registered nurse under a plan of care developed by the interdisciplinary team and the enrollee's physician and surgeon to an enrollee and his or her family that pertain to the palliative, supportive services required by an enrollee with a terminal illness. Skilled nursing services include, but are not limited to, enrollee assessment, evaluation and case management of the medical nursing needs of the enrollee, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the enrollee and his or her family, and the instruction of caregivers in providing personal care to the enrollee. Skilled nursing services shall provide for the continuity of services for the enrollee and his or her family. Skilled nursing service shall be available on a 24-hour on-call basis.

(10) "Social service/counseling services" means those counseling and spiritual services that assist the enrollee and his or her family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

(11) "Terminal disease" or "terminal illness" means a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course. This definition is not intended to limit the ability of health plans and hospices to develop and utilize comprehensive, evidence-based medical and psychosocial criteria or "best practice" guidelines for hospice referrals that are not dependent upon an estimated time of death, that are predictive of the need and appropriateness of palliative care and that are consistent with standards among palliative care professionals.

(12) "Volunteer services" means those service provided by trained hospice volunteers who have agreed to provide service under the direction of a hospice staff member who has been designated by the hospice to provide direction to hospice volunteers. Hospice volunteers may be used to provide support and companionship to the enrollee and his or her family during the remaining days of the enrollee's life and to the surviving family following the enrollee's death.

(b) Hospice services provided pursuant to the requirements of Section 1368.2 shall comply with the following requirements:

(1) Only an entity licensed pursuant to the California Hospice Licensure Act of 1990, (Health and Safety Code Section 1745, et seq.) or a licensed home health agency with federal medicare certification (Health and Safety Code sections 1726 and 1747.1) may provide hospice services to plan enrollees, except that an entity licensed as a hospice may arrange to provide hospice services required to be provided pursuant to this section with appropriately licensed individuals or entities.

(2) Plans are required to provide to enrollees with a "terminal illness", through their contractual arrangements with hospices, the following services, at a minimum, when the enrollee qualifies for and chooses hospice care:

(A) Interdisciplinary team care with development and maintenance of an appropriate plan of care.

(B) Skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse.

(C) Bereavement Services.

(D) Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.

(E) Medical direction with the medical director being also responsible for meeting the general medical needs of the enrollees to the extent that these needs are not met by the attending physician.

(F) Volunteer services.

(G) Short-term inpatient care arrangements.

(H) The following shall be provided to the extent reasonable and necessary for the palliation and management of terminal illness and related conditions: pharmaceuticals, medical equipment and supplies.

(I) Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.

(c) Covered services are to be made available on a 24 hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions.

(d) Special Coverage Requirements.

(1) Periods of Crisis:

Nursing care services must be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an enrollee at home. Hospitalization must be covered pursuant to 1300.68.2(b)(2)(G), when the interdisciplinary team makes the determination that inpatient skilled nursing care is required at a level that cannot be provided in the home. Either homemaker or home health aide services or both may be covered on a 24 hour continuous basis during periods of crisis but the care provided during these periods must be predominantly nursing care. A period of crisis is a period in which the enrollee requires continuous care to achieve palliation or management of acute medical symptoms.

(2) Respite Care:

Respite care is short-term inpatient care provided to the enrollee only when necessary to relieve the family members or other persons caring for the enrollee. Coverage of respite care may be limited to an occasional basis and to no more than five consecutive days at a time.

(e) Every plan shall include notice of the coverage specified in subdivisions (b), (c) and (d) in the plan's evidence of coverage and disclosure form on or after January 1, 2002.

(f) All contracts between plans and hospices must be in accordance with all federal and state hospice licensure requirements.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference cited: Section 1368.2, Health and Safety Code.

History:

1. New section filed 6-26-2001; operative 7-26-2001 (Register 2001, No. 26).

§ 1300.69. Public Policy Participation by Subscribers.

Unless a plan complies with the requirements of the Health Maintenance Organization Act of 1973 in affording subscribers and enrollees procedures to participate in establishing the public policy of the plan, as defined in Section 1369 of the Act, it shall comply with each of the following requirements:

(a) If the plan is a corporation, either:

(1) At least one-third of its governing board shall be subscribers and/or enrollees, or

(2) There shall be established a standing committee which shall be responsible for participating in establishing public policy of the plan as defined in Section 1369 of the Act, and whose recommendations and reports are regularly and timely reported to the governing board. The governing board shall act upon such recommendations and such action shall be recorded in the board's minutes. The membership of the standing committee shall comply with each of the following:

(A) At least 51% of the members shall be subscribers and/or enrollees,

(B) At least one member shall be a member of the governing board of the plan, and

(C) At least one member shall be a provider.

(b) If the plan is a partnership, trust or unincorporated association, there shall be established a standing committee of the governing body or executive committee of the plan, which committee shall be responsible for participation in establishing public policy of the plan as defined in Section 1369 of the Act and whose recommendations and reports are regularly and timely reported to the governing body or executive committee of the plan. The governing body or executive committee of the plan shall act upon such recommendations and such action shall be recorded in its minutes. The membership of the standing committee shall comply with each of the following:

(1) At least 51% of the members shall be subscribers and/or enrollees,

(2) At least one member shall also be a member of the governing body or executive committee of the plan, and

(3) At least one member shall be a provider.

(c) If the plan is a sole proprietorship, it shall establish a standing committee which shall be responsible for participation in establishing public policy of the plan as defined in Section 1369 of the Act and whose recommendations are reported regularly and timely to the sole proprietor. The sole proprietor shall act upon such recommendations and such action shall be recorded. The membership of the standing committee shall comply with each of the following:

(1) At least 51% of the members shall be subscribers and/or enrollees,

(2) The sole proprietor shall be a member, and

(3) At least one provider shall be a member.

(d) Those individuals who fulfill the requirements stated in this section for subscriber and/or enrollee membership upon the governing body or standing

committee shall be persons who are not employees of the plan, providers of health care services, subcontractors to the plan or group contract brokers, or persons financially interested in the plan.

(e) Advisory committees do not meet the requirements of subsections (a), (b) or (c).

(f) Enrollees and subscribers participating in establishing public policy shall have access to information available from the plan regarding public policy, including financial information and information about the specific nature and volume of complaints received by the plan and their disposition.

(g) In connection with the selection of enrollee and subscriber members of any governing board or standing committee, the plan shall generally consider the makeup of its enrollee and subscriber population, including but not limited to factors such as ethnic extraction, demography, occupation and geography as well as identifiable and individual group participation. Any such selection or election of enrollee or subscriber members shall be conducted on a fair and reasonable basis. This subsection does not require the plan to maintain supporting statistical data.

(h) The public policy participation procedure shall be incorporated into the bylaws or other governing documents of the plan. The terms of subscriber and enrollee members of the public policy making body shall be of reasonable length and overlap so as to provide continuity and experience in representation. A standing committee shall meet at least quarterly.

(i) The plan shall (1) in each evidence of coverage or combined evidence of coverage and disclosure form, or at least annually by other means, furnish to its subscribers and enrollees a description of its system for their participation in establishing public policy, and (2) communicate material changes affecting public policy to subscribers and enrollees.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1369, Health and Safety Code.

History:

1. Amendment of subsection (i) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.70. Health Care Service Plan Quality Assurance Program.

(a) Intent and Regulatory Purpose.

(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

(2) This section is not intended to set forth a prescriptive approach to QA methodology. This section is intended to afford each plan flexibility in meeting Act quality of care requirements.

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

(4) The Department's assessment of a plan's QA program will focus on:

(A) the scope of QA activities within the organization;

(B) the structure of the program itself and its relationship to the plan's administrative structure;

(C) the operation of the QA program; and

(D) the level of activity of the program and its effectiveness in identifying and correcting deficiencies in care.

(b) Quality Assurance Program Structure and Requirements.

(1) Program Structure.

To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:

(A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees;

(B) quality of care problems are identified and corrected for all provider entities;

(C) physicians (or in the case of specialized plans, dentists, optometrists, psychologists or other appropriate licensed professionals) who provide care to the plan's enrollees are an integral part of the QA program;

(D) appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others; and

(E) the plan does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(A) There must be a written QA plan describing the goals and objectives of the program and organization arrangements, including staffing, the methodology for on-going monitoring and evaluation of health services, the scope of the program, and required levels of activity.

(B) Written documents shall delineate QA authority, function and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.

(C) The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.

(D) Implementation of the QA program shall be supervised by a designated physician(s), or in the case of specialized plans, a designated dentist(s), optometrist(s), psychologist(s) or other licensed professional provider, as appropriate.

(E) Physician, dentist, optometrist, psychologist or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.

(F) There must be administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out their assigned QA activities for the plan and delegated entities.

(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.

If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

(1) Inform each provider of the plan's QA program, of the scope of that provider's QA responsibilities, and how it will be monitored by the plan.

(2) Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise and budgetary resources.

(3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.

(4) Require that standards for evaluating that enrollees receive health care consistent with professionally recognized standards of practice are included in the provider's QA program, and be assured of the entity's continued adherence to these standards.

(5) Ensure that for each provider the quality assurance/utilizati on review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

(6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

(H) A plan that has capitation or risk-sharing contracts must:

1. Ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations; the plan shall have systems in place to monitor QA functions.

2. Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible under utilization of specialist services and preventive health care services.

(I) Inpatient Care.

1. A plan must have a mechanism to oversee the quality of care provided in an inpatient setting to its enrollees which monitors that:

a. providers utilize equipment and facilities appropriate to the care; and

b. if hospital services are fully capitated that appropriate referral procedures are in place and utilized for services not customarily provided at that hospital.

2. The plan may delegate inpatient QA functions to hospitals, and may rely on the hospital's existing QA system to perform QA functions. If a plan does delegate QA responsibilities to a hospital, the plan must ascertain that the hospital's quality assurance procedure will specifically review hospital services provided to the plan's enrollees, and will review services provided by plan

physicians within the hospital in the same manner as other physician services are reviewed.

(c) In addition to the internal quality of care review system, a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the to the Department.

NOTE: Authority cited: Sections 1344 and 1370, Health and Safety Code. Reference: Section 1370, Health and Safety Code.

History:

1. Amendment filed 12-20-90; operative 1-19-91 (Register 91, No. 6).
2. Editorial correction of printing error (Register 91, No. 17).

§ 1300.70.4. Independent Medical Reviews Experimental and Investigational Therapies.

(a) Enrollees of a health care service plan may request an independent medical review pursuant to sections 1370.4, 1374.30 through 1374.34 of the Act and section 1300.74.30 of title 28 when the plan has denied a therapy or medical service that would otherwise be covered based on the plan's determination that the therapy or medical service is experimental or investigational. This eligibility also applies to Medicare enrollees to the extent it does not conflict with federal law.

(b) At the time of the plan's denial of coverage for experimental or investigational therapy, or denial of urgent care or emergency services, as defined in section 1300.67(g)(2), the plan shall notify the enrollee of the ability to seek independent medical review.

(1) The notification must include, at a minimum, information on the independent medical review process, an application and envelope addressed to the Department, the physician certification form and the Department's toll-free information number.

(2) Pursuant to Health and Safety Code section 1368.03(a), the Department does not require that an enrollee participate in the plan's grievance system prior to seeking independent medical review.

(c) Included with the enrollee's application to the Department for independent medical review shall be a copy of the plan or contracted provider's written denial of the therapy or medical service based on the determination that the therapy or service is experimental or investigational.

(d) A certification from the enrollee's treating physician shall be included with the application for independent medical review. The physician's certification shall be on a form from the Department entitled, "Physician Certification Experimental/ Investigational Denials" (DMHC/IMR 110-11/27/00), or contain all of the following information:

(1) The enrollee has a condition as defined in Health and Safety Code section 1370.4(a)(1):

(2) Background information including the name of the enrollee and the health plan; the physician's name, specialty, board certification, address, telephone, and fax number; whether the physician is contracted with the plan; the enrollee's medical condition; and the specific drug, device, procedure, or other therapy recommended or requested for the enrollee's medical condition.

(3) For non-contracting physicians, the certification shall also include the following:

(A) The physician's license, board-certification or board eligibility to practice in the area appropriate to treat the enrollee's condition; and,

(B) Reference to, or copies of, two documents from the medical or scientific literature, specified in section 1370.4(d) of the Act.

(4) The following statement and physician's signature: "I certify that the requested therapy is likely to be more beneficial than any standard therapy. The information provided herein is true and correct;"

(5) Where expedited review is requested the certification shall include a statement that imminent and serious threat to the health of the enrollee exists pursuant to Health and Safety Code section 1374.31, or the proposed therapy would be significantly less effective if not promptly initiated; and

(6) Attachments, including any additional references or copies of medical and/or scientific literature considered relevant to the requested therapy and any other information relevant to the request.

(e) Incomplete applications will not be referred to an independent medical review organization. However, the Department may waive this requirement in exceptional or compelling circumstances where the need for a prompt determination precludes obtaining all information in writing. In cases accepted for an urgent review, the enrollee's physician must certify in writing, at a minimum, that the enrollee has a life-threatening or seriously debilitating condition, as defined in Health and Safety Code section 1370.4(a), that the requested therapy is likely to be more beneficial to the enrollee than any available standard therapy and describe the medical and scientific evidence relied upon in making the recommendation.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1370.4, Health and Safety Code.

History:

1. New section filed 11-12-2002; operative 12-12-2002 (Register 2002, No. 46).
2. Amendment of subsections (a) and (b) filed 6-17-2005; operative 7-17-2005 (Register 2005, No. 24).

§ 1300.71. Claims Settlement Practices.

(a) Definitions.

(1) "Automatically"" means the payment of the interest due to the provider within five (5) working days of the payment of the claim without the need for any reminder or request by the provider.

(A) If the interest payment is not sent in the same envelope as the claim payment, the plan or the plan"s capitated provider shall identify the specific claim or claims for which the interest payment is made, include a statement setting forth the method for calculating the interest on each claim and document the specific interest payment made for each claim.

(B) In the event that the interest due on an individual late claim payment is less than $2.00 at the time that the claim is paid, a plan or plan"s capitated provider that pays claims hereinafter referred to as "the plan"s capitated provider"") may pay the interest on that claim along with interest on other such claims within ten (10) calendar days of the close of the calendar month in which the claim was paid, provided the plan or the plan"s capitated provider includes with the interest payment a statement identifying the specific claims for which the interest is paid, setting forth the method for calculating interest on each claim and documenting the specific interest payment made for each claim.

(2) "Complete claim"" means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: "reasonably relevant information"" as defined by section a)(10), "information necessary to determine payer liability"" as defined in section (a)(11) and:

(A) For emergency services and care provider claims as defined by section 1371.35(j):

(i) the information specified in section 1371.35(c) of the Health and Safety Code; and

(ii) any state-designated data requirements included in statutes or regulations.

(B) For institutional providers:

(i) the completed UB 92 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC;

(ii) entries stated as mandatory by NUBC and required by federal statute and regulations; and

(iii) any state-designated data requirements included in statutes or regulations.

(C) For dentists and other professionals providing dental services:

(i) the form and data set approved by the American Dental Association;

(ii) Current Dental Terminology (CDT) codes and modifiers; and

(iii) any state-designated data requirements included in statutes or regulations.

(D) For physicians and other professional providers:

(i) the Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee NUCC) submitted on the designated paper or electronic format;

(ii) Current Procedural Terminology CPT) codes and modifiers and International Classification of Diseases (ICD-9CM or its successors) codes;

(iii) entries stated as mandatory by NUCC and required by federal statute and regulations; and

(iv) any state-designated data requirements included in statutes or regulations.

(E) For pharmacists:

(i) a universal claim form and data set approved by the National Council on Prescription Drug Programs; and

(ii) any state-designated data requirements included in statutes or regulations.

(F) For providers not otherwise specified in these regulations:

(i) A properly completed paper or electronic billing instrument submitted in accordance with the plan"s or the plan"s capitated provider"s reasonable specifications; and

(ii) any state-designated data requirements included in statutes or regulations.

(3) Except as required by section 1300.71.31, "Reimbursement of a Claim"" means:

(A) For contracted providers with a written contract, including in-network point-of-service (POS) and preferred provider organizations (PPO): the agreed upon contract rate;

(B) For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph C) below: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider"s training, qualifications, and length of time in practice; (ii) the nature of the services provided; iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v other aspects of the economics of the medical provider"s practice that are relevant; and (vi) any unusual circumstances in the case; and

(C) For non-emergency services provided by non-contracted providers to PPO and POS enrollees: the amount set forth in the enrollee"s Evidence of Coverage.

(4) "Date of contest,"" "date of denial"" or "date of notice"" means the date of postmark or electronic mark accurately setting forth the date when the contest, denial or notice was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant"s office or other address of record with proper postage prepaid. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code Section 641.

(5) "Date of payment"" means the date of postmark or electronic mark accurately setting forth the date when the payment was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant"s office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the date of payment, the Department may consider, when auditing claims payment compliance, the date the check is printed and the date the check is presented for payment. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code Section 641.

(6) "Date of receipt"" means the working day when a claim, by physical or electronic means, is first delivered to either the plan"s specified claims payment office, post office box, or designated claims processor or to the plan"s capitated provider for that claim. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641. In the situation where a claim is sent to the incorrect party, the "date of receipt"" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.

(7) "Date of Service,"" for the purposes of evaluating claims submission and payment requirements under these regulations, means:

(A) For outpatient services and all emergency services and care: the date upon which the provider delivered separately billable health care services to the enrollee.

(B) For inpatient services: the date upon which the enrollee was discharged from the inpatient facility. However, a plan and a plan"s capitated provider, at a minimum, shall accept separately billable claims for inpatient services on at least a bi-weekly basis.

(8) A "demonstrable and unjust payment pattern"" or "unfair payment pattern"" means any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

The following practices, policies and proceduresmay constitute a basis for a finding that the plan or the plan"s capitated provider has engaged in a "demonstrable and unjust payment pattern"" as set forth in section (s)(4):

(A) The imposition of a Claims Filing Deadline inconsistent with section (b)(1) in three (3) or more claims over the course of any three-month period;

(B) The failure to forward at least 95% of misdirected claims consistent with sections (b)(2)(A) and (B) over the course of any three-month period;

(C) The failure to accept a late claim consistent with section (b)(4) at least 95% of the time for the affected claims over the course of any three-month period;

(D) The failure to request reimbursement of an overpayment of a claim consistent with the provisions of sections b)(5) and d)(3), 4), (5) and (6) at least 95% of the time for the affected claims over the course of any three-month period;

(E) The failure to acknowledge the receipt of at least 95% of claims consistent with section (c) over the course of any three-month period;

F) The failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section d)(1) at least 95% of the time for the affected claims over the course of any three-month period;

G) The inclusion of contract provisions in a provider contract that requires the provider to submit medical records that are not reasonably relevant, as defined by section a)(10), for the adjudication of a claim on three 3) or more occasions over the course of any three month period;

H) The failure to establish, upon the Department"s written request, that requests for medical records more frequently than in three percent 3%) of the claims submitted to a plan or a plan"s capitated provider by all providers over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with the section a)(2). The calculation of the 3% threshold and the limitation on requests for medical records shall not apply to claims involving emergency or unauthorized services or where the plan establishes reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices;

I) The failure to establish, upon the Department"s written request, that requests for medical records more frequently than in twenty percent 20%) of the emergency services and care professional provider claims submitted to the plan"s or the plan"s capitated providers for emergency room service and care over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with section a)(2). The calculation of the 20% threshold and the limitation on requests for medical records shall not apply to claims where the plan demonstrates reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices;

J) The failure to include the mandated contractual provisions enumerated in section e) in three 3) or more of its contracts with either claims processing organizations and/or with plan"s capitated providers over the course of any three-month period;

K) The failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period;

L) The failure to contest or deny a claim, or portion thereof, within the timeframes of section h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims over the course of any three-month period;

M) The failure to provide the Information for Contracting Providers and the Fee Schedule and Other Required Information disclosures required by sections (*l* and (o) to three (3) or more contracted providers over the course of any three-month period;

N) The failure to provide three 3) or more contracted providers the required notice for Modifications to the Information for Contracting Providers and to the Fee Schedule and Other Required Information consistent with section m) over the course of any three month period;

O) Requiring or allowing any provider to waive any protections or to assume any obligation of the plan inconsistent with section p) on three 3) or more occasions over the course of any three month period;

P) The failure to provide the required Notice to Provider of Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b) at least 95% of the time for the affected claims over the course of any three-month period;

(Q) The imposition of a provider dispute filing deadline inconsistent with section 1300.71.38(d) in three 3) or more affected claims over the course of any three-month period;

(R) The failure to acknowledge the receipt of at least 95% of the provider disputes it receives consistent with section 1300.71.38(e) over the course of any three-month period;

(S) The failure to comply with the Time Period for Resolution and Written Determination enumerated in section 1300.71.38(f) at least 95% of the time over the course of any three-month period; and

(T) An attempt to rescind or modify an authorization for health care services after the provider renders the service in good faith and pursuant to the authorization, inconsistent with section 1371.8, on three (3) or more occasions over the course of any three-month period.

(U) A pattern of failure to pay noncontracting individual health professionals the reimbursement described in section 1300.71.31 and required pursuant to section 1371.31 of the Knox-Keene Act for health care services subject to section 1371.9 of the Knox-Keene Act.

(V) A pattern of failure to determine the average contracted rate for health care services subject to section 1371.9 of the Knox-Keene Act in a manner consistent with section 1300.71.31.

(9) "Health Maintenance Organization"" or "HMO"" means a full service health care service plan that maintains a line of business that meets the criteria of Section 1373.10(b)(1)-(3).

(10) "Reasonably relevant information"" means the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan"s or the plan"s capitated provider"s liability, if any, and to comply with any governmental information requirements.

(11) "Information necessary to determine payer liability"" means the minimum amount of material information in the possession of third parties related to a provider"s billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan"s or the plan"s capitated provider"s liability, if any, and to comply with any governmental information requirements.

12) "Plan"" for the purposes of this section means a licensed health care service plan and its contracted claims processing organization.

13) "Working days"" means Monday through Friday, excluding recognized federal holidays.

(b) Claim Filing Deadline.

(1) Neither the plan nor the plan"s capitated provider that pays claims shall impose a deadline for the receipt of a claim that is less than 90 days for contracted providers and 180 days for non-contracted providers after the date of service, except as required by any state or federal law or regulation. If a plan or a plan"s capitated provider is not the primary payer under coordination of benefits, the plan or the plan"s capitated provider shall not impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payer that is less than 90 days from the date of payment or date of contest, denial or notice from the primary payer.

(2) If a claim is sent to a plan that has contracted with a capitated provider that is responsible for adjudicating the claim, then the plan shall do the following:

(A) For a provider claim involving emergency service and care, the plan shall forward the claim to the appropriate capitated provider within ten 10) working days of receipt of the claim that was incorrectly sent to the plan.

(B) For a provider claim that does not involve emergency service or care: (i) if the provider that filed the claim is contracted with the plan"s capitated provider, the plan within ten (10) working days of the receipt of the claim shall either: (1) send the claimant a notice of denial, with instructions to bill the capitated provider or (2) forward the claim to the appropriate capitated provider; (ii) in all other cases, the plan within ten 10) working days of the receipt of the claim incorrectly sent to the plan shall forward the claim to the appropriate capitated provider.

(3) If a claim is sent to the plan"s capitated provider and the plan is responsible for adjudicating the claim, the plan"s capitated provider shall forward the claim to the plan within ten 10) working days of the receipt of the claim incorrectly sent to the plan"s capitated provider.

(4) A plan or a plan"s capitated provider that denies a claim because it was filed beyond the claim filing deadline, shall, upon provider"s submission of a provider dispute pursuant to section 1300.71.38 and the demonstration of good cause for the delay, accept, and adjudicate the claim according to Health and Safety Code section 1371 or 1371.35, which ever is applicable, and these regulations.

(5) A plan or a plan"s capitated provider shall not request reimbursement for the overpayment of a claim, including requests made pursuant to Health and Safety Code Section 1371.1, unless the plan or the plan"s capitated provider sends a written request for reimbursement to the provider within 365 days of the Date of Payment on the over paid claim. The written notice shall include the information specified in section d)(3). The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.

(c) Acknowledgement of Claims. The plan and the plan"s capitated provider shall identify and acknowledge the receipt of each claim, whether or not complete, and disclose the recorded date of receipt as defined by section 1300.71(a)(6) in the same manner as the claim was submitted or provide an electronic means, by phone, website, or another mutually agreeable accessible method of notification, by which the provider may readily confirm the plan"s or the plan"s capitated provider"s receipt of the claim and the recorded date of receipt as defined by 1300.71(a)(6) as follows:

(1) In the case of an electronic claim, identification and acknowledgement shall be provided within two 2) working days of the date of receipt of the claim by the office designated to receive the claim, or

(2) In the case of a paper claim, identification and acknowledgement shall be provided within fifteen 15) working days of the date of receipt of the claim by the office designated to receive the claim.

(A) If a claimant submits a claim to a plan or a plan"s capitated provider using a claims clearinghouse, the plan"s or the plan"s capitated provider"s identification and acknowledgement to the clearinghouse within the timeframes set forth in subparagraphs (1) or 2), above, whichever is applicable, shall constitute compliance with this section.

(d) Denying, Adjusting or Contesting a Claim and Reimbursement for the Overpayment of Claims.

(1) A plan or a plan"s capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is either denied, adjusted or contested, the plan or the plan"s capitated provider shall provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes specified in sections (g) and (h).

(2) In the event that the plan or the plan"s capitated provider requests reasonably relevant information from a provider in addition to information

that the provider submits with a claim, the plan or plan"s capitated provider shall provide a clear, accurate and written explanation of the necessity for the request. If the plan or the plan"s capitated provider subsequently denies the claim based on the provider"s failure to provide the requested medical records or other information, any dispute arising from the denial of such claim shall be handled as a provider dispute pursuant to Section 1300.71.38 of title 28.

(3) If a plan or a plan"s capitated provider determines that it has overpaid a claim, it shall notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service and including a clear explanation of the basis upon which the plan or the plan"s capitated provider believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

(4) If the provider contests the plan"s or the plan"s capitated provider"s notice of reimbursement of the overpayment of a claim, the provider, within 30 working days of the receipt of the notice of overpayment of a claim, shall send written notice to the plan or the plan"s capitated provider stating the basis upon which the provider believes that the claim was not over paid. The plan or the plan"s capitated provider shall receive and process the contested notice of overpayment of a claim as a provider dispute pursuant to Section 1300.71.38 of title 28.

5 If the provider does not contest the plan"s or the plan"s capitated provider"s notice of reimbursement of the overpayment of a claim, the provider shall reimburse the plan or the plan"s capitated provider within 30 working days of the receipt by the provider of the notice of overpayment of a claim.

(6) A plan or a plan"s capitated provider may only offset an uncontested notice of reimbursement of the overpayment of a claim against a provider"s current claim submission when: (i) the provider fails to reimburse the plan or the plan"s capitated provider within the timeframe of section 5) above and ii) the provider has entered into a written contract specifically authorizing the plan or the plan"s capitated provider to offset an uncontested notice of overpayment of a claim from the contracted provider"s current claim submissions. In the event that an overpayment of a claim or claims is offset against a provider"s current claim or claims pursuant to this section, the plan or the plan"s capitated provider shall provide the provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

(e) Contracts for Claims Payment. A plan may contract with a claims processing organization for ministerial claims processing services or contract with capitated providers that pay claims, "plan"s capitated provider"") subject to the following conditions:

(1) The plan"s contract with a claims processing organization or a capitated provider shall obligate the claims processing organization or the capitated provider to accept and adjudicate claims for health care services provided to plan enrollees in accordance with the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28.

(2) The plan"s contract with the capitated provider shall require that the capitated provider establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28, unless the plan assumes this function.

(3) The plan"s contract with a claims processing organization or a capitated provider shall require:

(i) the claims processing organization and the capitated provider to submit a Quarterly Claims Payment Performance Report ("Quarterly Claims Report"") to the plan within thirty (30) days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose the claims processing organization"s or the capitated provider"s compliance status with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28;

(ii) the capitated provider to include in its Quarterly Claims Report a tabulated record of each provider dispute it received, categorized by date of receipt, and including the identification of the provider, type of dispute, disposition, and working days to resolution, as to each provider dispute received. Each individual dispute contained in a provider"s bundled notice of provider dispute shall be reported separately to the plan; and

(iii) that each Quarterly Claims Report be signed by and include the written verification of a principal officer, as defined by section 1300.45(o), of the claims processing organization or the capitated provider, stating that the report is true and correct to the best knowledge and belief of the principal officer.

(4) The plan"s contract with a capitated provider shall require the capitated provider to make available to the plan and the Department all records, notes and documents regarding its provider dispute resolution mechanism(s) and the resolution of its provider disputes.

(5) The plan"s contract with a capitated provider shall provide that any provider that submits a claim dispute to the plan"s capitated provider"s dispute resolution mechanism(s) involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to the plan"s dispute resolution process for a *de novo* review and resolution for a period of 60 working days from the capitated provider"s Date of Determination, pursuant to the provisions of section 1300.71.38(a)(4) of title 28.

(6) The plan"s contract with a claims processing organization or the capitated provider shall include provisions authorizing the plan to assume responsibility for the processing and timely reimbursement of provider claims in the event that the claims processing organization or the capitated provider fails to timely and accurately reimburse its claims including the payment of interest and penalties). The plan"s obligation to assume responsibility for the processing and timely reimbursement of a capitated provider"s provider claims may be altered to the extent that the capitated provider has established an approved corrective action plan consistent with section 1375.4(b)(4) of the Health and Safety Code.

(7) The plan"s contract with the capitated provider shall include provisions authorizing a plan to assume responsibility for the administration of the capitated provider"s dispute resolution mechanism(s) and for the timely resolution of provider disputes in the event that the capitated provider fails to timely resolve its provider disputes including the issuance of a written decision.

(8) The plan"s contract with a claims processing organization or a capitated provider shall not relieve the plan of its obligations to comply with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28.

(f) Disclosures.

(1) A plan or a plan"s capitated provider, with the agreement of the contracted provider, may utilize alternate transmission methods to deliver any disclosure required by this regulation so long as the contracted provider can readily

determine and verify that the required disclosures have been transmitted or are accessible and the transmission method complies with all applicable state and federal laws and regulations.

(2) To the extent that the Health Insurance Portability and Accountability Act of 1996, as amended, limits the plan"s or the plan"s capitated provider"s ability to electronically transmit any required disclosures under this regulation, the plan or the plan"s capitated provider shall supplement its electronic transmission with a paper communication that satisfies the disclosure requirements.

(g) Time for Reimbursement. A plan and a plan"s capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan"s capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan"s capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

(1) To the extent that a full service health care service plan that meets the definition of an HMO as set forth in paragraph 1300.71(a)(9) also maintains a PPO or POS line of business, the plan shall reimburse all claims relating to or arising out of non-HMO lines of business within thirty (30) working days.

(2) If a specialized health care service plan contracts with a plan that is a health maintenance organization to deliver, furnish or otherwise arrange for or provide health care services for that plan"s enrollees, the specialized plan shall reimburse complete claims received for those services within thirty 30) working days.

(3) If a non-contracted provider disputes the appropriateness of a plan"s or a plan"s capitated provider"s computation of the reasonable and customary value, determined in accordance with section (a)(3)(B), for the health care services rendered by the non-contracted provider, the plan or the plan"s capitated provider shall receive and process the non-contracted provider"s dispute as a provider dispute in accordance with section 1300.71.38.

(4) Every plan contract with a provider shall include a provision stating that except for applicable co-payments and deductibles, a provider shall not invoice or balance bill a plan"s enrollee for the difference between the provider"s billed charges and the reimbursement paid by the plan or the plan"s capitated provider for any covered benefit.

(h) Time for Contesting or Denying Claims. A plan and a plan"s capitated provider may contest or deny a claim, or portion thereof, by notifying the provider, in writing, that the claim is contested or denied, within thirty 30) working days after the date of receipt of the claim by the plan and the plan"s capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the claim by the plan or the plan"s capitated provider.

(1) To the extent that a full service health care service plan that meets the definition of an HMO as set forth in paragraph 1300.71(a)(9) also maintains a PPO or POS line of business, the plan shall contest or deny claims relating to or arising out of non-HMO lines of business within thirty (30) working days.

(2) If a specialized health care service plan contracts with a plan that is a health maintenance organization to deliver, furnish or otherwise arrange for or provide health care services for that plan"s enrollees, the specialized plan shall contest or deny claims received for those services within thirty (30) working days.

(3) A request for information necessary to determine payer liability from a third party shall not extend the Time for Reimbursement or the Time

for Contesting or Denying Claims as set forth in sections (g and h) of this regulation. Incomplete claims and claims for which "information necessary to determine payer liability"" that has been requested, which are held or pended awaiting receipt of additional information shall be either contested or denied in writing within the timeframes set forth in this section. The denial or contest shall identify the individual or entity that was requested to submit information, the specific documents requested and the reason(s) why the information is necessary to determine payer liability

(i) Interest on the Late Payment of Claims.

(1) Late payment on a complete claim for emergency services and care, which is neither contested nor denied, shall automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late.

(2) Late payments on all other complete claims shall automatically include interest at the rate of 15 percent per annum for the period of time that the payment is late.

(j) Penalty for Failure to Automatically Include the Interest Due on a Late Claim Payment as set forth in section (i). A plan or a plan"s capitated provider that fails to automatically include the interest due on a late claim payment shall pay the provider $10 for that late claim in addition to any amounts due pursuant to section (i).

(k) Late Notice or Frivolous Requests. If a plan or a plan"s capitated provider fails to provide the claimant with written notice that a claim has been contested or denied within the allowable time period prescribed in section (h), or requests information from the provider that is not reasonably relevant or requests information from a third party that is in excess of the information necessary to determine payor liability as defined in section a)(11), but ultimately pays the claim in whole or in part, the computation of interest or imposition of penalty pursuant to sections i) and j) shall begin with the first calendar day after the expiration of the Time for Reimbursement as defined in section (g).

(*l* Information for Contracting Providers. On or before January 1, 2004, (unless the plan and/or the plan"s capitated provider confirms in writing that current information is in the contracted provider"s possession), initially upon contracting and in addition, upon the contracted provider"s written request, the plan and the plan"s capitated provider shall disclose to its contracting providers the following information in a paper or electronic format, which may include a website containing this information, or another mutually agreeable accessible format:

(1) Directions including the mailing address, email address and facsimile number) for the electronic transmission if available), physical delivery and mailing of claims, all claim submission requirements including a list of commonly required attachments, supplemental information and documentation consistent with section a)(10), instructions for confirming the plan"s or the plan"s capitated provider"s receipt of claims consistent with section c), and a phone number for claims inquiries and filing information;

(2) The identity of the office responsible for receiving and resolving provider disputes;

(3) Directions including the mailing address, email address and facsimile number) for the electronic transmission (if available), physical delivery, and mailing of provider disputes and all claim dispute requirements, the timeframe for the plan"s and the plan"s capitated provider"s acknowledgement of the receipt of a provider dispute and a phone number for provider dispute inquiries and filing information; and

4) Directions for filing substantially similar multiple claims disputes and other billing or contractual disputes in batches as a single provider dispute that includes a numbering scheme identifying each dispute contained in the bundled notice.

(m) Modifications to the Information for Contracting Providers and to the Fee Schedules and Other Required Information. A plan and a plan"s capitated provider shall provide a minimum of 45 days prior written notice before instituting any changes, amendments or modifications in the disclosures made pursuant to paragraphs (*l* and (o).

n) Notice to the Department. Within 7 calendar days of a Department request, the plan and the plan"s capitated providers shall provide a pro forma copy of the plan"s and the plan"s capitated provider"s "Information to Contracting Providers"" and "Modification to the Information for Contracting Providers.""

(o) Fee Schedules and Other Required Information. On or before January 1, 2004, unless the plan and/or the plan"s capitated provider confirms in writing that current information is in the contracted provider"s possession), initially upon contracting, annually thereafter on or before the contract anniversary date, and in addition upon the contracted provider"s written request, the plan and the plan"s capitated provider shall disclose to contracting providers the following information in an electronic format:

1) The complete fee schedule for the contracting provider consistent with the disclosures specified in section 1300.75.4.1(b); and

2) The detailed payment policies and rules and non-standard coding methodologies used to adjudicate claims, which shall, unless otherwise prohibited by state law:

A) when available, be consistent with Current Procedural Terminology CPT), and standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies and major credentialing organizations;

B) clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments, and

C) at a minimum, clearly and accurately state the policies regarding the following: i) consolidation of multiple services or charges, and payment adjustments due to coding changes, ii) reimbursement for multiple procedures, iii) reimbursement for assistant surgeons, iv) reimbursement for the administration of immunizations and injectable medications, and v) recognition of CPT modifiers.

The information disclosures required by this section shall be in sufficient detail and in an understandable format that does not disclose proprietary trade secret information or violate copyright law or patented processes, so that a reasonable person with sufficient training, experience and competence in claims processing can determine the payment to be made according to the terms of the contract.

A plan or a plan"s capitated provider may disclose the Fee Schedules and Other Required Information mandated by this section through the use of a website so long as the plan or the plan"s capitated provider provides written notice to the contracted provider at least 45 days prior to implementing a website transmission format or posting any changes to the information on the website.

p) Waiver Prohibited. The plan and the plan"s capitated provider shall not require or allow a provider to waive any right conferred upon the provider or any obligation imposed upon the plan by sections 1371, 1371.1, 1371.2, 1371.22,

1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28, relating to claims processing or payment. Any contractual provision or other agreement purporting to constitute, create or result in such a waiver is null and void.

(q) Required Reports.

(1) Within 60 days of the close of each calendar quarter, the plan shall disclose to the Department in a single combined document: A) any emerging patterns of claims payment deficiencies; (B) whether any of its claims processing organizations or capitated providers failed to timely and accurately reimburse 95% of its claims including the payment of interest and penalties) consistent with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28; and C) the corrective action that has been undertaken over the preceding two quarters. The first report from the plan shall be due within 45 days after the close of the calendar quarter that ends 120 days after the effective date of these regulations.

(2) Within 15 days of the close of each calendar year, beginning with the 2004 calendar year, the plan shall submit to the Director, as part of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report as specified in section 1367(h) of the Health and Safety Code and section 1300.71.38(k) of title 28, in an electronic format (to be supplied by the Department), information disclosing the claims payment compliance status of the plan and each of its claims processing organizations and capitated providers with each of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28. The Annual Plan Claims Payment and Dispute Resolution Mechanism Report for 2004 shall include claims payment and dispute resolution data received from October 1, 2003 through September 30, 2004. Each subsequent Annual Plan Claims Payment and Dispute Resolution Mechanism Report shall include claims payment and dispute resolution data received for the last calendar quarter of the year preceding the reporting year and the first three calendar quarters for the reporting year.

(A) The claims payment compliance status portion of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report shall: (i) be based upon the plan"s claims processing organization"s and the plan"s capitated provider"s Quarterly Claims Payment Performance Reports submitted to the plan and upon the audits and other compliance processes of the plan consistent with section 1300.71.38(m) and ii) include a detailed, informative statement: (1) disclosing any established or documented patterns of claims payment deficiencies, (2) outlining the corrective action that has been undertaken, and (3) explaining how that information has been used to improve the plan"s administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results). The information provided pursuant to this section shall be submitted with the Annual Plan Claims Payment and Dispute Resolution Mechanism Report and may be accompanied by a cover letter requesting confidential treatment pursuant to section 1007 of title 28.

(r) Confidentiality.

The claims payment compliance status portion of the plan"s Annual Plan Claims Payment and Dispute Resolution Mechanism Report and the Quarterly disclosures pursuant to section (q)(1) to the Department shall be public information except for information disclosed pursuant to section q)(2)(A)(ii), that the Director, pursuant to a plan"s written request, determines should be maintained on a confidential basis.

(s) Review and Enforcement.

(1) The Department may review the plan"s and the plan"s capitated provider"s claims processing system through periodic medical surveys and financial examinations under sections 1380, 1381 or 1382 of the Health and Safety Code, and when appropriate, through the investigation of complaints of demonstrable and unjust payment patterns.

(2) Failure of a plan to comply with the requirements of sections 1371, 1371.1, 1371.2, 1371.22, 1371.31, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.31, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28 may constitute a basis for disciplinary action against the plan. The civil, criminal, and administrative remedies available to the Director under the Health and Safety Code and this regulation are not exclusive, and may be sought and employed in any combination deemed advisable by the Director to enforce the provisions of this regulation.

(3) Violations of the Health and Safety Code and this regulation are subject to enforcement action whether or not remediated, although a plan"s identification and self-initiated remediation of deficiencies may be considered in determining the appropriate penalty.

(4) In making a determination that a plan"s or a plan"s capitated provider"s practice, policy or procedure constitutes a "demonstrable and unjust payment pattern"" or "unfair payment pattern,"" the Director shall consider the documentation or justification for the implementation of the practice, policy or procedure and may consider the aggregate amount of money involved in the plan"s or the plan"s capitated provider"s action or inaction; the number of claims adjudicated by the plan or plan"s capitated provider during the time period in question, legitimate industry practices, whether there is evidence that the provider had engaged in an unfair billing practice, the potential impact of the payment practices on the delivery of health care or on provider practices; the plan"s or the plan"s capitated provider"s intentions or knowledge of the violation(s); the speed and effectiveness of appropriate remedial measures implemented to ameliorate harm to providers or patients, or to preclude future violations; and any previous related or similar enforcement actions involving the plan or the plan"s capitated provider.

(5) Within 30 days of receipt of notice that the Department is investigating whether the plan"s or the plan"s capitated provider"s practice, policy or procedure constitutes a demonstrable and unjust payment pattern, the plan may submit a written response documenting that the practice, policy or procedure was a necessary and reasonable claims settlement practice and consistent with sections 1371, 1371.35 and 1371.37 of the Health and Safety Code and these regulations;

(6) In addition to the penalties that may be assessed pursuant to section (s)(2), a plan determined to be engaged in a Demonstrable and Unjust Payment Pattern may be subject to any combination of the following additional penalties:

(A) The imposition of an additional monetary penalty to reflect the serious nature of the demonstrable and unjust payment pattern;

(B) The imposition, for a period of up to three (3) years, of a requirement that the plan reimburse complete and accurate claims in a shorter time period than the time period prescribed in section g) of this regulation and sections 1371 and 1371.35 of the Health and Safety Code; and

(C) The appointment of a claims monitor or conservator to supervise the plan"s claim payment activities to insure timely compliance with claims payment obligations.

The plan shall be responsible for the payment of all costs incurred by the Department in any administrative and judicial actions, including the cost to monitor the plan"s and the plan"s capitated provider"s compliance.

(t) Compliance. Plans and the plans" capitated providers shall be fully compliant with these regulations on or before January 1, 2004.

NOTE: Authority cited: Sections 1344, 1371.31, 1371.38, 1371.1 and 1371.8, Health and Safety Code. Reference: Sections 1367, 1370, 1371.9, 1371.31, 1371.35 and 1371.38, Health and Safety Code.

History:

1. New section filed 7-24-2003; operative 8-23-2003 (Register 2003, No. 30). For prior history of title 10, section 1300.71, see Register 80, No. 19.
2. Amendment of subsections (a)(2), (h)(2) and (s)(1) and amendment of Note filed 5-7-2014; operative 7-1-2014 (Register 2014, No. 19).
3. Amendment of subsection (a)(3), new subsections (a)(8)(U)-(V and amendment of subsection (s)(2) and Note filed 9-13-2018; operative 1-1-2019 (Register 2018, No. 37).

§ 1300.71.4. Emergency Medical Condition and Post-Stabilization Responsibilities for Medically Necessary Health Care Services.

The following rules set forth emergency medical condition and post-stabilization responsibilities for medically necessary health care services after stabilization of an emergency medical condition and until an enrollee can be discharged or transferred. These rules do not apply to a specialized health care service plan contract that does not provide for medically necessary health care services following stabilization of an emergency condition.

(a) Prior to stabilization of an enrollee's emergency medical condition, or during periods of destabilization (after stabilization of an enrollee's emergency medical condition) when an enrollee requires immediate medically necessary health care services, a health care service plan shall pay for all medically necessary health care services rendered to an enrollee.

(b) In the case when an enrollee is stabilized but the health care provider believes that the enrollee requires additional medically necessary health care services and may not be discharged safely, the following applies:

(1) A health care service plan shall approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request.

(2) If a health care service plan fails to approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request, the necessary post-stabilization medical care shall be deemed authorized. Notwithstanding the foregoing sentence, the health care service plan shall have the authority to disapprove payment for (A) the delivery of such necessary post-stabilization medical care or (B) the continuation of the delivery of such care; provided, that the health care service plan notifies the provider prior to the commencement of the delivery of such care or during the continuation of the delivery of such care (in which case, the plan shall not be obligated to pay for the continuation of such care from and after the time it provides such notice to the provider, subject to the remaining provisions of this paragraph) and in both cases the disruption of such care (taking into account the time necessary to effect the enrollee's transfer or discharge) does not have an adverse impact upon the efficacy of such care or the enrollee's medical condition.

(3) Notwithstanding the provisions of subsection (b) of this rule, a health care service plan shall pay for all medically necessary health care services provided to an enrollee which are necessary to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer or the enrollee is discharged.

(c) In the case where a plan denies the request for authorization of post-stabilization medical care and elects to transfer an enrollee to another health care provider, the following applies:

(1) When a health care service plan responds to a health care provider's request for post-stabilization medical care authorization by informing the provider of the plan's decision to transfer the enrollee to another health care provider, the plan shall effectuate the transfer of the enrollee as soon as possible,

(2) A health care service plan shall pay for all medically necessary health care services provided to an enrollee to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer.

(d) All requests for authorizations, and all responses to such requests for authorizations, of post-stabilization medically necessary health care services shall be fully documented. All provision of medically necessary health care services shall be fully documented. Documentation shall include, but not be limited to, the date and time of the request, the name of the health care provider making the request, and the name of the plan representative responding to the request.

NOTE: Authority cited: Sections 1344 and 1371.4(g) and (h), Health and Safety Code. Reference: Sections 1317.1 and 1371.4, Health and Safety Code.

History:

1. New section filed 5-9-95 as an emergency; operative 5-9-95 (Register 95, No. 19). A Certificate of Compliance must be transmitted to OAL by 9-6-95 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 9-5-95 as an emergency; operative 9-6-95 (Register 95, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-96 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 12-19-95 as an emergency; operative 1-4-96 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4-17-96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance, including amendment of section and Note, transmitted to OAL 3-7-96 and filed 4-11-96 (Register 96, No. 15).
5. Editorial correction of first paragraph and subsections (b)(2), (c) and (c)(1) (Register 96, No. 23).
6. Editorial correction of first paragraph (Register 99, No. 26).
7. Amendment filed 6-24-99 as an emergency; operative 6-24-99 (Register 99, No. 26). A Certificate of Compliance must be transmitted to OAL by 10-22-99 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 6-24-99 order transmitted to OAL 9-30-99 and filed 11-8-99 (Register 99, No. 46).

§ 1300.71.31. Methodology for Determining Average Contracted Rate; Default Reimbursement Rate.

(a) The following definitions apply for the purpose of this section:

(1) "Average contracted rate"" and ACR mean the claims-volume weighted average of the contracted commercial rates paid by the payor for the same or similar services in the geographic region, in the applicable calendar year, for services most frequently subject to section 1371.9 of the Knox-Keene Act. The applicable calendar year is two years prior to the year in which the health care service was rendered.

(2) "Default reimbursement rate"" means the greater of the average contracted rate or 125 percent of the Medicare rate, payable to a noncontracting individual health professional pursuant to section 1371.31 of the Knox-Keene Act.

(3) "Geographic region"" has the meaning described in subdivision a)(6) of section 1371.31 of the Knox-Keene Act, whether the default reimbursement rate is based on the Medicare rate or the average contracted rate.

(4) "Medicare rate"" means the amount Medicare reimburses on a fee-for service basis for the same or similar health care services in the geographic

region in which the health care services were rendered, for the calendar year in which the health care service was rendered, on a "par"" basis. "Par"" basis means the reimbursement rate paid to health care service providers participating in the Medicare program by accepting Medicare assignment.

(5) "Payor"" means a health plan or its delegated entity that has the responsibility for payment of a claim for health care services subject to section 1371.9 of the Knox-Keene Act. The term Payor excludes health plans and entities described in subdivision (e) of section 1371.31 of the Knox-Keene Act.

(6) "Services most frequently subject to section 1371.9"" of the Knox-Keene Act means the health care services that, when added together, comprise at least 80 percent of the payor"s statewide claims volume for health care services subject to section 1371.9 in the applicable calendar year, as defined in subdivision a) 1) of this section.

(7) "Services subject to section 1371.9"" of the Knox-Keene Act are nonemergency health care services provided to an enrollee by a noncontracting individual health professional at a contracting health facility where the enrollee received covered health care services, or nonemergency health care services provided to the enrollee by a noncontracting individual health professional as a result of covered health care services received at a contracting health facility.

(8) The definitions in subdivision (f) of section 1371.9 of the Knox-Keene Act apply for the purpose of this section.

(b) For all health care services subject to section 1371.9 of the Knox-Keene Act, payors shall comply with subdivision (e) and do the following:

(1) For health care services most frequently subject to 1371.9, payors shall use the methodology described in this section to determine the average contracted rate; or

(2) For health care services that do not fall under subdivision b)(1), the payor may, but is not required to, use the methodology described in this section to determine the average contracted rate. If the payor uses a different methodology, that different methodology shall be a reasonable method of determining the average contracted commercial rates paid by the payor for the same or similar services in the geographic region, in the applicable calendar year.

(c) Methodology for determining the average contracted rate.

(1) Except as specified in subdivision (c)(6), for each health care service procedure code for services most frequently subject to section 1371.9 of the Knox-Keene Act, the payor shall calculate the claims volume-weighted mean rate:

Rate sum of [the allowed amount for the health service code under each contract x number of claims paid for each allowed amount]/Total number of claims paid for that code across all commercial contracts

Example:

For hypothetical health care service code Z, and for a particular combination of the factors described in subdivision (c)(3), the payor"s allowed amounts under its commercial contracts are: Contract A $10), Contract B $15), Contract C $12). During the applicable calendar year, the payor paid, for code Z, 25 claims under Contract A, 30 claims under contract B, and 45 claims under contract C. The rate calculation pursuant to this subdivision (c)(1) is: ($10x25)+($15x30)+($12x45) / total claims: 100) a base ACR rate of $12.40 for health care service code Z.

(2) The payor shall include the highest and lowest contracted rates when calculating the rate pursuant to subdivision (c)(1) by ensuring that the "number of claims paid at that allowed amount"" multiplier for each of the payor"s highest and lowest contracted rates is at least 1 (one).

(3) The payor shall calculate a rate described in subdivision (c)(1) taking into account each combination of these factors, at a minimum:

(A) Health care service codes, including but not limited to Current Procedural Terminology (CPT) codes,

(B) Geographic region,

(C) Provider type and specialty,

(D) Facility type, and,

(E) Information from the independent dispute resolution process, if any, pursuant to section 1371.30 of the Knox-Keene Act.

(4) For the purpose of subdivision (c)(3)(A), the payor shall use unmodified health care service codes to calculate the average contracted rate, except that the payor shall calculate separate average contracted rates pursuant to this subdivision (c) only for CPT code modifiers "26 (professional component) and "TC (technical component). For the purpose of this section, a modifier is a code applied to the service code that makes the service description more specific and may adjust the reimbursement rate or affect the processing or payment of the code billed.

(5) When the average contracted rate is the appropriate default reimbursement rate pursuant to subdivision (a)(1) of section 1371.31 of the Knox-Keene Act, the payor may adjust the rate determined under this subdivision (c) when it reimburses the noncontracting individual health professional, as appropriate. Appropriate reimbursement shall account for relevant payment modifiers and other health care service-or claim-specific factors in compliance with the Knox-Keene Act that affect the amount for reimbursement of health care services rendered by contracting individual health professionals.

(6) For anesthesia services subject to section 1371.9 of the Knox-Keene Act:

(A) The payor shall use the anesthesia conversion factors set forth in the payor s provider contracts instead of an "allowed amount to complete the calculation pursuant to subdivision (c)(1).

(B) The factors that affect reimbursement pursuant to subdivision (c)(5) of this section shall include the sum of American Society of Anesthesiologists Relative Value Guide (RVG) base units, time units, and physical status modifier.

(7) The following claims shall be excluded from the average contracted rate calculation, except as specified:

(A) Case rates, bundled payments, and global rates shall be excluded, except that the payor shall include the CPT code in which a global rate is embedded per the American Medical Association CPT code description.

(B) Claims paid pursuant to capitation, risk sharing arrangements, and sub-capitation, except for fee-for-service payments made by a payor who receives capitation from another entity.

(C) Denied claims.

(D) Claims not in final disposition status, meaning claims for which a final reimbursement amount pursuant to claims settlement practices required by the Knox Keene Act has not been determined by the payor, including disputed claims.

(E) Secondary payment rates pursuant to coordination of benefits clauses.

(d) Payors subject to subdivision (a)(3)(C) of section 1371.31 of the Knox-Keene Act shall use a statistically credible database reflecting rates paid to noncontracting individual health professionals for services provided in a geographic region to determine an average contracted rate required pursuant to this section and section 1371.31 of the Knox-Keene Act. This subdivision (d) applies notwithstanding any other provision of this section.

(e) Payment of default reimbursement rate.

(1) Unless otherwise agreed by the payor and the noncontracting individual health professional, and except as provided in subdivision (b) of section 1371.31 of the Knox-Keene Act, the payor shall reimburse the noncontracting individual health professional, for all services subject to section 1371.9 of the Knox-Keene Act, the default reimbursement rate.

(2) The payor shall indicate on claims payment documents the manner by which the payor satisfied this subdivision (e).

(f) Filing requirements.

(1) Payors shall electronically file with the department the policies and procedures used to determine the average contracted rates in compliance with this section by August 15, 2019, and thereafter when the policies and procedures are amended.

(2) If applicable, the payor shall demonstrate in its policies and procedures access to and use of a statistically credible database pursuant to subdivision (d) of this section including the following information:

(A) Explanation and justification of the determination that, based on the payor s model, the payor does not pay a statistically significant number or dollar amount of claims covered under section 1371.9 of the Knox-Keene Act;

(B) Information regarding which database is used for the determination of an ACR;

(C) Certification that the database is statistically credible; and

(D) Explanation and justification of the percentile or other methodology used to determine the average contracted rate, using the database.

(3) For the purpose of subdivision (f)(2), a statistically credible database shall be a nonprofit database that is unaffiliated with a payor.

(g) Enforcement. The Director shall have the civil, criminal, and administrative remedies available under the Knox-Keene Act, including section 1394.

NOTE: Authority cited: Sections 1344 and 1371.31, Health and Safety Code. Reference: Sections 1371.9 and 1371.31, Health and Safety Code.

HISTORY:

1. New section filed 9-13-2018; operative 1-1-2019 (Register 2018, No. 37).

§ 1300.71.38. Fast, Fair and Cost-Effective Dispute Resolution Mechanism.

All health care service plans and their capitated providers that pay claims (plan's capitated provider) shall establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. The plan and the plan's capitated provider may maintain separate dispute resolution mechanisms for contracted and non-contracted provider disputes and separate dispute resolution mechanisms for claims and other types of billing and contract disputes, provided that each mechanism complies with sections 1367(h), 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28. Arbitration shall not be deemed a provider dispute or a provider dispute resolution mechanism for the purposes of this section.

(a) Definitions:

(1) "Contracted Provider Dispute" means a contracted provider's written notice to the plan or the plan's capitated provider challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other

contract dispute (or a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim that contains, at a minimum, the following information: the provider's name; the provider's identification number; contact information; and:

(A) If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;

(B) If the dispute is not about a claim, a clear explanation of the issue and the provider's position thereon; and

(C) If the dispute involves an enrollee or group of enrollees: the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider's position thereon.

(2) "Non-Contracted Provider Dispute" means a non-contracted provider's written notice to the plan or the plan's capitated provider challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim that contains, at a minimum, the following information: the provider's name, the provider's identification number, contact information and:

(A) If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement of an overpayment of a claim or other action is incorrect.

(B) If the dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider's position thereon.

(3) "Date of receipt" means the working day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the plan's or the plan's capitated provider's designated dispute resolution office or post office box. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641.

(4) "Date of Determination" means the date of postmark or electronic mark on the written provider dispute determination or amended provider dispute determination that is delivered, by physical or electronic means, to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the Date of Determination, the Department may consider, when auditing the plan's or the plan's capitated provider's provider dispute mechanism, the date the check is printed for any monies determined to be due and owing the provider and date the check is presented for payment. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641.

(5) "Plan" for the purposes of this section means a licensed health care service plan and its contracted claims processing organization(s).

(b) Notice to Provider of Dispute Resolution Mechanism(s). Whenever the plan or the plan's capitated provider contests, adjusts or denies a claim, it shall inform the provider of the availability of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions, including the mailing address, for filing a provider dispute.

(c) Submission of Provider Disputes. The plan and the plan's capitated provider shall establish written procedures for the submission, receipt, processing and resolution of contracted and non-contracted provider disputes that, at a minimum, provide that:

(1) Provider disputes be submitted utilizing the same number assigned to the original claim; thereafter the plan or the plan's capitated provider shall process and track the provider dispute in a manner that allows the plan, the plan's capitated provider, the provider and the Department to link the provider dispute with the number assigned to the original claim.

(2) Contracted Provider Disputes be submitted in a manner consistent with procedures disclosed in sections 1300.71(*l*)(1) -(4).

(3) Non-contracted Provider Disputes be submitted in a manner consistent with the directions for obtaining forms and instructions for filing a provider dispute attached to the plan's or the plan's capitated provider's notice that the subject claim has been denied, adjusted or contested or pursuant to the directions for filing Non-contracted Provider Disputes contained on the plan's or the plan's capitated provider's website.

(4) The plan shall resolve any provider dispute submitted on behalf of an enrollee or a group of enrollees treated by the provider in the plan's consumer grievance process and not in the plan's or the plan's capitated provider's dispute resolution mechanism. The plan may verify the enrollee's authorization to proceed with the grievance prior to submitting the complaint to the plan's consumer grievance process. When a provider submits a dispute on behalf of an enrollee or a group of enrollees, the provider shall be deemed to be joining with or assisting the enrollee within the meaning of section 1368 of the Health and Safety Code.

(d) Time Period for Submission.

(1) Neither the plan nor the plan's capitated provider that pays claims, except as required by any state or federal law or regulation, shall impose a deadline for the receipt of a provider dispute for an individual claim, billing dispute or other contractual dispute that is less than 365 days of plan's or the plan's capitated provider's action or, in the case of inaction, that is less than 365 days after the Time for Contesting or Denying Claims has expired. If the dispute relates to a demonstrable and unfair payment pattern by the plan or the plan's capitated provider, neither the plan nor the plan's capitated provider shall impose a deadline for the receipt of a dispute that is less than 365 days from the plan's or the plan's capitated provider's most recent action or in the case of inaction that is less than 365 days after the most recent Time for Contesting or Denying Claims has expired.

(2) The plan or the plan's capitated provider may return any provider dispute lacking the information enumerated in either section (a)(1) or (a)(2), if the information is in the possession of the provider and is not readily accessible to the plan or the plan's capitated provider. Along with any returned provider dispute, the plan or the plan's capitated provider shall clearly identify in writing the missing information necessary to resolve the dispute consistent with sections 1300.71(a)(10) and (11) and 1300.71(d)(1), (2) and (3). Except in situation where the claim documentation has been returned to the provider, no plan or a plan's capitated provider shall request the provider to resubmit claim information or supporting documentation that the provider previously submitted to the plan or the plan's capitated provider as part of the claims adjudication process.

(3) A provider may submit an amended provider dispute within thirty (30) working days of the date of receipt of a returned provider dispute setting forth the missing information.

(e) Time Period for Acknowledgment. A plan or a plan's capitated provider shall enter into its dispute resolution mechanism system(s) each provider dispute submission (whether or not complete), and shall identify and acknowledge the receipt of each provider dispute:

(1) In the case of an electronic provider dispute, the acknowledgement shall be provided within two (2) working days of the date of receipt of the electronic provider dispute by the office designated to receive provider disputes, or

(2) In the case of a paper provider dispute, the acknowledgement shall be provided within fifteen (15) working days of the date of receipt of the paper provider dispute by the office designated to receive provider disputes.

(f) Time Period for Resolution and Written Determination. The plan or the plan's capitated provider shall resolve each provider dispute or amended provider dispute, consistent with applicable state and federal law and the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.37, 1371.4 and 1371.8 of the Health and Safety Code and section 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of title 28, and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.

Copies of provider disputes and determinations, including all notes, documents and other information upon which the plan or the plan's capitated provider relied to reach its decision, and all reports and related information shall be retained for at least the period specified in section 1300.85.1 of title 28.

(g) Past Due Payments. If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan or the plan's capitated provider shall pay any outstanding monies determined to be due, and all interest and penalties required under sections 1371 and 1371.35 of the Health and Safety Code and section 1300.71 of title 28, within five (5) working days of the issuance of the Written Determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" as forth in section 1300.71(g).

(h) Designation of Plan Officer. The plan and the plan's capitated provider shall each designate a principal officer, as defined by section 1300.45(o) of title 28, to be primarily responsible for the maintenance of their respective provider dispute resolution mechanism(s), for the review of its operations and for noting any emerging patterns of provider disputes to improve administrative capacity, plan-provider relations, claim payment procedures and patient care. The designated principal officer shall be responsible for preparing, the reports and disclosures as specified in sections 1300.71(e)(3) and (q) and 1300.71.38(k) of title 28.

(i) No Discrimination. The plan or the plan's capitated provider shall not discriminate or retaliate against a provider (including but not limited to the cancellation of the provider's contract) because the provider filed a contracted provider dispute or a non-contracted provider dispute.

(j) Dispute Resolution Costs. A provider dispute received under this section shall be received, handled and resolved by the plan and the plan's capitated provider without charge to the provider. Notwithstanding the foregoing, the plan and the plan's capitated provider shall have no obligation to reimburse a provider for any costs incurred in connection with utilizing the provider dispute resolution mechanism.

(k) Required Reports. Beginning with the 2004 calendar year and for each subsequent year, the plan shall submit to the Department no more than fifteen (15) days after the close of the calendar year, an "Annual Plan Claims

Payment and Dispute Resolution Mechanism Report," described in part in Section 1300.71(q) of this regulation, on an electronic form to be supplied by the Department Managed Health Care pursuant to section 1300.41.8 of title 28 containing the following, which shall be reported based upon the date of receipt of the provider dispute or amended provider dispute:

(1) Information on the number and types of providers using the dispute resolution mechanism;

(2) A summary of the disposition of all provider disputes, which shall include an informative description of the types, terms and resolution. Disputes contained in a bundled submission shall be reported separately as individual disputes. Information may be submitted in an aggregate format so long as all data entries are appropriately footnoted to provide full and fair disclosure; and

(3) A detailed, informative statement disclosing any emerging or established patterns of provider disputes and how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results) and how the information has been used in the development of appropriate corrective action plans. The information provided pursuant to this paragraph shall be submitted with, but separately from the other portions of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report and may be accompanied by a cover letter requesting confidential treatment pursuant section 1007 of title 28.

(4) The first report shall be due on or before January 15, 2005.

(*l*) Confidentiality.

(1) The plan's Annual Plan Claims Payment and Dispute Resolution Mechanism Report to the Department regarding its dispute resolution mechanism shall be public information except for information disclosed pursuant to section (k)(3) above, that the Director, pursuant to a plan's written request, determines should be maintained on a confidential basis.

(2) The plan's quarterly disclosures pursuant to section 1300.71(q)(1) shall be public information except for the information relating to the plan's corrective action strategies that the Director, pursuant to a plan's written request, determines should be maintained on a confidential basis.

(m) Review and Enforcement.

(1) The Department shall review the plan's and the plan's capitated provider's provider dispute resolution mechanism(s), including the records of provider disputes filed with the plan and remedial action taken pursuant to section 1300.71.38(m)(3), through medical surveys and financial examinations under sections 1380, 1381 or 1382 of the Health and Safety Code, and when appropriate, through the investigation of complaints of unfair provider dispute resolution mechanism(s).

(2) The failure of a plan to comply with the requirements of this regulation shall be a basis for disciplinary action against the plan. The civil, criminal, and administrative remedies available to the Director under the Health and Safety Code and this regulation are not exclusive, and may be sought and employed in any combination deemed advisable by the Director to enforce the provisions of this regulation.

(3) Violations of the Act and this regulation are subject to enforcement action whether or not remediated, although a plan's self-identification and self-initiated remediation of violations or deficiencies may be considered in determining the appropriate penalty.

NOTE: Authority cited: Sections 1344 and 1371.38, Health and Safety Code. Reference: Sections 1367, 1371 and 1371.38, Health and Safety Code.

History:
1. New section filed 7-24-2003; operative 8-23-2003 (Register 2003, No. 30).

§ 1300.71.39. Unfair Billing Patterns.

(a) Except for services subject to the requirements of Section 1367.11 of the Act, "unfair billing pattern" includes the practice, by a provider of emergency services, including but not limited to hospitals and hospital-based physicians such as radiologists, pathologists, anesthesiologists, and on-call specialists, of billing an enrollee of a health care service plan for amounts owed to the provider by the health care service plan or its capitated provider for the provision of emergency services.

(b) For purposes of this section:

(1) "Emergency services" means those services required to be covered by a health plan pursuant to Health & Safety Code sections 1345(b)(6), 1367(i), 1371.4, 1371.5 and Title 28, California Code of Regulations, sections 1300.67(g) and 1300.71.4.

(2) Co-payments, coinsurance and deductibles that are the financial responsibility of the enrollee are not amounts owed the provider by the health care service plan.

(3) "The plan's capitated provider" shall have the same meaning as that provided in section 1300.71(a).

NOTE: Authority cited: Sections 1344, 1371.39 and 1371.4, Health and Safety Code. Reference: Sections 1317.1, 1317.7, 1342, 1345, 1346, 1362.8, 1367, 1371, 1371.1, 1371.35, 1371.36, 1371.38, 1371.39, 1371.4, 1371.5 and 1379, Health and Safety Code.

History:
1. New section filed 9-15-2008; operative 10-15-2008 (Register 2008, No. 38).

§ 1300.73.21. Arbitration and Settlement Agreements.

(a) All health care service plans (plans) shall ensure that all arbitration decisions involving the plan and a current or former enrollee shall be provided to the Department as follows:

(1) Within thirty (30) days of receiving a written arbitration decision, the plan shall provide a copy of the complete arbitration decision to the Department. The complete arbitration decision shall have no part of the decision altered or redacted. The complete arbitration decision shall indicate the prevailing party, the amount and other relevant terms of any award, and the reasons for the decision.

(2) On a quarterly basis, plans shall provide the Department with redacted copies of all written arbitration decisions. The plan shall be responsible for redacting the written arbitration decisions ensuring that the names of the enrollee, the plan, witnesses, attorneys, providers, plan employees and health facilities have been removed from the decision. The redacted arbitration decisions will be available for public inspection on the Department's web page (www.dmhc.ca.gov).

(b) Every written arbitration decision, and every written settlement agreement resolving any dispute between a plan and a current or former enrollee shall contain the following language in bold, twelve (12) point type:

Nothing in this arbitration decision (or settlement agreement) prohibits or restricts the enrollee from discussing or reporting the underlying facts, results, terms and conditions of this decision (or settlement agreement) to the Department of Managed Health Care.

(c) All health care service contracts containing an arbitration clause; all arbitration agreements and decisions; and all settlement agreements resolving any dispute between a plan and a current or former enrollee, shall contain no

language that expressly or impliedly prohibits the enrollee from discussing or reporting the underlying facts, outcome, results or decision with the Department.

(d) For purposes of this section, a "settlement agreement" shall be broadly construed to include any writing resolving a dispute between a plan and a current or former enrollee wherein the nature of the dispute relates to services, benefits, treatment or other rights and obligations created pursuant to the enrollee and plan's contract for health care coverage, and includes settlements reached in, but not limited to, a mediation, arbitration, or other alternative dispute resolution process, or any civil lawsuit.

NOTE: Authority Cited: Sections 1344, 1346 and 1373.21, Health and Safety Code. Reference: Sections 1373.19 and 1373.20, Health and Safety Code.

History:

1. New section filed 8-19-2002; operative 9-18-2002 (Register 2002, No. 34).

§ 1300.74.16. Standing Referral to HIV/AIDS Specialist.

(a) The definitions and requirements of this section are applicable only to standing referrals made pursuant to Section 1374.16 of the Act. Nothing in this section requires an enrollee to transfer to a different primary care provider or limits referral authorizations that are not subject to Section 1374.16 of the Act.

(b) For the purposes of this section "AIDS" means Acquired Immunodeficiency Syndrome.

(c) For the purposes of this section "category 1 continuing medical education" means:

(1) For physicians, continuing medical education courses recognized as qualifying for category 1 credit by the Medical Board of California;

(2) For nurse practitioners, continuing education contact hours recognized by the California Board of Registered Nursing;

(3) For physician assistants, continuing education units approved by the American Association of Physician Assistants or those described in either subsection (c)(1) or (c)(2), above.

(d) For the purposes of this section "HIV" means the Human Immunodeficiency Virus.

(e) For the purposes of this section an "HIV/AIDS specialist" means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four criteria:

(1) Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; or

(2) Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; or

(3) Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:

(A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and

(B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or

(4) Meets the following qualifications:

(A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and

(B) Has completed any of the following:

1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or

2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or

3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.

(f) When authorizing a standing referral to a specialist pursuant to Section 1374.16(a) of the Act for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, a health care service plan must refer the enrollee to an HIV/AIDS specialist. When authorizing a standing referral to a specialist for purposes of having that specialist coordinate the enrollee's health care pursuant to Section 1374.16(b) of the Act for an enrollee who is infected with HIV, a health care service plan must refer the enrollee to an HIV/AIDS specialist. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician assistant if:

(1) The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and

(2) The nurse practitioner or physician assistant meets the qualifications specified in subsection (e)(4); and

(3) The nurse practitioner or physician assistant and that provider's supervising HIV/AIDS specialist have the capacity to see an additional patient.

(g) Subsection (f) does not require a health care service plan to refer an enrollee to any provider who is not employed by or under contract with the health care service plan to provide health care services to its enrollees, unless there is no HIV/AIDS specialist, or appropriately qualified nurse practitioner or physician assistant under the supervision of an HIV/AIDS specialist, within the plan's network appropriate to provide care to the enrollee, as determined by the primary care physician in consultation with the plan medical director.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1344 and 1374.16, Health and Safety Code.

History:

1. Renumbering of former section 1300.67.60 to new section 1300.74.16, including repealer of subsections (h)-(i), filed 1-10-2008; operative 2-9-2008 (Register 2008, No. 2).

§ 1300.74.30. Independent Medical Review System.

(a) Plan enrollees may request independent medical review pursuant to this regulation for decisions that are eligible for independent medical review under Article 5.55 and section 1370.4 of the Act. The independent medical review process shall resolve decisions that deny, modify, or delay health care services, that deny reimbursement for urgent or emergency services or that involve experimental or investigational therapies. Specialized plans shall provide for independent medical reviews under this section if a covered service relates to the practice of medicine or is provided pursuant to a contract with a health

plan providing medical, surgical and hospital services. The Department shall be the final arbiter when there is a question as to whether a dispute over a health care service is eligible for independent medical review, and whether extraordinary and compelling circumstances exist that waive the requirement that the enrollee first participate in the plan's grievance system.

(b) An enrollee may apply for an independent medical review under the conditions specified in Section 1374.30(j) of the Act. The Department may waive the requirement that the enrollee participate in the plan's grievance process if the Department determines that extraordinary and compelling circumstances exist, which include, but are not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate, and serious deterioration of the health of the enrollee.

(c) In cases involving a claim for out of plan emergency or urgent services that a provider determined were medically necessary, the independent medical review shall determine whether the services were emergency or urgent services necessary to screen and stabilize the enrollee's condition. For purposes of this section "emergency services" are services for emergency medical conditions as defined in section 1300.71.4 of title 28, and "urgent services" are all services, except emergency services, where the enrollee has obtained the services without prior authorization from the plan, or from a contracting provider.

(d) Applications for independent medical review shall be submitted on a one-page form entitled Independent Medical Review Application (DMHC IMR 11/00), which is incorporated by reference, and shall be provided by the Department. The form shall contain a signed release from the enrollee, or a person authorized pursuant to law to act on behalf of the enrollee, authorizing release of medical and treatment information. Additionally, the enrollee may provide any relevant material or documentation with the application including, but not limited to:

(1) A copy of the adverse determination by the plan or contracting provider notifying the enrollee that the request for health care services was denied, delayed or modified, in whole or in part, based on the determination that the service was not medically necessary;

(2) Medical records, statements from the enrollee's provider or other documents establishing that the dispute is eligible for review;

(3) A copy of the grievance requesting the health care service or benefit filed with the plan or any entity with delegated authority to resolve grievances, and the response to the grievance, if any;

(4) If expedited review is requested for a decision eligible for independent medical review pursuant to Article 5.55 of the Act, the application shall include, a certification from the enrollee's physician or provider indicating that an imminent and serious threat to the health of the enrollee exists. If expedited review is requested for a decision eligible for independent medical review pursuant to section 1370.4 of the Act, the application shall include a certification from the enrollee's physician that the proposed therapy would be significantly less effective if not promptly initiated.

(e) If additional information is needed to complete an application or to determine the enrollee's eligibility for independent medical review, the Department shall advise the enrollee or the enrollee's representative, the enrollee's provider, the enrollee's health care plan or the enrollee's attending physician, as appropriate, by the most efficient means available.

(f) The Department shall evaluate complaints received under subsection (b) of Section 1368 of the Act and applications submitted under this regulation and determine whether the enrollee is eligible for an independent medical review. The Department's determination will consider all information provided

to the Department, the enrollee's medical condition and the disputed health care service. If the Department determines that the case should not be referred to independent medical review, the request shall be considered a complaint under subsection (b) of Section 1368 and sections 1300.68 and 1300.68.01. The enrollee or the enrollee's representative, health plan and any involved provider shall be advised of the Department's determination.

(1) The request for independent medical review shall be filed with the Department within six months of the plan's written response to the enrollee's grievance. The six-month period does not begin to run until the enrollee, or the enrollee's representative, has been properly notified in writing of the plan's resolution of the grievance. Applications will not be rejected as untimely solely because the enrollee, the enrollee's provider, or the plan failed to submit supporting documentation. Requests for extensions or late applications shall be approved if a timely submission was reasonably impaired by inadequate notice of the independent medical review process or by the applicant's medical circumstances.

(2) An application will not be eligible for independent medical review if the enrollee's complaint has previously been submitted and reviewed by the Department. Exceptions may be approved if the application for independent medical review includes medical records and a statement from the enrollee's physician or provider demonstrating significant changes in the enrollee's medical condition or in medical therapies available have occurred since the Department's disposition of the complaint.

(3) Enrollees of Medi-Cal health care service plans are eligible for an independent medical review if the enrollee has not presented the disputed health care service for resolution by the Medi-Cal fair hearing process. Reviews shall be conducted in accordance with the statutes and regulations of the Medi-Cal program.

(4) This regulation applies to Medicare enrollees, to the extent the regulation does not conflict with federal law, including 42 USCS §1395w-26 (2004).

(g) Except for Medi-Cal enrollees, and Medicare enrollees exempted by federal law, as described at subsection (f)(4), the independent medical review system established pursuant to this section shall be the exclusive independent medical review process offered to enrollees for disputes involving the medical necessity of covered health care services. Nothing in this section shall preclude a health plan from offering other independent review processes for disputes that do not involve medical necessity.

(h) When the Department finds that a plan fails to advise an enrollee of the availability of independent medical review as required under Health and Safety Code section 1374.30(i), or engages in a practice of mischaracterizing determinations substantially based on medical necessity as coverage decisions, or otherwise interferes with the rights of enrollees to obtain independent medical review, the Department shall impose administrative penalties on the plan in accordance with the Act.

(i) The director shall notify the enrollee and the enrollee's health care plan if an application for independent medical review has been accepted within seven (7) calendar days of receipt of a completed application for a routine request and within 48 hours of receipt of a completed application for an expedited review. The notification shall identify the independent medical review organization, whether the review shall be conducted on an expedited or routine basis and other information deemed necessary by the Department. The director shall also transmit to the enrollee's health care plan a copy of the enrollee's signed release of medical and treatment information and copies of all other materials submitted with the enrollee's application.

(j) Following receipt of the Department's notification that an application for independent medical review has been assigned to an independent medical review organization, the plan shall provide the organization with all information that was considered in relation to the disputed health care service, the enrollee's grievance and the plan's determination. The plan shall forward all information to the medical review organization within three (3) business days for a regular review and within one (1) calendar day in the case of an expedited review.

(1) Unless otherwise advised in the notification or by the assigned review organization, the plan shall submit a complete set of the materials described below for the independent review organization.

(A) A copy of all correspondence from and received by the plan concerning the disputed health care service, including but not limited to, any enrollee grievance relating to the requested service;

(B) A complete and legible copy of all medical records and other information used by the plan in making its decision regarding the disputed health care service. An additional copy of medical records shall be submitted for each reviewer.

(C) A copy of the cover page of the evidence of coverage and complete pages with the referenced sections highlighted or underlined sections, if the evidence of coverage was referenced in the plan's resolution of the enrollee's grievance;

(D) The plan's response to any additional issues raised in the enrollee's application for independent medical review.

(2) The plan shall promptly provide the enrollee with an annotated list of all documents submitted to the independent medical review organization, together with information on how copies may be requested.

(k) Plans shall be responsible for providing additional information as follows:

(1) Any medical records or other relevant matters not available at the time of the Department's initial notification, or that result from the enrollee's ongoing medical care or treatment for the medical condition or disease under review. Such matters shall be forwarded as soon as possible upon receipt by the health plan, not to exceed five (5) business days in routine cases or one (1) calendar day in expedited cases.

(2) Additional medical records or other information requested by the IMR organization shall be sent within five (5) business days in routine cases or one (1) calendar day in expedited cases. In expedited reviews, the health care plan shall immediately notify the enrollee and the enrollee's health care provider by telephone or facsimile to identify and request the necessary information, followed by written notification, when the request involves materials not in the possession of the plan or its contracting providers.

(*l*) Each assigned reviewer shall issue a separate written analysis of the case, explaining the determination made, using plain English where possible. The analysis shall describe how the determination relates to the enrollee's medical condition and history, relevant medical records and other documents considered, and references to the specific medical and scientific evidence listed in Sections 1370.4(d) or 1374.33(b) of the Act, as applicable. For requests made pursuant to Article 5.55 of the Act, reviewers shall determine whether the disputed service is medically necessary for the enrollee. For requests made pursuant to section 1370.4 of the Act, the reviewers shall determine whether the requested therapy is likely to be more beneficial for the enrollee then other available standard therapies, and whether the plan shall provide the requested therapy. Reviews based on section 1300.70.4 of these regulations shall also reference the medical and scientific evidence considered in assessing whether the requested health care service is likely to be more beneficial than other available standard

therapies. The analysis may also discuss the risks and benefits considered by the reviewer in considering proposed and standard treatments.

(m) The Department, the enrollee, or his/her representative may withdraw a case from the independent review system at any time. The plan may seek withdrawal of the case from the review system by providing the disputed health care service, subject to the concurrence of the enrollee.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1370.4, 1374.30 and 1374.33, Health and Safety Code.

History:

1. New section filed 2-18-2003; operative 3-20-2003 (Register 2003, No. 8).
2. New subsection (f)(4) and amendment of subsection (g) filed 7-25-2005; operative 8-24-2005 (Register 2005, No. 30).

§ 1300.74.72. Mental Health Parity.

(a) The mental health services required for the diagnosis, and treatment of conditions set forth in Health and Safety Code section 1374.72 shall include, when medically necessary, all health care services required under the Act including, but not limited to, basic health care services within the meaning of Health and Safety Code sections 1345(b) and 1367(i), and section 1300.67 of Title 28. These basic health care services shall, at a minimum, include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from licensed mental health providers including, but not limited to, psychiatrists and psychologists.

(b) A plan shall provide coverage for the diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 through health care providers within the meaning of Health and Safety Code section 1345(i) who are:

(1) acting within the scope of their licensure, and

(2) acting within their scope of competence, established by education, training and experience, to diagnose, and treat conditions set forth in Health and Safety Code section 1374.72.

(c) A diagnosis within the meaning of Health and Safety Code section 1374.72 shall be made in accordance with professionally recognized diagnostic criteria including, but not limited to, the diagnostic criteria set forth in the Diagnostic and Statistical Manual for Mental Disorders — IV — Text Revision (June 2000).

(d) A preliminary or initial diagnosis made by a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above, that an enrollee has one or more of the conditions set forth in Health and Safety Code section 1374.72, shall constitute the diagnosis for the length of time necessary to make a final diagnosis, whether or not the final diagnosis confirms the preliminary or initial diagnosis.

(e) "Pervasive Developmental Disorders" shall include Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified (including Atypical Autism), in accordance with the Diagnostic and Statistical Manual for Mental Disorders — IV — Text Revision (June 2000).

(f) A plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 and for related health care services as appropriate upon referral from a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above.

(g) If a plan contracts with a specialized health care service plan for the purpose of providing Health and Safety Code section 1374.72 services, the following requirements shall apply:

(1) the specialized health care service plan shall maintain a telephone number that an enrollee may call during normal business hours to obtain information about benefits, providers, coverage and any other relevant information concerning an enrollee's mental health services;

(2) if the plan issues identification cards to enrollees, the identification cards shall include the telephone number required to be maintained above and a brief statement indicating that enrollees may call the telephone number for assistance about mental health services and coverage;

(3) the plan shall monitor the continuity and coordination of care that enrollees receive, and take action, when necessary, to assure continuity and coordination of care, in a manner consistent with professionally recognized evidence-based standards of practice, across the health care network;

(4) the plan shall monitor, as often as necessary, but not less frequently than once every year, the collaboration between medical and mental health providers including, but not limited to, the following:

(A) exchange of information,

(B) appropriate diagnosis, treatment and referral, and

(C) access to treatment and follow-up for enrollees with co-existing medical and mental health disorders;

(5) the plan shall retain full responsibility for assuring continuity and coordination of care, in accordance with the requirements of this subsection, notwithstanding that, by contract, it has obligated a specialized health care service plan to perform some or all of these activities.

(h) Nothing in this section shall be construed to mandate coverage of services that are not medically necessary or preclude a plan from performing utilization review in accordance with the Act.

(i) A plan shall include in its Evidence of Coverage or Combined Evidence of Coverage and Disclosure Form a list of mental conditions required to be covered pursuant to Health and Safety Code section 1374.72.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1367 and 1374.72, Health and Safety Code.

History:

1. New section filed 9-23-2003; operative 10-23-2003 (Register 2003, No. 39).

§ 1300.74.73. Pervasive Developmental Disorder and Autism Coverage.

Health plans subject to Section 1374.73 of the Act shall comply with this section.

(a) Requirements

(1) For health plans that provide hospital, medical or surgical coverage under contract with the Healthy Families Program or the Board of Administration of the California Public Employees' Retirement System, section 1374.73 of the Act does not affect, reduce or limit the obligation to provide coverage for the diagnosis and medically necessary treatment of pervasive developmental disorder (PDD) and autism, including medically necessary behavioral health treatment, pursuant to Health and Safety Code section 1374.72.

(2) Nothing in subdivision (a)(1) of this section shall be construed to mandate coverage of services that are not medically necessary or preclude a plan from performing utilization review in accordance with the Act.

(3) Each health plan that is subject to the requirements of section 1374.73 of the Act shall submit a report to the Department no later than December

31, 2012, demonstrating that the health plan has an adequate network of qualified autism service providers, qualified autism service professionals and/or qualified autism service paraprofessionals. The required report shall include the following information:

(A) The name of each qualified autism service provider entity or organization/group, listed by county and zip code. For each identified qualified autism service provider entity or organization/group, state the following information:

1. The number of individual qualified autism service providers available to the entity or organization/group;

2. The number of qualified autism service professionals available to the entity or organization/group; and,

3. The number of qualified autism service paraprofessionals available to the entity or organization/group.

(B) The number of the health plan's individual qualified autism service providers, listed by county and zip code. For each qualified autism service provider identified, state the following information:

1. The number of qualified autism service professionals available to the qualified autism service provider pursuant to Health and Safety Code section 1374.73(c)(4)(B); and,

2. The number of qualified autism service paraprofessionals available to the qualified autism service provider pursuant to Health and Safety Code section 1374.73(c)(5)(A).

(C) A description of how the health plan is determining provider network adequacy, including how geographic accessibility and timely access for health plan enrollees to medically necessary PDD and autism health care services is being met. This information should include:

1. Data describing the adequacy of the health plan's provider network for each region or service area, including utilization data and information on the health plan's enrollee population, such as age, gender and other relevant factors used by the health plan; and,

2. A description of the health plan's system for monitoring and evaluating provider network adequacy in each region or service area.

(D) Upon request, the health plan shall submit within 30 calendar days any additional information the Director may request to determine the adequacy of the plan's network to ensure that health plan enrollees are receiving medically necessary PDD and autism health care services, including timely screening, diagnosis, evaluation and treatment.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1367, 1374.72 and 1374.73, Health and Safety Code.

History:

1. New section filed 9-6-2012 as an emergency; operative 9-6-2012 (Register 2012, No. 36). A Certificate of Compliance must be transmitted to OAL by 3-5-2013 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 9-6-2012 order transmitted to OAL 2-28-2013 and filed 4-8-2013 (Register 2013, No. 15).

ARTICLE 9
Financial Responsibility

Section

1300.75. Agreements with Subsequent Providers. [Repealed]
1300.75.1. Fiscal Soundness, Insurance, and Other Arrangements.
1300.75.2. Plan As Subsequent Provider. [Repealed]
1300.75.3. Subsequent Provider Exemption. [Repealed]

RISK-BEARING ORGANIZATIONS

1300.75.4. Definitions.
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1300.77.4. Reimbursements on a Fee-for-Services Basis: Determination of Status of Claims.
1300.78. Administrative Costs.

§ 1300.75. Agreements with Subsequent Providers. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Stats. 1978, Ch. 285.

History:

1. Repealer filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).

§ 1300.75.1. Fiscal Soundness, Insurance, and Other Arrangements.

(a) A plan shall demonstrate fiscal soundness and assumption of full financial risk as follows:

(1) Demonstrate through its history of operations and through projections (which shall be supported by a statement as to the facts and assumptions upon which they are based) that the plan's arrangements for health care services and the schedule of its rates and charges are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness.

(2) Demonstrate that its working capital is adequate, including provisions for contingencies.

(3) Demonstrate an approach to the risk of insolvency which allows for the continuation of benefits for the duration of the contract period for which payment has been made, the continuation of benefits to subscribers and enrollees who are confined on the date of insolvency in an in-patient facility until their discharge, and payments to unaffiliated providers for services rendered.

(b) As a part of its program pursuant to subsection (a), a plan may obtain insurance or make other arrangements:

(1) For the cost of providing to any member covered health care services the aggregate value of which exceeds $5,000 in any year;

(2) For the cost of covered health care services provided to its members other than through the plan because medical necessity required their provision before they could be secured through the plan; and

(3) For not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year.

(c) In passing upon a plan's showing pursuant to this section, the Director will consider all relevant factors, including but not limited to:

(1) The method of compensating providers and the terms of provider contracts, especially as to the obligations of providers to subscribers and enrollees in the event of plan insolvency.

(2) The methods by which the plan controls and monitors the utilization of health care services.

(3) The administrative expenses (actual and projected) of the plan and especially as to new or expanding plans, the fiscal soundness of its program to acquire and service an expanded subscriber population.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1375.1, Health and Safety Code.

History:
1. Repealer and new section filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).
2. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).
3. Change without regulatory effect amending subsection (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.75.2. Plan As Subsequent Provider. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Stats. 1978, Ch. 285.

History:
1. Repealer filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).

§ 1300.75.3. Subsequent Provider Exemption. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Stats. 1978, Ch. 285.

History:
1. Repealer filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).

RISK-BEARING ORGANIZATIONS

§ 1300.75.4. Definitions.

As used in these Solvency Regulations:

(a) "External party" means the Department of Managed Health Care or its designated agent, which may be contracted or appointed to fulfill the functions stated in these Solvency Regulations. Whenever these Solvency Regulations reference the Department of Managed Health Care it shall mean the Department of Managed Health Care (Department) or its designated agent.

(b) "Organization" means a risk-bearing organization as defined in Health and Safety Code Section 1375.4(g). An organization includes an entity that contracts directly with the plan or subcontracts with another organization to arrange for the health care services of a plan's enrollees and meets the requirements of Health and Safety Code section 1375.4(g).

(c) "Plan" means full-service health care service plan, as defined by Health and Safety Code section 1345(f).

(d) "Risk arrangement" is defined to include both "risk-sharing arrangement" and "risk-shifting arrangement," which are defined as follows:

(1) "Risk-sharing arrangement" means any compensation arrangement between an organization and a plan under which the organization shares the risk of financial gain or loss with the plan.

(2) "Risk-shifting arrangement" means a contractual arrangement between an organization and a plan under which the plan pays the organization on a fixed, periodic or capitated basis, and the financial risk for the cost of services provided pursuant to the contractual arrangement is assumed by the organization.

(e) "Solvency Regulations" means sections 1300.75.4 through 1300.75.4.8 of Title 28 of the California Code of Regulations.

(f) "Cash-to-claims ratio" is an organization's cash, readily available marketable securities and HMO capitation receivables due within thirty (30) days, divided by the organization's unpaid claims (claims payable and incurred but not reported [IBNR] claims) liability. The organization shall report only

those HMO capitation receivables due within thirty (30) days the organization reasonably believes will be received by that time.

(g) "Corrective action plan" (CAP) means a plan reflected in a document containing requirements for correcting and monitoring an organization's efforts to correct any financial solvency deficiencies in the Grading Criteria or other financial or other claims payment deficiencies, determined through the Department's review or audit process, indicating that the organization may lack the capacity to meets its contractual obligations consistent with the requirements of section 1300.70(b)(2)(H)(1) of Title 28, California Code of Regulations.

(h) "Grading Criteria" means the four grading/reviewing criteria specified in Health and Safety Code sections 1375.4(b)(1)(A)(i), (ii), (iii), and (iv) and the cash-to-claims ratio as defined in subsection (f) above.

(i) "In a manner that does not adversely affect the integrity of the contract negotiation process" means the disclosure of an organization's financial data submissions in a format that does not impair the organization's ability to negotiate its contracts for the delivery of health care services or does not allow a contracting party to calculate: (1) an organization's precise profit/loss margins on any line of business, or (2) the rates that the organization has negotiated with any contracting entity or vendor during a prior accounting period.

(j) "Sponsoring organization" shall have the same meaning as Health and Safety Code section 1375.4(b)(1)(B).

(k) "Sub-delegating organization" means an organization that delegates any portion of the responsibility for providing or arranging for the health care services of a plan's enrollees to another organization on a capitated or fixed period payment basis.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

History:

1. New section filed 3-22-2001 as an emergency; operative 3-22-2001 (Register 2001, No. 12). A Certificate of Compliance must be transmitted to OAL by 7-20-2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 3-22-2001 order, including amendment of subsection (d)(1), transmitted to OAL 7-20-2001 and filed 8-31-2001 (Register 2001, No. 35).
3. Amendment of first paragraph and subsections (a)-(e) and new subsections (f)-(i) filed 8-10-2005; operative 9-9-2005 (Register 2005, No. 32).
4. Change without regulatory effect amending subsection (i) filed 12-14-2005 pursuant to section 100, title 1, California Code of Regulations (Register 2005, No. 50).
5. Amendment of subsections (a)-(b) and (f) and new subsections (j)-(k) filed 7-10-2019; operative 10-1-2019 (Register 2019, No. 28).

§ 1300.75.4.1. Risk Arrangement Disclosure.

(a) Every contract involving a risk arrangement between a plan and an organization or between a sub-delegating organization and an organization shall require the plan or the sub-delegating organization to do all of the following:

(1) Disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a monthly basis within fifteen (15) calendar days of the beginning of each report month, the following information for each enrollee assigned to the organization: member identification number, name, birth date, gender, address (including zip code), plan contract selected, employer group identification, the identity of any other third party coverage, if known to the health plan, enrollment/disenrollment dates, medical group/IPA number, provider effective date, type of change to coverage, co-payment, deductible, the amount of capitation to be paid per enrollee per month, and the primary care

physician when the selection of a primary care physician is required by the plan.

(2) Disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a monthly basis within fifteen (15) calendar days of the beginning of each report month, the names, member identification numbers, and total numbers of enrollees added or terminated under each benefit plan or sub-delegating organization contract served by the organization.

(3) If the information provided in paragraphs (1) and (2) is provided in more than one report, the plan or sub-delegating organization shall disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a quarterly basis, within forty-five (45) calendar days of the close of each quarter, a reconciliation of the variances between the information provided in paragraphs (1) and (2) above. If the information in paragraphs (1) and (2) is provided in more than one report, all reports shall be processed as of the same date.

(4) On the contract anniversary date, disclose to the organization, for the purpose of assisting the organization to be informed regarding the financial risk assumed under the contract, the following information for each and every type of risk arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, and commercial, including large group, small group, and individual) under the contract, including:

(A) a matrix of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to the organization, facility, the plan or the sub-delegating organization under the risk arrangement;

(B) expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, primary care physician, specialist, pharmacy, home health, durable medical equipment (DME), ambulance and other), the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by benefit plan type for the type of risk arrangement; and

(C) all factors used to adjust payments or risk-sharing targets, including but not limited to the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

(5) Disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a quarterly basis, within forty-five (45) calendar days of the close of each quarter, a detailed description of each and every amount (including expenses and income) that is sufficient to allow verification of the amounts allocated to the organization and to the plan or the sub-delegating organization under each and every risk-sharing arrangement. Where applicable, the following information, at a minimum, shall be provided:

(A) The total number of member months;

(B) The total budget allocation for the member months;

(C) The total expenses paid during the period;

(D) A description of the incurred but not reported (IBNR) claims methodology used for incurred expenses during the period; and

(E) A description of each and every amount of expense allocated to the risk arrangement by member identification number, date of service, description of service by claim codes, net payment and date of payment.

(6) For all risk-sharing arrangements, provide the organization with a preliminary payment report consistent with the requirements of paragraph (5) no later than one-hundred and fifty (150) days and payment no later than one-

hundred and eighty (180) days after the close of the organization's contract year, or the contract termination date, whichever occurs first.

(b) In addition to the disclosures required by subsection (a) of this regulation, every contract involving a risk-sharing arrangement between a plan and an organization and, between a sub-delegating organization and an organization, shall require the plan or sub-delegating organization to disclose annually on the contract anniversary date, the amount of payment for each and every service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the contract shall incorporate that fee schedule by reference, and further specify the Medicare RBRVS year if RBRVS is the methodology or if another model or methodology is used for fee schedule development. For any proprietary fee schedule, the contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

(c) In addition to the disclosures required by subsection (a) of this regulation, every contract involving a risk-shifting arrangement between a plan and an organization or, between a sub-delegating organization and an organization, shall require the plan or the sub-delegating organization to disclose annually on the contract anniversary date, in the case of capitated payment, the amount to be paid per enrollee per month, or the respective amount under a percentage of premium arrangement. For any deductions that the plan or sub-delegating organization may take from any capitation payment, the plan or sub-delegating organization shall provide details sufficient to allow the organization to verify the accuracy and appropriateness of the provided deduction.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

History:

1. New section filed 3-22-2001 as an emergency; operative 3-22-2001 (Register 2001, No. 12). A Certificate of Compliance must be transmitted to OAL by 7-20-2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 3-22-2001 order, including amendment section, transmitted to OAL 7-20-2001 and filed 8-31-2001 (Register 2001, No. 35).
3. Amendment filed 7-10-2019; operative 10-1-2019 (Register 2019, No. 28).

§ 1300.75.4.2. Organization Information.

Every contract involving a risk arrangement between a plan and an organization shall require the organization or sub-delegating organization to do the following:

(a) Maintain at all times a minimum "cash-to-claims ratio," as defined in section 1300.75.4(f), of 0.75 except as specified below. Beginning October 1, 2019 and ending on October 1, 2020, an organization shall comply with the cash-to-claims ratio definition, which is defined as an organization's cash, readily available marketable securities and receivables, excluding all risk pool, risk-sharing, incentive payment program and pay-for-performance receivables, reasonably anticipated to be collected within sixty (60) days divided by the organization's unpaid claims (claims payable and incurred but not reported (IBNR) claims) liability.

(b) DMHC Quarterly Financial Survey Report Form ("quarterly financial survey report"). For each quarter, submit to the Department, not more than forty-five (45) days after the close of each quarter of the fiscal year, a quarterly financial survey report on the DMHC Quarterly Financial Survey Report Form, dated September, 2018, as incorporated herein by reference, and published by the Department on its webpage: www.dmhc.ca.gov. The DMHC Quarterly Financial Survey Report Form shall be filed pursuant to section 1300.41.8 of

Title 28, California Code of Regulations, and shall contain all of the following information:

(1) Quarterly financial survey report information (including the following: a balance sheet; an income statement; a statement of cash flows; a statement of net worth; cash and cash equivalent; receivables and payables; risk pool and other incentives; claims aging; notes to financial statements; enrollment information; mergers, acquisitions and discontinued operations; the incurred but not reported (IBNR) methodology; and administrative expenses), or in the case of a nonprofit entity comparable financial statements and supporting schedule information (including but not limited to, aging of receivable information), reflecting the results of operations for the immediately preceding quarter and year-to-date, prepared in accordance with generally accepted accounting principles (GAAP) and the identification of the individual or office in the organization designated to receive public inquiries.

(A) Sub-delegating organizations shall list all contracting organizations, including their names, addresses, contact persons, telephone numbers, and number of enrollees assigned to the organization as of the last day of the quarter being reported.

(B) Quarterly financial survey reports of an organization required pursuant to these rules shall be on a combining basis with an affiliate, if either the organization or such affiliate is legally or financially responsible for the payment of the organization's claims. Any affiliated entity included in this report shall be separately identified and reported in a combining schedule format. Upon the request of the Director, the organization or affiliate subject to this subdivision shall provide financial statements on a separate DMHC Quarterly Financial Survey Report Form. The Director shall consider at least the following information when determining whether to make the request:

(i) Whether financial solvency concerns exist with the organization or the affiliate, which impact the organization's ability to maintain compliance with the Grading Criteria or processing and paying claims in compliance with Claims Settlement Practices as detailed in section 1300.71 of Title 28, California Code of Regulations;

(ii) Whether there are concerns regarding the transparency of the affiliate relationship; and,

(iii) Whether financial documentation is not presented in accordance with GAAP.

(C) For the purposes of this section, an organization's use:

(i) Of a "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating tangible net equity, working capital, and cash-to-claims ratio; or

(ii) An affiliated entity to provide claims processing services shall not be construed to automatically create a legal or financial obligation to pay the claims liability for the health care services for enrollees.

(2) A statement as to what percentage of completed claims the organization has timely reimbursed, contested, or denied during the quarter in accordance with the requirements of Health and Safety Code sections 1371 and 1371.35, section 1300.71 of Title 28 of the California Code of Regulations, and any other applicable state and federal laws and regulations. If less than 95% of all complete claims have been reimbursed, contested or denied on a timely basis, the statement shall be accompanied by a report that describes the reasons why the claims adjudication process is not meeting the requirements of applicable law, any action taken to correct the deficiency, and any results of that action. This claims payment report is for the purpose of monitoring the financial solvency of the organization and is not intended to change or alter existing

state and federal laws and regulations relating to claims payment settlement practices and timeliness.

(3) A statement as to whether or not:

(A) The organization has estimated and documented, on a monthly basis, its liability for IBNR claims, pursuant to a method specified in section 1300.77.2; and

(B) The estimates are the basis for the quarterly financial survey report submitted under these Solvency Regulations. If the estimated and documented liability has not met the requirements of section 1300.77.2 in any way, a statement shall be included in the quarterly financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, the action taken to correct the deficiency, and the results of that action. An organization failing:

(i) To estimate and document, on a monthly basis, its liability for IBNR claims; or

(ii) To maintain its books and records on an accrual accounting basis shall be deemed to have failed to maintain, at all times, positive tangible net equity (TNE) and positive working capital as set forth in subsection (4) below.

(4) A statement as to whether or not the organization has at all times during the quarter maintained positive TNE, as defined in section 1300.76(c) of Title 28 California Code of Regulations; and has at all times during the quarter maintained positive working capital, calculated in a manner consistent with GAAP, that excludes unsecured affiliate receivables except those arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates. If the required TNE, cash-to-claims ratio, or the required working capital has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the following, with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(A) The organization may reduce its liabilities or increase its cash for purposes of calculating its TNE, working capital and cash-to-claims ratio in a manner allowed by Health and Safety Code section 1375.4(b)(1)(B) and this section so long as the sponsoring organization has filed with the Department:

(i) Its audited annual financial statements within one-hundred and twenty (120) days of the end of the sponsoring organization's fiscal year; and

(ii) A copy of the written guarantee meeting the requirements of Health and Safety Code section 1375.4(b)(1)(B). For purposes of Health and Safety Code section 1375.4(b)(1)(B), a sponsoring organization shall have a TNE of at least twice the total of all amounts that it has guaranteed to all persons and entities, or a lesser amount in situations where the organization can demonstrate to the Director's satisfaction and written approval that a lesser amount of TNE is sufficient. If an organization has a sponsoring organization, the organization shall provide information to the Department demonstrating the capacity of the sponsoring organization to guarantee the organization's debts, as well as the nature and scope of the guarantee provided, consistent with Health and Safety Code section 1375.4(b)(1)(B).

a. An organization may rely on a sponsoring organization for no more than one (1) fiscal year to reduce the organization's liabilities or increase its cash for purposes of calculating its TNE, working capital and cash-to-claims ratio. Requests by an organization to extend the one (1) year period and to rely on a sponsoring organization during a subsequent period shall be submitted to the Department and may be approved at the Director's discretion. Only a single twelve (12) month extension of the use of a sponsoring organization may be

requested by the organization. The Director shall consider at least the following information when determining whether to grant the request:

1. Financial projections demonstrating the compliance timeframes outlined by the organization;

2. Specific actions taken and proposed by the organization to improve financial solvency; and,

3. Any modifications or changes to the guarantee provided by the sponsoring organization.

b. An organization shall apply to the Department to request the use of a sponsoring organization. The application shall include projections showing how the organization will obtain and maintain compliance with requirements of Health and Safety Code section 1375.4(b)(1)(A) once the guarantee from the sponsoring organization terminates.

c. If the period that an organization has a sponsoring organization is longer than twelve (12) months, the organization shall annually, from the date of the sponsoring organization contract, report to the Department projections showing how the organization will obtain and maintain compliance with the requirements of Health and Safety Code section 1375.4(b)(1)(A) once the guarantee from the sponsoring organization terminates.

(5) A statement as to whether or not the organization has, at all times during the quarter, maintained a cash-to-claims ratio as required in section (a), calculated in a manner consistent with GAAP. If the required cash-to-claims ratio has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the following with respect to the deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(c) DMHC Annual Financial Survey Report Form ("annual financial survey report"). An organization shall submit to the Department, not more than one hundred fifty (150) days after the close of the organization's fiscal year and not more than one hundred fifty (150) days after the close of each of the organization's subsequent fiscal years, an annual financial survey report on the DMHC Annual Financial Survey Report Form, dated September 2018, as incorporated herein by reference and published by the Department on its webpage: www.dmhc.ca.gov. The DMHC Annual Financial Survey Report Form shall be filed pursuant to section 1300.41.8 of Title 28 of the California Code of Regulations, and shall be based upon the organization's annual audited financial statement prepared in accordance with generally accepted accounting principles (GAAP). The annual financial survey report shall contain all of the following:

(1) Annual financial survey report, based upon the organization's annual audited financial statements (including at least the following: a balance sheet; an income statement; a statement of cash flows; a statement of net worth; cash and cash equivalent; receivables and payables; risk pool and other incentives; claims aging; notes to financial statements; enrollment information; mergers, acquisitions and discontinued operations; the incurred but not reported (IBNR) methodology; administrative expenses; and footnote disclosures), or in the case of a nonprofit entity, comparable financial statements, and supporting schedule information (including, but not limited to, aging of receivable information and debt maturity information), for the immediately preceding fiscal year, prepared by the independent certified public accountant in accordance with GAAP.

(A) A sub-delegating organization shall include the allocation of risk between the sub-delegating organization and each organization with which it contracts

and shall disclose whether the sub-delegating organization provides stop-loss coverage to the organization, and if so, the nature of all stop-loss arrangements.

(B) Annual financial survey reports of an organization required pursuant to these Solvency Regulations shall be on a combining basis with an affiliate if either the organization or such affiliate is legally or financially responsible for the payment of the organization's claims. Any affiliated entity included in the report shall be separately identified. Upon the request of the Director, the organization or affiliate subject to this subdivision shall provide financial statements on a separate DMHC Annual Financial Survey Report Form. The Director shall consider at least the following information when determining whether to make the request:

(i) Whether financial solvency concerns exist with the organization or the affiliate, which impact the organization's ability to maintain compliance with the Grading Criteria or processing and paying claims in compliance with Claims Settlement Practices as detailed in section 1300.71 of Title 28, California Code of Regulations;

(ii) Whether there are concerns regarding the transparency of the affiliate relationship; and,

(iii) Whether financial documentation is not presented in accordance with GAAP.

(C) For the purposes of this section, an organization's use of:

(i) A "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating TNE and working capital, cash-to-claims ratio; or

(ii) An affiliated entity to provide claims processing services shall not be construed to automatically create a legal or financial obligation to pay claims liability for health care services for enrollees.

(D) When combined financial statements are required by this regulation, the independent accountant's report or opinion shall address all the entities included in the combined financial statements. If the accountant's report or opinion makes reference to the fact that another auditor performed a part of the examination, the organization shall also file the report or opinion issued by the other auditor.

(i) For purposes of determining the independence of the certified public accountant, the regulations of the California State Board of Accountancy (Division 1, sections 1 through 99.2, Title 16, California Code of Regulations), shall apply.

(E) The opinion of the independent certified public accountant indicating whether the organization's annual audited financial statements present fairly, in all material respects, the financial position of the organization, and whether the financial statements were prepared in accordance with GAAP. If the opinion is qualified in any way, the survey report shall include an explanation regarding the nature of the qualification.

(2) A statement as to whether or not the organization has estimated and documented, on a monthly basis, its liability for IBNR claims, pursuant to a method specified in section 1300.77.2, and that these estimates are the basis for the financial survey reports submitted under these Solvency Regulations. If the estimated and documented liability has not met the requirements of section 1300.77.2, a statement shall be included in the annual financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, the action taken to correct the deficiency, and the results of that action. An organization failing:

(A) To estimate and document, on a monthly basis, its liability for IBNR claims; or

(B) To maintain its books and records on an accrual accounting basis, shall be deemed to have failed to maintain, at all times, positive TNE and positive working capital as set forth in subsection (3)(A) below.

(3) A statement as to whether or not the organization has, at all times during the year, maintained positive TNE, as defined in section 1300.76(c) of Title 28, California Code of Regulations; and has, at all times during the year, maintained positive working capital, calculated in a manner consistent with GAAP, that excludes unsecured affiliate receivables except those arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates. If either the required TNE, cash-to-claims ratio, or the required working capital has not been maintained at all times, a statement shall be included in the annual financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(A) The organization may reduce its liabilities for purposes of calculating its TNE and working capital in a manner allowed by Health and Safety Code section 1375.4(b)(1)(B) and this section, so long as the sponsoring organization has filed with the Department:

(i) Its audited annual financial statements within one-hundred and twenty (120) days of the end of the sponsoring organization's fiscal year and

(ii) A copy of the written guarantee meeting the requirements of Health and Safety Code section 1375.4(b)(1)(B). For purposes of Health and Safety Code section 1375.4(b)(1)(B), a sponsoring organization shall have a TNE of at least twice the total of all amounts that it has guaranteed to all persons and entities, or a lesser amount in situations where the organization can demonstrate to the Director's satisfaction and written approval that a lesser amount of TNE is sufficient. If an organization has a sponsoring organization, the organization shall provide information to the Department demonstrating the capacity of the sponsoring organization to guarantee the organization's debts as well as the nature and scope of the guarantee provided consistent with Health and Safety Code section 1375.4(b)(1)(B).

a. An organization may rely on a sponsoring organization for no more than one (1) fiscal year to reduce the organization's liabilities or increase its cash for purposes of calculating its TNE, working capital and cash-to-claims ratio. Requests by an organization to extend the one (1) year period and to rely on a sponsoring organization during a subsequent period shall be submitted to the Department and may be approved at the Director's discretion. Only a single twelve (12) month extension of the use of a sponsoring organization may be requested by the organization. The Director shall consider at least the following information when determining whether to grant the request:

1. Financial projections demonstrating the compliance timeframes outlined by the organization;

2. Specific actions taken and proposed by the organization to improve financial solvency; and,

3. Any modifications or changes to the guarantee provided by the sponsoring organization.

b. An organization shall apply to the Department to request the use of a sponsoring organization. The application shall include projections showing how the organization will obtain and maintain compliance with the requirements of Health and Safety Code section 1375.4(b)(1)(A) once the guarantee from the sponsoring organization terminates.

c. If the period that an organization has a sponsoring organization is longer than twelve (12) months, the organization shall annually, from the date of

the sponsoring organization contract, report to the Department projections showing how the organization will obtain and maintain compliance with the requirements of Health and Safety Code section 1375.4(b)(1)(A) once the guarantee from the sponsoring organization terminates.

(4) A statement as to whether or not the organization has at all times during the year maintained a cash-to-claims ratio as required in section (a), calculated in a manner consistent with GAAP. If the required cash-to-claims ratio has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the following with respect to the deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(5) A statement as to whether the organization maintains reinsurance and/or professional stop-loss coverage.

(6) The annual financial survey report shall include, as an attachment, a copy of the complete annual audited financial statement, including footnotes and the certificate or opinion of the independent certified public accountant.

(d) Statement of Organization Survey. Submit to the external party, a "Statement of Organization," in an electronic format, prepared by the Department, to be filed along with the annual financial survey report, which shall include the following information, as of December 31 of each calendar year prior to the filing:

(1) Name and address of the organization;

(2) A financial and public contact person, with title, address, telephone number, fax number, and e-mail address;

(3) A list of all health plans with which the organization maintains risk arrangements;

(4) Whether the organization is an Independent Practice Association (IPA), Medical Group, Foundation, other entity, or some combination thereof. If the organization is a foundation, identify each and every medical group within the foundation, and whether any of those medical groups independently qualifies as a risk-bearing organization as defined in Health and Safety Code section 1375.4(g);

(5) Whether the organization is a professional corporation, partnership, not-for-profit corporation, sole proprietor, or other form of business;

(6) The name, business address and principal officer of each of the organization's affiliates as defined in Title 28, California Code of Regulations, section 1300.45(c)(1) and (2);

(7) Whether the organization is partially or wholly owned by a hospital or hospital system;

(8) A matrix listing all major categories of medical care offered by the organization, including, but not limited to, anesthesiology, cardiology, orthopedics, ophthalmology, oncology, obstetrics/gynecology and radiology.

(A) Next to each listed category in the matrix, a disclosure of the primary compensation model (salary, fee-for-service, capitation, other) used by the organization to compensate the majority of providers of that category of care;

(9) An approximation of the number of enrollees served by the organization under a risk arrangement, pursuant to a list of ranges developed by the Department;

(10) Any Management Services Organization (MSO) that the organization contracts with for administrative services;

(11) The total number of contracted physicians in employment and/or contractual arrangements with the organization;

(12) Disclosure of the organization's primary service area (excluding out-of-area tertiary facilities and providers) by California county or counties;

(13) The identification of the organization's address, telephone number and website link, if available, where providers may access written information and instructions for filing of provider disputes with the organization's Dispute Resolution Mechanism consistent with requirements of section 1300.71.38 of Title 28, California Code of Regulations; and,

(14) Provide any other information that the Director deems reasonable and necessary, as permitted by law, to understand the operational structure and finances of the organization.

(e) Submit a written verification for each report made under subsections (b), (c), and (d) of this section stating that the report is true and correct to the best knowledge and belief of a principal officer of the organization, and, if the report is a combined report, a principal officer of the affiliate, and signed by both principal officers, as defined by section 1300.45(o) of Title 28, California Code of Regulations. This verification shall be submitted by delivering a hard copy with an original signature to the Director, care of the Office of Financial Review, Department of Managed Health Care, 980 Ninth Street, Suite 500, Sacramento, CA 95814.

(f) Notify the Department and each contracting health plan or sub-delegating organization no later than five (5) business days after discovering that the organization has experienced any event that materially alters its financial situation or threatens its solvency. Each sub-delegating organization shall have adequate procedures in place to ensure the Department of Managed Health Care or its designated agent is notified no later than five (5) business days from discovering that any of its contracting organizations experienced any event which materially alters the organization's financial situation, or threatens its solvency.

(g) Permit the Department to make any examination that it deems reasonable and necessary to implement Health and Safety Code section 1375.4, and provide to the Department, upon request, any books or records deemed relevant or useful to implementing this section for inspection and copying, as permitted by law.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

History:

1. New section filed 8-10-2005; operative 9-9-2005 (Register 2005, No. 32). For prior history, see Register 2002, No. 28.
2. Amendment filed 7-10-2019; operative 10-1-2019 (Register 2019, No. 28).

§ 1300.75.4.3. Plan Reporting.

(a) Plan Quarterly Survey. Every plan that contracts with an organization shall, by May 15, 2001, and not more than forty-five (45) days after the close of each subsequent calendar quarter, submit a quarterly survey report in an electronic format to the Director listing all its contracting organizations, including their names, addresses, contact persons, telephone numbers, and number of enrollees assigned to the organization as of the last day of the quarter being reported.

(b) Plan Annual Survey. Along with the quarterly report due May 15, 2001, and for the report due by May 15 of each subsequent year (i.e., an annual reporting period), every plan shall submit an annual survey report in an electronic format to the Director, containing the following information, as of December 31 of the prior calendar year, for each organization with which the plan has a risk arrangement:

(1) For the plan's commercial, Medicare+Choice, and Medi-Cal product lines, the report shall disclose, in a separate matrix for each product line, the

allocation of risk between the plan, the organization, and the facility by major expense category. For each of the plan's commercial, Medicare+Choice, and Medi-Cal product lines, the report shall disclose the number of covered lives and the counties primarily served by the organization.

(2) The report shall disclose whether the plan provides stop-loss insurance to the organization, and if so, the nature of any and all stop-loss arrangements.

(c) Each quarterly and annual survey report and matrix submitted to the Department shall include a written verification stating that the plan has complied with all the risk arrangement disclosure requirements of section 1300.75.4.1 and that the survey report or matrix is true and correct to the best knowledge and belief of a principal officer of the plan, and signed by a principal officer, as defined by regulation 1300.45(o) of Title 28 of the California Code of Regulations.

(d) Upon request, the plan shall provide any additional information that the Director may from time to time require to understand the type, amount, or appropriateness, of the financial risk assumed by the plan's contracting organizations.

(e) Every plan that contracts with an organization shall have adequate procedures in place to ensure that the plan notifies the Department of Managed Health Care or its designated agent no later than five (5) business days from discovering that any of its contracting organizations experienced any event which materially alters the organization's financial situation, or threatens its solvency.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

History:

1. New section filed 3-22-2001 as an emergency; operative 3-22-2001 (Register 2001, No. 12). A Certificate of Compliance must be transmitted to OAL by 7-20-2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 3-22-2001 order, including amendment section, transmitted to OAL 7-20-2001 and filed 8-31-2001 (Register 2001, No. 35).

§ 1300.75.4.4. Confidentiality.

(a) Financial and other records produced, disclosed or otherwise made available by an organization pursuant to Health and Safety Code section 1375.4, and to these Solvency Regulations shall be received and maintained on a confidential basis and protected from public disclosure, unless the Director makes a specific finding that the information can be released in a manner that does not adversely affect the integrity of the contract negotiation process; except that the organization's annual audited financial statement as required by section 1300.75.4.2(c) shall be permanently maintained on a confidential basis.

(b) The Director has determined that the disclosure of the following information in the format provided below will not adversely affect the integrity of an organization's contract negotiation process and, therefore, will be made available to the public as follows:

(1) Within 120 days following each reporting period due date, the Department of Managed Health Care (Department) will make the following information available, on its website, for public inspection:

(A) A list of all provider organizations currently identified as risk-bearing organizations;

(B) A list of all risk-bearing organizations that have submitted substantially complete financial survey forms, if required, and whether the risk-bearing organization's submission reflects that the organization has met or not met each of the Grading Criteria, as follows:

1. The designation of "met" to be assigned for each Grading Criteria met by the organization;

2. The designation of "not met" to be assigned for each Grading Criteria not met by the organization;

3. The disclosure of whether the organization has implemented and is compliant with a final CAP designed to remedy any deficiencies reported in the Grading Criteria;

4. The relative working capital of each organization, consistent with section 1300.75.4(h), presented as a ratio of current assets divided by current liabilities;

5. The relative tangible net equity (TNE) of each organization, consistent with section 1300.75.4(h), presented as a ratio of tangible net assets divided by total liabilities;

6. Claims payment timeliness in a percentage format, consistent with section 1300.75.4.(h), reflecting the amount of claims that the organization is paying on a timely basis; and,

7. To the extent feasible, each financial item described in paragraphs 1. through 5. shall be presented for both the current and the four previous reporting periods, following the effective date of these regulations.

(C) A list of all "non-compliant" organizations that fail to substantially comply with the reporting obligations, including the submission of the financial survey reports specified in section 1300.75.4.2 of Title 28, California Code of Regulations; and

(D) All information contained in the Statement of Organization of a risk-bearing organization, except responses to sections 1300.75.4.2(d)(8)(A), (d)(14) and financial documentation provided pursuant to section 1300.75.4.2 (d)(4); and

(E) Comparative, aggregated data on all organizations, and information that enables consumers to assess an organization's relative financial viability in a format that does not identify any individual organizations and consistent with section 1300.75.4.4 of Title 28, California Code of Regulations.

(c) Information received and maintained on a confidential basis pursuant to this section may be disclosed by the Director under the following circumstances:

(1) To other local, state or federal regulatory or law-enforcement agencies in accordance with the law;

(2) When necessary or appropriate in any proceeding or investigation conducted by the Department to enforce the provisions of the Knox-Keene Act;

(3) In the event that an organization publicly questions or challenges the Department's decision to approve or disapprove an organization's proposed CAP submitted in accordance with section 1300.75.4.8 of Title 28 of the California Code of Regulations, the Department may release the relevant portions of the organization's financial information to explain the Department's decision; and,

(4) Upon a determination by the Director, pursuant to Health and Safety Code section 1375.4(b)(7), that the justification for the confidential treatment no longer exists, provided that the information that is disclosed is at least two (2) years old.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

History:

1. New section filed 8-10-2005; operative 9-9-2005 (Register 2005, No. 32). For prior history, see Register 2002, No. 28.

§ 1300.75.4.5. Plan and Sub-Delegating Organization Compliance.

(a) Every plan and sub-delegating organization that maintains a risk arrangement with an organization shall have adequate procedures in place to ensure:

(1) That plan or sub-delegating organization personnel review all reports and financial information made available pursuant to Health and Safety Code section 1375.4, these Solvency Regulations, and as provided under the terms of the contract with an organization as part of the plan's responsibility to evaluate and ensure the financial viability of its arrangements consistent with section 1300.70(b)(2)(H)(1) of Title 28, California Code of Regulations;

(2) Appropriate action(s) are taken following the Department's written notification to an organization's contracting health plan(s) or sub-delegating organization(s) that the organization has:

(A) Failed to substantially comply with the reporting obligations specified in section 1300.75.4.2 of Title 28, California Code of Regulations, by failing to file a required periodic financial and organizational information disclosure, including the filing of an annual financial survey report based upon an audited financial statement prepared in accordance with generally accepted accounting principles (GAAP), or by failing to include significant portions of information on a required periodic financial organizational information disclosure;

(B) Refused to permit the activities of the Department as specified in Health and Safety Code section 1375.4 or in these Solvency Regulations; or,

(C) Failed to substantially comply with the requirements of a final CAP for a period of more than ninety (90) days, as determined by the Department.

(3) Appropriate action shall include, but is not limited to, a prohibition on the assignment or addition of any additional enrollees to the risk arrangement with that organization without the prior written approval of the Director. The prohibition on assignments of additional enrollees to an organization pursuant to subsection (2) shall not apply to dependents of enrollees who are already under the risk-arrangement with the organization or to enrollees who selected the organization during an open enrollment or other selection period that was prior to the effective date of the prohibition on the assignment of additional enrollees. The prohibition on the assignment of additional enrollees shall take effect thirty (30) days after the date of Department's notification to the organization's contracting plan(s), and shall remain in effect until the Department notifies the organization's contracting health plan in writing that the organization's non-compliance has been remedied.

(4) The plan or sub-delegating organization complies with the corrective action process and cooperates in the implementation of a final CAP, as defined in section 1300.75.4.8, including, but not limited to, implementing contingency plans for continuous delivery of health care services to plan enrollees served by the organization.

(5) The plan or sub-delegating organization shall advise the Department and the organization in writing within five (5) days of becoming aware:

(A) that a contracting organization is not in compliance with the requirements of a final CAP, or

(B) that an organization's conduct may cause the plan to be subject to disciplinary action pursuant to Health and Safety Code section 1386.

(6) If a plan proposes to transfer plan enrollees receiving care from an organization that is compliant with a final CAP to alternative providers and the reassignment is based, in part, on the organization's failure to meet one or more of the Grading Criteria, the plan shall, prior to transferring enrollees from that organization, file with the Department a Block Transfer Filing pursuant to Health and Safety Code section 1373.65. In addition to all other

criteria for reviewing block transfers, the Director may disapprove, postpone or suspend the plan's proposed transfer of enrollees if the department reasonably determines:

(A) That the proposed reassignment of enrollees will likely cause the organization's failure or result in the organization ceasing operations within three (3) months;

(B) That the organization has the financial and administrative capacity to provide timely access to care through an adequate network of qualified health care providers; and

(C) That the organization is not denying or delaying basic health care services or continuity of care for the plan's enrollees assigned to the organization.

(7) If a sub-delegating organization proposes to transfer plan enrollees receiving care from an organization that is compliant with a final CAP to alternative providers and the reassignment is based, in part, on the organization's failure to meet one (1) or more of the Grading Criteria, the sub-delegating organization shall notify the plan, prior to transferring enrollees from the organization, and the plan shall determine whether it is necessary to file with the Department a Block Transfer Filing pursuant to Health and Safety Code section 1373.65. In addition to all other criteria for reviewing block transfers, the Director may disapprove, postpone or suspend the sub-delegating organization's proposed transfer of enrollees if the Department reasonably determines:

(A) That the proposed reassignment of enrollees will likely cause the organization's failure or result in the organization ceasing operations within three (3) months;

(B) That the organization has the financial and administrative capacity to provide timely access to care through an adequate network of qualified health care providers; and

(C) That the organization is not denying or delaying basic health care services or continuity of care for the plan's enrollees assigned to the organization.

(8) Notwithstanding subsection (6) and (7) of this section, nothing in these regulations shall limit or impair:

(A) the Director's authority, consistent with Health and Safety Code sections 1367, 1373.65(b) and 1391.5, to require a plan to reassign or transfer plan enrollees to alternate providers or organizations on an expedited basis to avoid imminent harm to enrollees;

(B) an enrollee's right to self-select a new provider; or

(C) the plan's ability to transfer individual enrollees assigned to a provider who terminates his/her relationship with the organization to ensure that the enrollee receives appropriate continuity of care.

(b) Every contract involving a risk arrangement between a plan and an organization and every contract involving a risk arrangement between a sub-delegating organization and an organization, shall provide that an organization's failure to substantially comply with the contractual requirements required by these Solvency Regulations shall constitute a material breach of the risk arrangement contract. Neither a plan nor sub-delegating organization shall request or accept a waiver of any the contractual requirements set forth in these Solvency Regulations.

(c) Within thirty (30) days of notification pursuant to section 1300.75.4.5(a)(2)(C) of Title 28, California Code of Regulations, a plan or sub-delegating organization shall submit to the Department a specific Provider Transition Plan for the deficient organization which provides for the continuity of care for plan enrollees served by the organization.

(d) Any failure of a plan to comply with the requirements of Health and Safety Code section 1375.4 and these Solvency Regulations shall constitute grounds for disciplinary action against the plan pursuant to Health and Safety Code section 1386.

(e) The Director may seek and employ any combination of remedies and enforcement procedures provided under the Knox-Keene Act to enforce Health and Safety Code section 1375.4 and these Solvency Regulations.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

History:

1. New section filed 3-22-2001 as an emergency; operative 3-22-2001 (Register 2001, No. 12). A Certificate of Compliance must be transmitted to OAL by 7-20-2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 3-22-2001 order transmitted to OAL 7-20-2001 and filed 8-31-2001 (Register 2001, No. 35).
3. Repealer and new section filed 8-10-2005; operative 9-9-2005 (Register 2005, No. 32).
4. Amendment of section heading and section filed 7-10-2019; operative 10-1-2019 (Register 2019, No. 28).

§ 1300.75.4.6. Department Costs.

The Department's costs incurred in the administration of Health and Safety Code Sections 1347.15 and 1375.4 shall come from amounts paid by plans, except specialized plans, pursuant to Health and Safety Code Section 1356.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Sections 1347.15, 1356 and 1375.4, Health and Safety Code.

History:

1. New section filed 3-22-2001 as an emergency; operative 3-22-2001 (Register 2001, No. 12). A Certificate of Compliance must be transmitted to OAL by 7-20-2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 3-22-2001 order transmitted to OAL 7-20-2001 and filed 8-31-2001 (Register 2001, No. 35).

§ 1300.75.4.7. Organization Evaluation.

Every contract involving a risk arrangement between a plan and an organization or a sub-delegating organization and an organization shall:

(a) Require the organization to comply with the Department of Managed Health Care's review and audit process, in determining the organization's satisfaction of the Grading Criteria; and

(b) Permit the Department to perform any of the following activities in conjunction with the plan's oversight process:

(1) Obtain and evaluate supplemental financial information pertaining to the organization when:

(A) the organization fails to satisfactorily demonstrate its compliance with the Grading Criteria;

(B) the organization experiences an event that materially alters its ability to remain compliant with the Grading Criteria;

(C) the external party's review or audit process indicates that the organization may have insufficient financial capacity to continue to accept financial risk for the delivery of health care services consistent with the requirements of sections 1300.70(b)(2)(H)(1) of Title 28, California Code of Regulations; or

(D) the Department receives information from complaints submitted to the HMO Help Center, health plan reporting, medical audits and surveys or any other source that indicates the organization may be delaying referrals or authorizations or failing to meet access standards for basic health care services based on financial considerations.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

History:

1. New section filed 8-10-2005; operative 9-9-2005 (Register 2005, No. 32).
2. Amendment filed 7-10-2019; operative 10-1-2019 (Register 2019, No. 28).

§ 1300.75.4.8. Corrective Action.

Every contract involving a risk arrangement between a plan and an organization or a sub-delegating organization and an organization shall require the plan and the organization or the sub-delegating organization and the organization to comply with a process, set forth in this regulation and administered by the Department, for the development and implementation of Corrective Action Plans (CAPs).

(a) Organizations reporting deficiencies in any of the Grading Criteria shall submit a self-initiated CAP proposal on the DMHC Corrective Action Plan (CAP) Form, dated May, 2018, and incorporated by reference herein, published by the Department on its webpage at www.dmhc.ca.gov to the Department and to every plan and sub-delegating organization with which the organization maintains a contract involving a risk arrangement that meets the following requirements:

(1) Identifies the Grading Criteria that the organization has failed to meet;

(2) Identifies the amount by which the organization has failed to meet the Grading Criteria;

(3) Identifies all plans and sub-delegating organizations with which the organization contracts with, including the identification of the name, title, telephone and facsimile numbers, and postal and e-mail addresses for the person responsible at each contracting plan and sub-delegating organization for monitoring compliance with the final CAP;

(4) Describes the specific actions the organization has taken or will take to correct any deficiency identified in subsections (1) and (2) of this section. This description should include any written representations made by contracting plans and sub-delegating organizations to assist the organization in the implementation of its CAP. The actions shall be appropriate and reasonable in scope and breadth depending upon the nature and degree of the deficiency, and acceptable to the Department;

(5) Describes the timeframe for completing the corrective action and specifies a schedule for submitting progress reports to the Department and the organization's contracting plans and sub-delegating organizations. Except in situations where the organization can demonstrate to the Department's satisfaction and written approval that an extended period of time is necessary and appropriate to correct the deficiency, that:

(A) Timetables specified in the self-initiated CAP for correcting working capital deficiencies shall not exceed twelve (12) months;

(B) Timetables specified in the self-initiated CAP for correcting tangible net equity (TNE) deficiencies shall not exceed twelve (12) months;

(C) Timetables specified in the self-initiated CAP for incurred but not reported (IBNR) deficiencies shall not exceed three (3) months;

(D) Timetables specified in the self-initiated CAP for correcting claims timeliness deficiencies shall not exceed six (6) months;

(E) Timetables specified in the self-initiated CAP for correcting cash-to-claims ratio deficiencies shall not exceed twelve (12) months.

(6) Identifies the name, title, telephone and facsimile numbers, and postal and e-mail addresses for the person responsible at the organization for ensuring compliance with the final CAP; and

(7) An organization may avoid submitting a self-initiated CAP proposal if it demonstrates to the Department that necessary and prudent capital investments have caused or may cause a temporary deficiency in its TNE, working capital, or cash-to-claims ratios and that the organization has implemented an appropriate business plan that will correct the deficiency within a reasonable time period without causing a deficiency in the organization's claims processing timeliness. The organization shall seek and receive written approval from the Department to avoid submitting a self-initiated CAP proposal.

(b) To the extent possible, the self-initiated CAP proposal shall be set forth in a single document that addresses the concerns of all plans and sub-delegating organizations with which the organization maintains a contract that includes a risk arrangement.

(c) Unless, within fifteen (15) calendar days of the receipt of an organization's self-initiated CAP proposal, a contracting health plan or sub-delegating organization provides written notice to the Department and the organization stating the reason for its objections and recommendations for revisions, the self-initiated CAP shall be considered a final CAP subject to approval by the Department.

(d) In the event that a contracting plan or sub-delegating organization files a written objection with the Department and the organization, the Department shall, within ten (10) calendar days, review the objections and inform the organization if revisions to the CAP proposal are needed or if the objections can be resolved. If the objections can be resolved, the self-initiated CAP proposal shall be considered the final CAP subject to approval by the Department. If revisions to the CAP proposal are required, the organization will have ten (10) calendar days to:

(1) Implement all corrective action strategies contained in its self-initiated CAP proposal that were not objected to by a contracting plan; and

(2) Submit to each of its contracting plans and sub-delegating organizations and the Department a revised CAP proposal that addresses the concerns raised in the objections. To the extent possible, the revised CAP proposal shall be prepared as a single document that addresses the concerns of all plans and sub-delegating organizations with which the organization maintains a contract that includes a risk arrangement.

(e) Each contracting plan and sub-delegating organization shall have seven (7) calendar days to either accept or object to the self-initiated revised CAP proposal. If a plan or sub-delegating organization objects to the revised CAP proposal, the objection(s) and recommended revisions shall be submitted to the organization and the Department, in an electronic format prepared by the Department. If there are no objections, the self-initiated revised CAP proposal shall become the final CAP subject to approval by the Department.

(f) Within seven (7) calendar days of receipt of any contracting plans' or sub-delegating organization's objections and recommended revisions to the revised CAP proposal, the Department shall schedule a meeting ("CAP Settlement Conference") with the organization and all of its contracting plans and sub-delegating organizations to discuss and reconcile the differences.

(g) Within seven (7) calendar days of the CAP Settlement Conference, the organization shall submit a final self-initiated CAP proposal to all of its contracting plans, sub-delegating organizations, and the Department.

(h) Within twenty (20) calendar days of receipt of the organization's final self-initiated CAP proposal, the external party shall submit its recommendation to the Department to approve, disapprove or modify the organization's final self-initiated CAP proposal.

(i) Within seven (7) calendar days of receipt of the external party's recommendation, the Department shall approve, disapprove or modify the organization's final self-initiated CAP proposal, which shall then become the final CAP. If the Department does not act upon the recommendations of the external party within seven (7) calendar days, the external party's recommendation shall be deemed approved.

(j) A final CAP shall remain in effect until the organization demonstrates compliance with the requirements of the CAP, or the CAP expires in accordance with its own terms.

(k) In addition to the CAP requirements specified in subsection (a) above, the Department may direct an organization to initiate a CAP whenever its determines that an organization has experienced an event that materially alters its ability to remain compliant with the Grading Criteria or when the Department's review process indicates that the organization may lack sufficient financial capacity to meet its contractual obligations consistent with the requirements of section 1300.70(b)(2)(H) of Title 28, California Code of Regulations.

(*l*) CAP Reporting:

(1) Each periodic progress report prepared pursuant to a final CAP shall be submitted to the Department and all plans and sub-delegating organizations with which the organization has a contract involving a risk arrangement, and shall include a written verification stating that the periodic progress report is true and correct to the best knowledge and belief of a principal officer of the organization, as defined by section 1300.45(o) of Title 28 California Code of Regulations.

(2) In addition to the quarterly progress reports specified in a CAP, every contract involving a risk arrangement between a plan or sub-delegating organization and an organization shall require:

(A) the organization advise the plan and the Department in writing within five (5) calendar days if the organization experiences an event that materially alters the organization's ability to remain compliant with the requirements of a final CAP; and

(B) the organization, upon the Department's request, provides additional documentation to the Department and its contracting plans to demonstrate the organization's progress towards fulfilling the requirements of a CAP.

(3) Non-disclosure of CAP documentation and supporting work papers:

(A) All draft, preliminary and final CAPs and all CAP compliance reports required by a final CAP, including supporting documentation and supplemental financial information, submitted to the Department shall be received and maintained on a confidential basis and shall not be disclosed, except for the information outlined in section 1300.75.4.4(c)(3) to any party other than the organization and, as necessary, to its contracting plans and sub-delegating organizations that are participating in the CAP.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

History:

1. New section filed 8-10-2005; operative 9-9-2005 (Register 2005, No. 32).
2. Amendment filed 7-10-2019; operative 10-1-2019 (Register 2019, No. 28).

§ 1300.76. Plan Tangible Net Equity Requirement.

(a) Except as provided in subsection (b), each plan licensed pursuant to the provisions of the Act shall, at all times, have and maintain a tangible net equity at least equal to the greater of:

(1) $1 million; or

(2) the sum of two percent (2%) of the first $150 million of annualized premium revenues plus one percent (1%) of annualized premium revenues in excess of $150 million; or

(3) an amount equal to the sum of:

(A) eight percent (8%) of the first $150 million of annualized health care expenditures except those paid on a capitated basis or managed hospital payment basis; plus

(B) four percent (4%) of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of $150 million; plus

(C) four percent (4%) of annualized hospital expenditures paid on a managed hospital payment basis.

(b) Each plan licensed pursuant to the provisions of the Knox-Keene Act and which offers only specialized health care service contracts shall, at all times, have and maintain a tangible net equity at least equal to the greater of:

(1) $50,000; or

(2) the sum of two percent (2%) of the first $7,500,000 of annualized premium revenues plus one percent (1%) of annualized premium revenues in excess of $7,500,000; or

(3) an amount equal to the sum of:

(A) eight percent (8%) of the first $7,500,000 of annualized health care expenditures, except those paid on a capitated or managed hospital payment basis; plus

(B) four percent (4%) of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of $7,500,000; plus

(C) four percent (4%) of annualized hospital expenditures paid on a managed hospital payment basis.

(c) For the purpose of this section "net equity" means the excess of total assets over total liabilities, excluding liabilities that have been subordinated in a manner acceptable to the Director. "Tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not more than sixty (60) days past due; long term prepayments of deferred charges, and nonreturnable deposits. An obligation is fully secured for the purposes of this subsection if it is secured by tangible collateral, other than by securities of the plan or an affiliate, with an equity of at least one-hundred and ten percent (110%) of the amount owing.

(1) Beginning October 2, 2020, "positive tangible net equity" of an organization, as defined in Health and Safety Code section 1375.4(g), shall be at least equal to the greater of:

(A) one percent (1%) of annualized revenues; or

(B) four percent (4%) of annualized non-capitated medical expenses.

(2) The tangible net equity of an organization shall be determined pursuant to the criteria listed in subdivision (c) of this section.

(3) Beginning October 1, 2019 and ending October 1, 2020, an organization shall comply with the positive tangible net equity requirement of no less than one dollar ($1.00).

(d) For the purpose of this section, "capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the

type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

(e) For the purpose of this section, "managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1376, Health and Safety Code.

History:

1. Amendment of subsections (b) and (c) filed 4-27-79; effective thirtieth day thereafter (Register 79, No. 17).
2. Amendment of subsection (a), new subsections (b), (c),(d), (f) and (g), renumbering of former subsection (b) and repealer of former subsection (c) filed 12-14-90; operative 12-31-91 (Register 91, No. 6).
3. Editorial correction of printing error (Register 91, No. 17).
4. Change without regulatory effect amending subsections (d)-(e) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
5. Amendment of subsection (b), repealer of subsections (c)-(d), subsection relettering and amendment of newly designated subsection (c) filed 12-9-2015; operative 4-1-2016 (Register 2015, No. 50).
6. Amendment filed 7-10-2019; operative 10-1-2019 (Register 2019, No. 28).

§ 1300.76.1. Deposits.

(a) Except as provided in subsection (b), each plan licensed pursuant to the provisions of the Act shall deposit with the Director or at the discretion of the Director with any bank authorized to do business in this state and insured by the Federal Deposit Insurance Corporation, or savings and loan association doing business in this state and insured by the Savings Association Insurance Fund, an amount which at all times shall have a value of not less than $300,000, except for plans which only offer specialized health care service contracts, which shall deposit an amount which at all times shall have a value of not less than $150,000, or plans licensed as discount health plans, which shall deposit an amount which at all times shall have a value of not less than $50,000. Cash, investment certificates, accounts, or any combination of these shall be assigned to the Director, upon those terms as the Director may prescribed, until released by the Director.

(b) Each plan licensed pursuant to the provisions of the Act prior to the effective date of this section which only offers specialized health care service contracts shall make a deposit of two-thirds of the amount required by subsection (a) within 6 months of the effective date of this section, and 100 percent of the amount required by subsection (a) within 12 months of the effective date of this section.

(c) The deposit required by subsection (a) shall be an allowable asset of the plan in the determination of tangible net equity and all income from the deposit shall be an asset of the plan.

(d) A plan that has made a deposit pursuant to subsection (a) may withdraw that deposit or any part thereof, after making a substitute deposit of cash, investment certificates, accounts or any combination of these. Any substitute deposit shall be approved by the Director before being deposited or substituted.

(e) The deposits shall be used to protect the interests of the plan's enrollees and to assure continuation of health care services to enrollees of a plan whenever the Director has brought actions pursuant to sections 1386, 1392, 1393 or 1394.1. The Director may use the deposit for administrative costs directly attributable to a conservatorship, receivership or liquidation.

NOTE: Authority cited: Section 1344, Health & Safety Code. Reference: Section 1376, Health & Safety Code.

History:
1. New section filed 12-14-90; operative 12-31-90 (Register 91, No. 6).
2. Editorial correction of printing error (Register 91, No. 17).
3. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
4. Amendment of subsection (a), repealer of subsections (b) and (d), subsection relettering and amendment of newly designated subsection (b) filed 12-9-2015; operative 4-1-2016 (Register 2015, No. 50).

§ 1300.76.2. Solicitor Firm Financial Requirement.

(a) Each solicitor firm which handles funds of plans, subscribers, or other persons contracting with plans, shall at all times maintain a tangible net worth at least equal to 20 percent of such firm's aggregate indebtedness or $10,000, whichever is greater, and shall maintain liquid net assets of at least $5,000 in excess of it current liabilities.

(b) A solicitor firm which accepts only funds in the form of checks payable to plans, subscribers or other persons contracting with plans and forwards such checks to the payee by the close of the business day following receipt thereof does not "handle funds" within the meaning of this section.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1376, Health and Safety Code.

History:
1. Editorial correction adding NOTE filed 12-8-82 (Register 82, No. 50).

§ 1300.76.3. Fidelity Bond.

(a) Each plan shall at all times maintain a fidelity bond covering each officer, director, trustee, partner and employee of the plan, whether or not they are compensated. The fidelity bond may be either a primary commercial blanket bond or a blanket position bond written by an insurer licensed by the California Insurance Director, and it shall provide for 30 days' notice to the Director prior to cancellation. The fidelity bond shall provide at least the minimum coverage for the plan determined by the following schedule:

Annual Gross Income	Minimum Coverage
Up to $100,000	$10,000
100,000 to $300,000	20,000
300,000 to 500,000	30,000
500,000 to 750,000	50,000
750,000 to 1,000,000	75,000
1,000,000 to 2,000,000	100,000
2,000,000 to 4,000,000	200,000
4,000,000 to 6,000,000	400,000
6,000,000 to 10,000,000	600,000
10,000,000 to 20,000,000	1,000,000
20,000,000 and over	2,000,000

(b) The fidelity bond required pursuant to subsection (a) may contain a provision for a deductible amount from any loss which, except for such deductible provision, would be recoverable from the insurer. A deductible provision shall not be in excess of 10 percent of the required minimum bond coverage, but in no event shall the deductible amount be in excess of $100,000.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1376, Health and Safety Code.

History:
1. Editorial correction adding NOTE filed 12-8-82 (Register 82, No. 50).
2. Change without regulatory effect amending subsection (a) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.76.4. Prohibited Financial Practices.

(a) No solicitor shall maintain, and no plan or solicitor firm shall permit a solicitor in its employ to maintain, an account with a financial institution for funds of the plan, solicitor firm, subscribers or group representatives, except an account which is in the name of and under the control of the plan or solicitor firm.

(b) No solicitor shall receive funds on behalf of a plan or solicitor firm, and no plan or solicitor firm shall permit a solicitor in its employ to receive funds on behalf of the plan or solicitor firm, but this section shall not prohibit a solicitor from receiving only funds in the form of checks payable to the plan or solicitor firm if such solicitor deposits such checks to an account of the plan or solicitor firm by the close of the business day following receipt thereof or forwards such checks to the plan or solicitor firm by the close of the business day following receipt thereof.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1376, Health and Safety Code.

History:
1. New section filed 11-9-77 as an emergency; effective upon filing (Register 77, No. 46).
2. Certificate of Compliance filed 2-6-78 (Register 78, No. 6).
3. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).
4. Amendment of NOTE filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.77. Reimbursements.

(a) "Adequate insurance" for reimbursement for the purposes of subdivision (a)(2) of Section 1377 of the Act means a performance bond or insurance policy issued by an insurer licensed by the California Insurance Director, in an amount equal to at least the amount of cash, or cash equivalents, required to be maintained pursuant to subdivision (a)(1) of Section 1377 of the Act. The bond or insurance policy shall be payable to a corporate trustee for the benefit of noncontracting providers, subscribers and enrollees whose claims are unpaid upon the plan ceasing to do business because of insolvency or upon the plan being adjudged bankrupt.

(b) For the purposes of subdivision (a) of Section 1377 of the Act, "equivalents" to cash include only the following, provided that the investment in any one issuer of securities (other than securities issued or fully guaranteed or insured by the United States Government or any agency thereof) does not exceed 5% of the amount required pursuant to such subdivision:

(1) Shares listed on the New York Stock Exchange, the American Stock Exchange, the Pacific Stock Exchange or the O.T.C. Margin List, which shall be valued at 90 percent of their market value.

(2) Securities issued or guaranteed by the United States Government or any agency thereof, which shall be valued at the percentages of their market value specified below:

(A) less than 3 years to maturity—100%

(B) 3 or more years to maturity—98%

(3) Obligations of any state or political subdivision or instrumentality thereof which are rated A or better by Moody's Investors Service or A or better

by Standard & Poor's, which shall be valued at the percentages of their market value specified below:

(A) less than 5 years to maturity—98%

(B) 5 or more years to maturity—95%

(4) Certificates of deposit or other evidence of deposit in, or acceptance of, a bank insured by the F.D.I.C. or certificates of deposit or share accounts of a savings and loan association insured by the F.S.L.I.C., which shall be valued at their book value.

(5) Promissory notes or other evidences of indebtedness having a maturity date within nine months of issuance, exclusive of days of grace, or any renewal thereof which is likewise limited, and which are rated P2 or better by Moody's Investors Service and A2 or better by Standard & Poor's, which shall be valued at their market value.

(6) Nonconvertible debt securities having a fixed maturity which are rated A or better by Moody's Investors Service or A or better by Standard & Poor's, which shall be valued at the percentages of their market value specified below:

(A) less than 2 years to maturity—100%

(B) 2 years but less than 5 years to maturity—98%

(C) 5 or more years to maturity—95%.

(c) The Director may waive the "haircut" requirements set forth in subsection (b) subject to the condition that the plan establish and maintain a securities valuation reserve fund consisting of cash or equivalents in an amount not less than 10 percent of the total amount of "cash and equivalents" required under Section 1377 which is not otherwise maintained in cash, or such other amount as the Director may require.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1377, Health and Safety Code.

History:

1. Amendment of subsection (b) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. New subsection (c) filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).
3. Amendment filed 7-21-86; effective thirtieth day thereafter (Register 86, No. 30).
4. Change without regulatory effect amending subsection (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.77.1. Estimated Liability for Reimbursements.

A plan subject to subdivision (b) of Section 1377 shall estimate its liability for incurred and unreported claims and record such estimate as an accrual in its books and records at least monthly.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1375.1, 1376 and 1377, Health and Safety Code.

History:

1. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).

§ 1300.77.2. Calculation of Estimated Liability for Reimbursements.

(a) Each plan subject to subdivision (b) of Section 1377 shall calculate the estimate of incurred and unreported claims pursuant to a method held unobjectionable by the Director. Such method may include a lag study as defined and illustrated in subsection (c), an actuarial estimate as defined in subsection (d), or other reasonable method of estimating incurred and unreported claims. The amount required by Section 1300.77.1 to be accrued in the plan's books and records must equal the estimated total of all claims incurred but not yet received as of the end of the month as calculated in working papers, schedules or reports prepared in support of the unobjectionable lag study, actuarial estimate, or other method of estimating incurred and unreported claims.

(b) Working papers which support the incurred and unreported claims calculation shall be maintained as part of the records of the plan. Lag study working papers shall include a detailed allocation of all claims received each month to the various months in which the services were performed. Actuarial estimate working papers must detail all underlying assumptions and calculations in establishing the actuarial rate. Any other method used to determine the amount of incurred and unreported claims must be supported by adequate working papers, schedules or reports which detail all aspects of the incurred and unreported calculation.

(c) A "lag study" is a schedule which analyzes historical claims information on an ongoing basis to determine the length of time lag between the date of service and the date a claim is submitted to the plan for payment. Such a study distributes all claims received each month in which the services were performed. An example of a lag study containing the minimum information necessary to be held unobjectionable by the Director is as follows:

ABC HEALTH PLAN OF CALIFORNIA
SCHEDULE TO CALCULATE HISTORIC PERCENTAGE OF INCURRED BUT UNREPORTED CLAIMS FOR PRIOR MONTHLY PERIODS WHICH HAVE BEEN FULLY OR SUBSTANTIALLY REPORTED JULY 31, 19X2

	MONTH CLAIM RECEIVED							
	Same Month	*2nd*	*3rd*	*4th*	*5th*	*6th*	*7th*	*Totals for Months of Service*
Months of Service								
Oct. 19X1	$150	$500	$200	$100	$50		$1,000	
Nov. 19X1	220	500	240	110	30		1,110	
Dec. 19X1	150	600	300	100	75	$25		1,250
Jan. 19X2	210	750	375	105	60		1,500	
Feb. 19X2	230	670	290	85	100	75		1,450
Totals	$960	$3,020	$1,405	$500	$315	$100		$6,300
Percentages:								
Monthly	15%	48%	22%	8%	5%	2%		
Cumulative	15%	63%	85%	93%	98%	100%		

Explanatory notes:

1. The above represents the first schedule that is prepared to determine the incurred and unreported claims for any month following February.

2. The schedule allocates claims as they are received to the month in which the service was performed. For example, in October, the plan received $150 of claims which had service dates in October (same month). Because this schedule

begins in October, the $150 amount would be the only entry which the plan would be able to make in October. In November, the plan received $220 in claims which had service dates in November (same month), and $500 of claims which had service dates in October (second month). In December, the plan received $150 of claims which had service dates in December (same month), $500 of claims which had service dates in November (second month), and $200 in claims which had service dates in October (third month).

3. The schedule indicates that $6,300 in claims were received which had service dates of October through February. Of this amount, $960 was received during the month of service (same month), $3,020 in the following (second) month, $1,405 in the third month, $500 in the fourth month, etc. By converting these amounts to percentages of the total claims, the schedule indicates that on the average, 15% ($960 ÷ $6,300 =) of all claims incurred during any month are received in the same month, 48% are received in the following (second) month, for a cumulative total of 63% (15% + 48% =) of all claims incurring during any month being received in the same and second months. By employing these cumulative percentages, the amount incurred but unreported claims can be estimated as of July 31, after the claims information for the current but incomplete monthly periods is analyzed, as illustrated in the following schedule:

ABC HEALTH PLAN OF CALIFORNIA
SCHEDULE TO ESTIMATE THE AMOUNT OF INCURRED BUT UNREPORTED CLAIMS FOR THE CURRENT BUT INCOMPLETE MONTHLY PERIODS WHICH HAVE NOT BEEN FULLY OR SUBSTANTIALLY REPORTED JULY 31, 19X2

	MONTH CLAIM RECEIVED							
	Same Month	*2nd*	*3rd*	*4th*	*5th*	*6th*	*7th*	*Totals for Months of Service*
Months of Service								
Mar., 19X2	$225	$720	$300	$120	$50			$1,415
April 19X2	250	700	330	110				1,390
May 19X2	240	750	350					1,340
June 19X2	250	775						1,025
July 19X2	270					75		270
Total Claims received for period March 1 through July 31	$5,440							

COMPUTATION OF INCURRED BUT UNREPORTED CLAIMS AS OF JULY 31

(A)	(B)		(C)	(D)	(E)
Month of Service	Total claims received for each month of service as of July 31		Claims received as of July 31 as a cumulative percentages of total claims to be received	Total claims to be received (B-C)	Incurred But unreported (D-B)
July	$270	(i)	15%	$1,800	$1,530
June	1,025	(ii)	63%	1,625	600
May	1,340	(iii)	85%	1,575	235
April	390	(iv)	93%	1,495	105
March	1,415	(v)	98%	1,440	25
February	1,450	(vi)	100%	1,450	0
Total incurred but unreported claims as of July 31				$2,495	

Explanatory notes:

(i) Represents July claims received in July.

(ii) Represents June claims received in June and July.

(iii) Represents May claims received in May, June and July.

(iv) Represents April claims received in April, May, June and July.

(v) Represents March claims received in March, April, May, June and July.

(vi) Represents February claims received in February, March, April, May, June and July.

(d) An "actuarial estimate" is a calculation of incurred and unreported claims which is based on adequate and reasonable assumptions with respect to risk factors and trends which have been found to be applicable to the plan, such as utilization patterns of the plan's enrollees, the average benefit which will be payable, the enrollment mix in terms of age and sex of enrollees and geographic location, actual plan contract experience, and any other factors reasonably believed to affect the amount of incurred and unreported claims. Actuarial estimates must be supported by an actuarial certification, consisting of a signed declaration of any actuary who is a member in good standing of the American Academy of Actuaries in which such actuary states that the assumptions used in calculating the incurred and unreported claims are appropriate and reasonable. If the plan employs an actuarial study to estimate the amount of the incurred and unreported claims, it must compare the actual claims amounts to those estimated, and make adjustments at least quarterly whenever a 5% difference from actual experience is noted.

(e) A plan may employ any other unobjectionable alternative method of estimating the amount of incurred and unreported claims other than the "lag

study" or "actuarial estimate," so long as such alternative method accurately estimates incurred and unreported claims. For example, a plan may receive daily reports of actual hospital admissions and referrals, thereby permitting the plan to compare these reports to the actual invoices and calculate the estimated amount due hospitals for the enrollees whose claims had not been received by the plan at that time.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1375.1, 1376 and 1377, Health and Safety Code.

History:

1. New section filed 3-3-83; effective thirtieth day thereafter (Register 83, No. 10).
2. Change without regulatory effect amending subsections (a) and (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.77.3. Report on Reimbursements Exceeding Ten Percent.

(a) Every plan which reimburses providers of health care services or subscribers and enrollees in the manner described in subdivision (a) or (b) of Section 1377 of the Act shall make and maintain as part of its records a computation for each calendar month and calendar quarter of reimbursements made, classified as provided in Section 1377, and showing the percentage of each class of reimbursements made to total expenditures for health care services during such month or quarter.

(b) When a report is required by subdivision (a) of Section 1377 of the Act, such report shall be filed with the Director no later than 30 business days after the close of the calendar quarter.

(c) When a report is required by subdivision (b) of Section 1377 of the Act, such report shall be filed with the Director no later than 30 business days after the close of the calendar month during which actual reimbursements made, or the amount estimated for incurred and unreported claims, exceeds 10 percent of its total expenditures for health care services.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1377, Health and Safety Code.

History:

1. Editorial correction adding NOTE filed 12-8-82 (Register 82, No. 50).
2. Change without regulatory effect amending subsections (b) and (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.77.4. Reimbursements on a Fee-for-Services Basis: Determination of Status of Claims.

Every plan shall institute procedures whereby all claim forms received by the plan from providers of health care services for reimbursement on a fee-for-service basis and from subscribers and enrollees for reimbursement are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time, and rapid retrieval of any claim. Although any categories for status-determination held unobjectionable by the Director may be used, for the purposes of this section, the following status-determination categories, as a group, shall be presumptively reasonable:

(1) to be processed,
(2) processed, waiting for payment,
(3) pending, waiting for approval for payment or denial,
(4) pending, waiting for additional information,
(5) denied,
(6) paid, and, if appropriate,

(7) other. These procedures shall involve the use of either a claims log, claims numbering system, electronic data processing records, and/or any other method held unobjectionable by the Director.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1375.1, 1376 and 1377, Health and Safety Code.

History:
1. New section filed 3-3-83; effective thirtieth day thereafter (Register 83, No. 10).
2. Change without regulatory effect amending first paragraph and subsection (7) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.78. Administrative Costs.

(a) For the purposes of Section 1378 of the Act, "administrative costs" include only those costs which arise out of the operation of the plan as such, excluding direct and overhead costs incurred in the furnishing of health care services which would be ordinarily incurred in the provision of such services whether or not through a plan. Administrative costs include the following:

(1) Salaries, bonuses and benefits paid or incurred with respect to the officers, directors, partners, trustees or other principal management of the Plan, less to the extent that such persons also are providers of health care services, the minimum reasonable cost of obtaining such services from others.

(2) The cost of soliciting and enrolling subscribers and enrollees, including the solicitation of group contracts, and including any indirect costs of enrollment borne on behalf of the plan by the holder of a group contract.

(3) The cost of receiving, processing and paying claims of providers of health care services and of claims for reimbursement by subscribers and enrollees, excluding the actual amount paid on such claims.

(4) Legal and accounting fees and expenses.

(5) The premium on the fidelity and surety bonds, and any insurance maintained pursuant to Section 1377, and any insurance or other expense incurred for the purposes of complying with Section 1375 of the Act. Malpractice insurance is not included within this subsection.

(6) All costs associated with the establishment and maintenance of agreements with providers of health care services, excluding the cost of reviewing quality and utilization of such services, and the cost of reviewing utilization of health care services on a referral basis.

(7) The direct or pro rata portion of all expenses incurred in the operation of the plan which are not essential to the actual provision of health care services to subscribers and enrollees, including but not limited to office supplies and equipment, clerical services, interest expense, insurance, dues and subscriptions, licenses (other than licenses for medical facilities, equipment or personnel), utilities, telephone, travel, rent, repairs and maintenance, depreciation of facilities and equipment, and charitable or other contributions.

(b) The administrative cost incurred by a plan, directly, as herein defined, shall be reasonable and necessary, taking into consideration such factors as the plan's stage of development and other considerations. If the administrative costs of an established plan exceed 15 percent, or if the administrative costs of a plan in the development phase exceed 25 percent, during any period of the revenue obtained by the plan from subscribers and enrollees, or paid to the plan on their behalf, the plan shall demonstrate to the Director, if called upon to do so, that its administrative costs are not excessive administrative costs within the meaning of Section 1378 and are justified under the circumstances and/or that it has instituted procedures to reduce administrative costs which are proving effective. An established plan is a plan which has been in operation for a period of five years or more. For the purposes of Section 1378 of the Act,

money borrowed will be deemed to be money derived from revenue obtained from subscribers and enrollees to the extent that such revenue is exposed to liability for repayment of such borrowings or that repayment is anticipated from such revenues and "money not derived from" such revenues includes only net assets arising independently of the operation of the plan and not traceable on a historical basis to such revenues, whether as net profit or otherwise.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1378, Health and Safety Code.

History:

1. Editorial correction adding NOTE filed 12-8-82 (Register 82, No. 50).
2. Change without regulatory effect amending subsection (b) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

ARTICLE 10
Medical Surveys

Section
1300.80. Medical Survey Procedure.
1300.80.10. Medical Survey: Report of Correction of Deficiencies.

§ 1300.80. Medical Survey Procedure.

(a) Unless the Director in his discretion determines that advance notice will render the survey less useful, a plan will be notified approximately four weeks in advance of the date for commencement of an onsite medical survey. The Director may, without prior notice, conduct inspections of plan facilities or other elements of a medical survey, either in conjunction with the medical survey or as part of an unannounced inspection program.

(b) The onsite medical survey of a plan shall include, but not be limited to, the following procedures to the extent considered necessary based upon prior experience with the plan and in accordance with the procedures and standards developed by the Department.

(1) Review of the procedures for obtaining health services including, but not limited to, the scope of basic health care services.

(A) The availability and adequacy of facilities for telephone communication with health personnel, emergency care facilities, out-of-the-area coverage, referral procedures, and medical encounters.

(B) The means of advising enrollees of the procedures to obtain care, including the hours of operation, location and nature of facilities, types of care, telephone and other arrangements for appointment setting.

(C) The availability of qualified personnel at each facility referred to in Section 1368(b) to receive and handle inquiries concerning care, plan contracts, and grievances.

(2) Review of the design and implementation of procedures for reviewing and regulating utilization of services and facilities.

(3) Review of the design and implementation of procedures to review and control costs.

(4) Review of the design, implementation and effectiveness of the internal quality of care review systems, including review of medical records and medical records systems. A review of medical records and medical records systems may include, but is not limited to, determining whether:

(A) The entries establish the diagnosis stated, including an appropriate history and physical findings;

(B) The therapies noted reflect an awareness of current therapies;

(C) The important diagnoses are summarized or highlighted; (Important are those conditions that have a bearing on future clinical management.)

(D) Drug allergies and idiosyncratic medical problems are conspicuously noted;

(E) Pathology, laboratory and other reports are recorded;

(F) The health professional responsible for each entry is identifiable;

(G) Any necessary consultation and progress notes are evidenced as indicated;

(H) The maintenance of an appropriate system for coordination and availability of the medical records of the enrollee, including out-patient, in-patient and referral services and significant telephone consultations.

(5) Review of the overall performance of the plan in providing health care benefits, by consideration of the following:

(A) The numbers and qualifications of health professional and other personnel;

(B) The provision of, incentives for, and participation in, continuing education for health personnel and the provision for access to current medical literature;

(C) The adequacy of all physical facilities, including lighting, cleanliness, maintenance, equipment, furnishings, and convenience to enrollees, plan personnel and visitors;

(D) The practice of health professionals and allied personnel in a functionally integrated manner, including the extent of shared responsibility for patient care and coordinated use of equipment, medical records and other facilities and services;

(E) The appropriate functioning of health professionals and other health personnel, including specialists, consultants and referrals;

(F) Nursing practices, including reasonable supervision;

(G) Written nondiscriminatory personnel practices which attract and retain qualified health professionals and other personnel;

(H) The adequacy and utilization of pathology and other laboratory facilities, including the quality, efficiency and appropriateness of laboratory procedures and records and quality control procedures;

(I) X-ray and radiological services, including staffing, utilization, equipment, and the promptness of interpretation of X-ray films by a qualified physician;

(J) The handling and adequacy of medical record systems, including filing procedures, provisions for maintenance of confidentiality, the efficiency of procedures for retrieval and transmittal, and the utilization of sampling techniques for medical records audits and quality of care review;

(K) The adequacy, including convenience and readiness of availability to enrollees, of all provided services;

(L) The organization of the plan and its mechanisms for furnishing health care services, including the supervision of health professionals and other personnel;

(M) The extent to which individual medical decisions by qualified medical personnel are unduly constrained by fiscal or administrative personnel, policies or considerations;

(N) The adequacy of staffing, including medical specialties.

(6) Review of the overall performance of the plan in meeting the health needs of enrollees.

(A) Accessibility of facilities and services, based upon location of facilities, hours of operation, waiting periods for services and appointments, including elective services, the availability of parking and transportation;

(B) Continuity of care, including the ability of enrollees to select a primary care physician, staffing in medical specialties or arrangements therefor;

the referral system (including instructions, monitoring and follow-up); the maintenance and ready availability of medical records; and the availability of health education to enrollees;

(C) The grievance procedure required by Section 1368 of the Act, including the availability to enrollees and subscribers of grievance procedure information, the time required for and the adequacy of the response to grievances and the utilization of grievance information by plan management.

(7) In considering the above and in pursuit of the survey objectives, the survey team may perform any or all of the following procedures:

(A) Private interviews and group conferences with enrollees, physicians and other health professionals, and members of its administrative staff including, but not limited to, its principal management persons.

(B) Examination of any records, books, reports and papers of the plan and of any management company, provider or subcontractor providing health care or other services to the plan including, but not limited to, the minutes of medical staff meetings, peer review, and quality of care review records, duty rosters of medical personnel, surgical logs, appointment records, the written procedures for the internal operation of the plan, and contracts and correspondence with enrollees and with providers of health care services and of other services to the plan, and such additional documentation the Director may specifically direct the surveyors to examine.

(C) Physical examination of facilities, including equipment.

(D) Investigation of grievances or complaints from enrollees or from the general public.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1380, Health and Safety Code.

History:

1. Amendment of subsection (b)(7)(D) filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).
2. Change without regulatory effect amending subsections (a) and (b)(7)(B) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.80.10. Medical Survey: Report of Correction of Deficiencies.

Prior to or immediately upon the expiration of the 45-day period following notice to a plan of a deficiency as provided in subdivision (h) of Section 1380 of the Act, the plan shall file a written statement with the Director identifying the deficiency and describing the action taken to correct the deficiency and the results of such action. The report shall be signed by a principal officer of the plan.

Where such deficiencies may be reasonably adjudged to require long-term corrective action or to be of a nature which may be reasonably expected to require a period longer than 45 days to remedy, in some instances evidence that the plan has initiated remedial action and is on the way to achieving acceptable levels of compliance may be submitted.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1380, Health and Safety Code.

History:

1. Amendment filed 12-8-8; effective thirtieth day thereafter (Register 82, No. 50).
2. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
3. Amendment filed 5-7-2014; operative 7-1-2014 (Register 2014, No. 19).

ARTICLE 11
Examinations

Section
1300.81. Removal of Books and Records from State.
1300.82. Examination Procedure.
1300.82.1. Additional or Nonroutine Examinations and Surveys.

§ 1300.81. Removal of Books and Records from State.

The books and records of a plan, management company, solicitor firm, and any provider or subcontractor providing health care or other services to a plan, management company, or solicitor firm shall not be removed from this state without the prior consent of the Director.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1381, Health and Safety Code.

History:
1. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).
2. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.82. Examination Procedure.

Regular and additional or nonroutine examinations conducted by the Department pursuant to Section 1382 will ordinarily be commenced on an unannounced basis. To the extent feasible, deficiencies noted will be called to the attention of the responsible officers of the company under examination during the course of the examination, and in that event the company should take the corrective action indicated. When deemed appropriate, the company will be advised by letter of the deficiencies noted upon the examination. If the deficiency letter requires a report from the company, such report must be furnished within 15 days or such additional time as may be allowed.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1382, Health and Safety Code.

History:
1. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).

§ 1300.82.1. Additional or Nonroutine Examinations and Surveys.

(a) An examination or survey is additional or nonroutine for good cause for the purposes of Section 1382(b) when the reason for such examination or survey is any of the following:

(1) The plan's noncompliance with written instructions from the Department;

(2) The plan has violated, or the Director has reason to believe that the plan has violated, any of the provisions of Sections 1352, 1370, 1371, 1371.35, 1371.37, 1375.1, 1376, 1384 and 1385 of the Act and Sections 1300.71, 1300.71.38, 1300.76, 1300.80.10, 1300.81, 1300.82(a), 1300.84.2 and 1300.84.3 of these regulations.

(3) The plan has committed, or the Director has reason to believe that the plan has committed, any of the acts or omissions enumerated in Section 1386 of the Act.

(4) The Director deems such additional or nonroutine examination or survey necessary to verify representations made to this Department by a plan in response to a deficiency letter.

(b) Each situation giving rise to an additional or nonroutine examination or survey shall be evaluated on a case-by-case basis as to the seriousness of the violation, or lack of timely or adequate response by the plan to the Department's request to correct the violation. The plan shall be notified in

writing of the provisions of the Act or regulations which have been, or may have been, violated and which therefore caused such additional or nonroutine examination or survey to be performed. The expense of such examinations and surveys shall be charged to the plan being examined or surveyed in accordance with Section 1382(b).

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1352, 1370, 1375.1, 1376, 1380, 1382, 1384, 1385 and 1386, Health and Safety Code.

History:

1. New section filed 3-3-83; effective thirtieth day thereafter (Register 83, No. 10).
2. Change without regulatory effect amending subsections (a)(2)-(4) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
3. Amendment of subsection (a)(2) filed 12-9-2015; operative 4-1-2016 (Register 2015, No. 50).

ARTICLE 12
Reports

Section

1300.83. Annual Report. [Repealed]
1300.84. Financial Statements.
1300.84.05. Change of Independent Accountant.
1300.84.06. Plan Annual Report.
1300.84.1. Verification of Reports. [Repealed]
1300.84.2. Quarterly Financial Reports.
1300.84.3. Monthly Financial Reports.
1300.84.4. Financial Reports by Solicitor Firms. [Repealed]
1300.84.5. Public Entity Plans.
1300.84.6. Plan Annual Enrollee Report.
1300.84.7. Special Reports Relating to Charitable or Public Activities.

§ 1300.83. Annual Report. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Stats. 1979, Ch. 1083.

History:

1. Repealer filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).

§ 1300.84. Financial Statements.

(a) Whenever pursuant to these rules or pursuant to an order or request of the Director pursuant to the Act a financial statement or other report is required to be audited or be accompanied by the opinion of a certified public accountant or public accountant, such accountant shall be independent of the licensee, determined in accordance with section 602.02 of Financial Reporting Release Number 1 issued by the Securities and Exchange Commission.

(b) The financial statements required under subsections (a), (b) and (c) of Section 1384 of the Act shall be audited by an independent accountant in accordance with section 1300.45(e).

(c) Except as provided in subsection (d), financial statements of a plan required pursuant to these rules must be on a combining basis with an affiliate, if the plan or such affiliate is substantially dependent upon the other for the provision of health care, management or other services. An affiliate will normally be required to be combined, regardless of its form of organization, if the following conditions exist:

(1) The affiliate controls, is controlled by, or is under common control with, the plan, either directly or indirectly (see subsections (c) and (d) of section 1300.45), and

(2) The plan or the affiliate is substantially dependent, either directly or indirectly, upon the other for services or revenue.

(d) Upon written request of a plan, the Director may waive the requirement that an affiliate be combined in financial statements required pursuant to these rules. Normally, a waiver will be granted only when

(1) the affiliate is not directly engaged in the delivery of health care services or

(2) the affiliate is operating under an authority granted by a governmental agency pursuant to which the affiliate is required to submit periodic financial reports in a form prescribed by such governmental agency that cannot practicably be reformatted into the form prescribed by these rules (such as an insurance company).

(e) When combined financial statements are required by this section, the independent accountant's report or opinion must cover all the entities included in the combined financial statements. If the accountant's report or opinion makes reference to the fact that a part of the examination was performed by another auditor, the plan shall also file the individual financial statements and report or opinion issued by the other auditor.

(f) Plans which have subsidiaries that are required to be consolidated under generally accepted accounting principles must present either

(1) consolidating financial statements, or

(2) consolidating schedules for the balance sheet and statement of operations, which in either case must show the plan separate from the other entities included in the consolidated balances.

(g) This section shall not apply to a plan which is a public entity or political subdivision.

(h) All filings of financial statements required pursuant to these rules must include an original and one copy.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1384, Health and Safety Code.

History:

1. Amendment filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).
2. Amendment filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).
3. Amendment of subsection (e) and new subsection (h) filed 7-21-86; effective thirtieth day thereafter (Register 86, No. 30).
4. Amendment of subsection (a) filed 12-14-90; operative 12-31-90 (Register 91, No. 6).
5. Change without regulatory effect amending subsections (a) and (d) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.84.05. Change of Independent Accountant.

Whenever the financial statements required pursuant to subdivisions (a), (b) or (c) of Section 1384 are to be reported upon or certified by an accountant other than the accountant certifying the plan's most recent filing, the plan must furnish the Director with a separate letter stating whether in the eighteen (18) months preceding the engagement of the new accountants there was any disagreement with the former accountants on any matter of accounting principles or practices, financial statement disclosure or auditing procedures, which such disagreement if not resolved to the satisfaction of the former accountants would have caused him to make reference to the subject matter of such disagreement in his opinion or report. This letter must be verified by a principal officer of the plan. The plan shall also request the former accountants to furnish them with a letter addressed to the Director stating whether he agrees with the statements contained in the letter of the plan and, if not, stating the respects in which he does not agree. The notification by the plan along with the former accountant's letter, if necessary, must be furnished to the Director within 45 days of the engagement of the new accountants.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345 and 1384, Health and Safety Code.

History:

1. New section filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Change without regulatory effect amending section filed 7-14-99 pursuant to section 100, title 1, California Code of Regulations (Register 99, No. 29).
3. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.84.06. Plan Annual Report.

The annual report required of a plan pursuant to subdivision (c) of section 1384 of the Act shall include or be accompanied by the following information for the period covered by the report, except as otherwise specified:

(a) The "DMHC Annual Financial Reporting Form," as updated on January 23, 2013 and incorporated by reference, published by the Department on its Internet web page.

(b) Sufficient and appropriate supplemental information to provide adequate disclosure of at least the following:

(1) An explanation of the method of calculating the provision for incurred and unreported claims.

(2) ccounts and notes receivable from officers, directors, owners or affiliates, including the name of the debtor, nature of the relationship, nature of the receivable and its terms.

(3) Donated materials or services received by the plan for the period of the financial statements and the donor's name and affiliation with the plan, together with an explanation of the method used in determining the valuation of such materials or services.

(4) Forgiven debt or obligations during the period of the financial statements, including the creditor's name and affiliation with the plan and a summary of how the obligation arose.

(5) A calculation of the plan's tangible net equity in accordance with section 1300.76 of these rules. Such calculation shall include disclosure of the following information used to determine the required amount of tangible net equity pursuant to section 1300.76(a) and (b):

(A) Revenues

1. Two percent of the first $150 million, or $7.5 million for specialized plans, of annualized premium revenues;

2. One percent of annualized premium revenues in excess of $150 million, or $7.5 million for specialized plans;

3. Sum of 1. and 2. above.

(B) Healthcare Expenditures

1. Eight percent of the first $150 million, or $7,500,00 for specialized plans of annualized health care expenditures except those paid on a capitated basis or managed hospital payment basis.

2. Four percent of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of $150 million, or $7,500,000 for specialized plans;

3. Four percent of annualized hospital expenditures paid on a managed hospital payment basis.

4. Sum of 1., 2. and 3. above.

(6) The percentage of administrative costs to revenue obtained from subscribers and enrollees.

(7) The amount of health care expenses incurred during the six month period immediately preceding the date of the report which were or will be paid to noncontracting providers or directly reimbursed to subscribers and enrollees.

(8) Total costs for health care services for the immediately preceding six months.

(9) If the amount of health care expenses incurred during the six month period immediately preceding the date of the report which were or will be paid to noncontracting providers or directly reimbursed to subscribers and enrollees exceeds 10% of the total costs for health care services for the immediately preceding six months, the following information, determined as of the date of the report, shall be provided:

(A) Amount of all claims for noncontracting provider services received for reimbursement but not yet processed.

(B) Amount of all claims for noncontracting provider services denied for reimbursement during the previous 60 days.

(C) Amount of all claims for noncontracting provider services approved for reimbursement but not yet paid.

(D) An estimate of the amount of claims for noncontracting provider services incurred, but not reported.

(E) A calculation of compliance with section 1377(a) as determined in accordance with such section.

NOTE: Authority cited: Sections 1344 and 1384, Health and Safety Code. Reference: Section 1384, Health and Safety Code.

History:

1. New section filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).
2. Amendment filed 7-21-86; effective thirtieth day thereafter (Register 86, No. 30).
3. Amendment filed 12-14-90; operative 12-31-90 (Register 91, No. 6).
4. Repealer and new subsection (a) filed 12-9-2015; operative 4-1-2016 (Register 2015, No. 50).

§ 1300.84.1. Verification of Reports. [Repealed]

NOTE: Authority cited: Sections 1344 and 1384, Health and Safety Code.

History:

1. Repealer filed 7-21-86; effective thirtieth day thereafter (Register 86, No. 30).

§ 1300.84.2. Quarterly Financial Reports.

Within 45 days after the close of each quarter of its fiscal year, each licensed plan shall file with the Director its report consisting of the following information:

(a) Financial statements (which need not be certified) prepared in accordance with generally accepted accounting principles, prepared on a basis consistent with the certified financial report furnished by the plan pursuant to Section 1384(c) of the Act, unless the plan receives the written approval of the Director to vary from that basis and the variance is adequately noted in its report under this section. The financial statements shall include the following statements, reports and schedules contained in the "DMHC Annual Financial Reporting Form" identified in Section 1300.84.06(a) of these rules for the period covered by the report:

(1) First page: "Statement";

(2) Report #1-Part A: Balance Sheet Assets;

(3) Report #1-Part B: Balance Sheet Liabilities and Net Worth;

(4) Report #2: Statement of Revenue and Expenses;

(5) Report #3: Statement of Financial Position and Net Worth;

(6) Report #4: Enrollment and Utilization Table; and

(7) Section I of Schedule F: Unpaid Claims Analysis.

(b) The information required pursuant to Section 1300.84.06(b) of these rules for the period covered by the report, except as otherwise specified.

NOTE: Authority cited: Sections 1344 and 1384, Health and Safety Code. Reference: Section 1384, Health and Safety Code.

History:
1. Amendment filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).
2. Amendment filed 7-21-86; effective thirtieth day thereafter (Register 86, No. 30).
3. Change without regulatory effect amending first paragraph and subsection (a) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
4. Amendment of subsection (a) filed 12-9-2015; operative 4-1-2016 (Register 2015, No. 50).

§ 1300.84.3. Monthly Financial Reports.

(a) Each plan shall maintain internal procedures which provide one or more of its principal officers on at least a monthly basis with the information necessary for the report required pursuant to this section.

(b) Each plan shall report to the Director the increase during any calendar quarter of the amount owed by the plan to providers for health care services, if the amount of such increase exceeds 10 percent of the amount owed at the close of the previous quarter. In the event the amount owed to a provider is disputed, the amount claimed as due by the provider shall control for the purposes of this section. This report shall be filed within 30 days after the close of the quarter for which the report is made.

(c) Each plan shall promptly advise the Director of any extraordinary loss, or of any claim whether or not admitted by the plan or a contingent claim, which

(1) renders the plan unable to meet its obligations as they become due, or

(2) reduces (or would reduce) the tangible net equity of the plan below the amount required by section 1300.76 of these rules.

(d) Each plan shall, upon the occurrence of any of the events specified below, file a report with the Director within 30 days of the close of the month for which such condition is noted, and each month thereafter until notified by the Director to discontinue such reports. Each such report shall consist of a balance sheet and statement of operations of the plan, which need not be certified, a calculation of tangible net equity in accordance with section 1300.76 of these rules, and the verification required by subsection (e) of this rule. Such financial statements must be prepared on a basis consistent with the financial statements furnished by the plan pursuant to section 1300.84.2 of these rules. The events the occurrence of which shall require reporting under this section are the following:

(1) The tangible net equity of the plan, individually or on a combined basis with affiliates (Rule 1300.84(c)), is less than 130% of the minimum tangible net equity required by section 1300.76(a) or (b), as specified.

(2) The statement of operations of the plan, individually or on a combined basis with affiliates (Rule 1300.84(c)), reflects a loss during any month the amount of which exceeds the difference between the tangible net equity of the plan (or the combined entity) as of the end of such month and the minimum net equity required by Section 1300.76 of these rules.

(3) The plan has not been licensed for twelve (12) months.

(e) Each report required to be furnished by a plan pursuant to subsection (d) of this rule shall be verified by a principal officer of the plan as follows:

I certify (or declare) under penalty of perjury under the laws of the State of California that I have read this report and know the contents thereof, and that the statements therein are true and correct.

Executed at _____, on _____
(Place) (Date)

_____
(Signature)

NOTE: Authority cited: Sections 1344 and 1384, Health and Safety Code. Reference: Section 1384, Health and Safety Code.

History:
1. Amendment of subsection (d) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment of subsection (d) filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).
3. Amendment filed 7-21-86; effective thirtieth day thereafter (Register 86, No. 30).
4. Change without regulatory effect of subsection (d) (Register 86, No. 38).
5. Amendment of subsection (d) filed 12-14-90; operative 12-31-90 (Register 91, No. 6).
6. Change without regulatory effect amending subsection (e) filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
7. Change without regulatory effect amending subsections (b), (c) and (d) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
8. Amendment of subsection (d)(1) and repealer of subsections (d)(1)(A)-(G) filed 12-9-2015; operative 4-1-2016 (Register 2015, No. 50).

§ 1300.84.4. Financial Reports by Solicitor Firms. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1384, Health and Safety Code.

History:
1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Repealer filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).

§ 1300.84.5. Public Entity Plans.

(a) A plan which is a public entity or political subdivision shall be subject to the provisions of this section.

(1) Financial statements of a plan which is a public entity or political subdivision, including financial statements or reports of specific funds or groups of accounts where health plan activity is recorded, which are required to be submitted pursuant to Section 1351(h) or 1384(c) of the Act or by rule, order or request of the Director, shall be accompanied either by an opinion of a certified public accountant or public accountant or by a report of a government audit organization.

(2) For the purposes of Sections 1351 and 1384, governmental auditing standards are defined to include the standards set forth in this item. Every audit which results in the opinion or report referred to in Item (1) of this subsection shall be conducted in accordance with the governmental auditing standards indicated below:

(A) General Standards:

(i) The auditors assigned to perform the audit must collectively possess adequate professional proficiency for the tasks required.

(ii) In all matters relating to the audit work, the audit organization and the individual auditors, whether government or public, must be free from personal or external impairments to independence, must be organizationally independent, and shall maintain an independent attitude and appearance.

(iii) Due professional care is to be used in conducting the audit and in preparing related reports.

(B) Standards of Field Work:

(i) The work is to be adequately planned and assistants, if any, are to be properly supervised.

(ii) There is to be a proper study and evaluation of the existing internal control as a basis for reliance thereon and for the determination of the resultant extent of the tests to which auditing procedures are to be restricted.

(iii) Sufficient competent evidential matter is to be obtained through inspection, observation, inquiries, and confirmations to afford a reasonable basis for an opinion regarding the financial statements under examination.

(C) Standards of Reporting:

(i) The report shall state whether the financial statements are presented in accordance with generally accepted accounting principles.

(ii) The report shall state whether such principles have been consistently observed in the current period in relation to the preceding period.

(iii) Informative disclosures in the financial statement are to be regarded as reasonably adequate unless otherwise stated in the report.

(iv) The report shall either contain an expression of opinion regarding the financial statements, taken as a whole, or an assertion to the effect that an opinion cannot be expressed. When an overall opinion cannot be expressed, the reasons therefor should be stated. In all cases where an auditor's name is associated with financial statements, the report should contain a clear-cut indication of the character of the auditor's examination, if any, and the degree of responsibility he is taking.

(D) Additional Standards and Requirements on Examination and Evaluation for Government Financial and Compliance Audits.

(i) Planning shall include consideration of the requirements of all levels of government.

(ii) A review is to be made of compliance with applicable laws and regulations.

(iii) A written record of the auditors' work shall be retained in the form of working papers.

(iv) Auditors shall be alert to situations or transactions that could be indicative of fraud, abuse, and illegal expenditures and acts and if such evidence exists, extend audit steps and procedures to identify the effect on the entity's financial statements.

(E) Additional Standards and Requirements on Reporting for Government Financial and Compliance Audits.

(i) Written audit reports are to be submitted to the appropriate officials of the organization audited and to the appropriate officials of the organizations requiring or arranging for the audits unless legal restrictions or ethical considerations prevent it. Copies of the reports should also be sent to other officials who may be responsible for taking action and to others authorized to receive such reports. Unless restricted by law or regulations, copies should be made available for public inspection.

(ii) A statement in the auditors' report that the examination was made in accordance with generally accepted government auditing standards for financial and compliance audits will be acceptable language to indicate that the audit was made in accordance with these standards.

(iii) Either the auditors' report on the entity's financial statements or a separate report shall contain a statement of positive assurance on those items of compliance tested and negative assurance on those items not tested. It shall also include material instances of noncompliance and instances or indications of fraud, abuse, or illegal acts found during or in connection with the audit.

(iv) The auditors shall report on their study and evaluation of internal accounting controls made as part of the financial and compliance audit. They shall identify as a minimum: (a) the entity's significant internal accounting controls, (b) the controls identified that were evaluated, (c) the controls identified that were not evaluated (the auditor may satisfy this requirement by identifying any significant classes of transactions and related assets not included in the study and evaluation), and (d) the material weaknesses identified as a result of the evaluation.

(v) Either the auditors' report on the entity's financial statements or a separate report shall contain any other material deficiency findings identified during the audit not covered in (ii) above.

(vi) If certain information is prohibited from general disclosure, the report shall state the nature of the information omitted and the requirement that makes the omission necessary.

(3) Financial statements, including reports of specific funds or groups of accounts, which are to be submitted pursuant to this section must be previously approved as to form by the Director. When all health plan activity has been separately controlled and accounted for in an Enterprise Fund, the financial statements or reports of such funds are presumptively approved as to form for purposes of this subsection.

(b) A plan which is a public entity or political subdivision shall be granted a total or partial exemption from Sections 1300.84.06 and 1300.84.2 upon proper application therefor, when and to the extent that

(1) the Director determines that such plan has demonstrated that the information set forth in Sections 1300.84.06 and 1300.84.2 is neither available to the plan nor necessary for its internal management and cannot be produced without significant cost to the plan, and

(2) such plan undertakes to furnish alternative information which the Director finds to be reasonable and adequate in view of the circumstances of the plan.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1351, 1384 and 1385, Health and Safety Code.

History:

1. New section filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).
2. Amendment filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).
3. Change without regulatory effect amending subsections (a)(1), (a)(3) and (b)(1)-(2) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.84.6. Plan Annual Enrollee Report.

(a) On or before May 15th of each year, each licensed plan shall file a report in the following form and containing the information specified therein:

State of California
Department of Managed Care

Dept. of Managed Care
File Number _____

REPORT OF ENROLLMENT IN PLAN
Knox-Keene Health Care Service Plan Act

1. Name of Plan:

2. Name, mailing address, and telephone number of Plan official to whom communications concerning this report should be addressed:

_____ ( ) _____
Name Phone No.—Include area code

_____
Mailing Address

_____
City, State and ZIP Code

3. For the purposes of Section 1356(b) of the Knox-Keene Health Care Service Plan Act, the Plan reports that, as of March 31 of the year in which this report is made, its records reflected the following enrollments, in accordance with the definitions contained in Section 1345, Health and Safety Code:

Number of subscribers _____

Number of enrollees _____

(NOTE: As required by Section 1356(b), if the number of enrollees is estimated, the method used for determining the estimated enrollment must be disclosed.)

4. Execution: I certify under penalty of perjury that the above statement is true.

Executed at _____ on _____
City and State Date

_____
Signature

_____
Print or Type Name of Declarant

_____
Position with Plan

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1356, 1384 and 1385, Health and Safety Code.

History:
1. New section filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).
2. Change without regulatory effect amending section filed 1-23-91 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 10).
3. Change without regulatory effect amending subsection (a) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.84.7. Special Reports Relating to Charitable or Public Activities.

(a) Any plan whose purposes involve any charitable or public purposes shall provide a special report to the Director upon filing with the Attorney General any notice, request, or other materials pursuant to any law administered by the Attorney General and relating to matters which will or may have any financial effect on or implications for the plan. Such special report shall include the information provided to the Attorney General together with representations as to whether the transactions, actions, or other facts set forth in the materials submitted to the Attorney General will or may have any deleterious effect on the financial condition of the plan.

(b) Any plan whose purposes involved any charitable or public purposes shall provide a special report to the Director upon engaging in any transaction to which the corporation is a party and in which one or more of its directors has a material financial interest, if such transaction will or may have any material financial effect on or implications for the plan. Such special report shall specifically describe the transaction and shall contain representations as to whether the transaction will or may have any deleterious effect on the financial condition or operations of the plan.

(c) Any filing pursuant to this section may be combined with any appropriate filings pursuant to Article 2, Part 11, Division 2, Title 1 of the Corporations

Code and may utilize common exhibits, subject to the provisions of Section 1300.824(c).

NOTE: Authority cited: Section 1344, Health and Safety Code, Reference: Section 1384, Health and Safety Code.

History:
1. New section filed 4-16-82; effective thirtieth day thereafter (Register 82, No. 16).
2. Change without regulatory effect amending subsections (a) and (b) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

ARTICLE 13
Books and Records

Section
1300.85. Books and Records.
1300.85.1. Retention of Books and Records.

§ 1300.85. Books and Records.

(a) Each plan, solicitor firm, and solicitor shall keep and maintain their books of account and other records on a current basis.

(b) Each plan shall make or cause to be made and retain books and records which accurately reflect:

(1) The names and last known addresses of all subscribers to the plan.

(2) All contracts required to be submitted to the Department and all other contracts entered into by the plan.

(3) All requests made to the plan for payment of moneys for health care services, the date of such requests, and the dispositions thereof.

(4) A current list of the names and addresses of all individuals employed by it as a solicitor.

(5) A current list of the names and addresses of all solicitor firms with which it contracts.

(6) A current list of the names and addresses of all of the plan's officers, directors, principle shareholders, general managers, and other principle persons.

(7) The amount of any commissions paid to persons who obtain members for plans and the manner in which said commissions are determined.

(c) Each solicitor firm shall make and retain books and records which include a current list of the names and addresses of its partners, if any, and all of its employees who make act as solicitors.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1385, Health and Safety Code.

History:
1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.85.1. Retention of Books and Records.

Every plan and solicitor firm shall preserve for a period of not less than five years, the last two years of which shall be in an easily accessible place at the offices of the plan or solicitor firm, the books of account and other records required under the provisions of, and for the purpose of the Act. After such books and records have been preserved for two years, they may be warehoused or stored, or microfilmed, subject to their availability to the Director within not more than 5 days after request therefore.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1385, Health and Safety Code.

History:
1. Change without regulatory effect amending section and adding N ote filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

ARTICLE 14
Miscellaneous Provisions

Section
1300.86. Assessment of Administrative Penalties.
1300.87. Civil Penalties.
1300.89. Petition for Restoration.
1300.89.21. Rescissions.
1300.99. Application to Surrender License.
1300.99.7. Application for Conversion or Restructuring.

§ 1300.86. Assessment of Administrative Penalties.

(a) When assessing administrative penalties against a health plan the Director shall determine the appropriate amount of the penalty for each violation of the Act based upon one or more of the factors set forth in subsection (b).

(b) The factors referred to in subsection (a) include, but are not limited to the following:

(1) The nature, scope, and gravity of the violation;

(2) The good or bad faith of the plan;

(3) The plan's history of violations;

(4) The willfulness of the violation;

(5) The nature and extent to which the plan cooperated with the Department's investigation;

(6) The nature and extent to which the plan aggravated or mitigated any injury or damage caused by the violation;

(7) The nature and extent to which the plan has taken corrective action to ensure the violation will not recur;

(8) The financial status of the plan;

(9) The financial cost of the health care service that was denied, delayed, or modified;

(10) Whether the violation is an isolated incident; and/or

(11) The amount of the penalty necessary to deter similar violations in the future.

NOTE: Authority cited: Sections 1341, 1344 and 1386, Health and Safety Code. Reference: Section 1386, Health and Safety Code.

History:
1. New section filed 11-8-2004; operative 12-8-2004 (Register 2004, No. 46).

§ 1300.87. Civil Penalties.

For purposes of section 1387 of the Health and Safety Code:

(a) A violation that is ongoing and continuous is subject to a civil penalty not to exceed two thousand five hundred dollars ($2,500) for each day that the violation continues.

(b) Each enrollee harmed by a violation of the Act constitutes a separate and distinct violation subject to a civil penalty not to exceed two thousand five hundred dollars ($2,500).

NOTE: Authority cited: Sections 1344 and 1387, Health and Safety Code. Reference: Section 1387, Health and Safety Code; and Section 11425.50, Government Code.

History:
1. New section filed 9-18-2003; operative 9-18-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 38).

§ 1300.89. Petition for Restoration.

(a) The fee for the filing of a petition for restoration shall be $100 for a solicitor, $250 for a solicitor firm, and $500 for a plan.

(b) A petition for restoration shall be made upon the following form:

(Official Use Only)	DEPARTMENT OF MANAGED CARE File No. _____ (Insert file number of previous filings before the Department, if any.)
Fee Paid $_____	FILING FEE: Solicitor: $100 Solicitor firm: $250 Plan: $500
Receipt No. _____	Not refundable except pursuant to Section 250.15, Title 10, California Code of Regulations.

EXECUTION PAGE

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

PETITION FOR RESTORATION
UNDER THE
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

INDICATE TYPE OF FILING BY CHECKING ONE OF THE FOLLOWING:
[ ] ORIGINAL PETITION FOR SOLICITOR
[ ] ORIGINAL PETITION FOR SOLICITOR FIRM
[ ] ORIGINAL PETITION FOR PLAN
[ ] AMENDMENT TO PETITION FOR SOLICITOR
[ ] AMENDMENT TO PETITION FOR SOLICITOR FIRM
[ ] AMENDMENT TO PETITION FOR PLAN
[ ] SUBSEQUENT PETITION
Date first petitioned for restoration _____
Date of any subsequent petitions _____

1. Name of petitioner (Complete name as appearing on articles of incorporation, partnership agreement, etc.)

_____

2. Address of principle office of petitioner.
(Number and Street) (City) (State) (Zip Code)

_____

3. Address of principle office of petitioner in the State of California.
(Number and Street) (City) (State) (Zip Code)

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4. Name and address of person to whom communications should be addressed concerning this petition.

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5. Within 20 days of a request from the Director, the petitioner shall furnish additional information as the Director may require pursuant to subsection (c) of this section.

EXECUTION

The undersigned, duly authorized by the petitioner, has signed this petition on the petitioner's behalf.

_____ By:_____
(Petitioner) Title: _____

I certify under penalty of perjury that I have read this petition and the exhibits and attachments and know the contents, and that the statements are true.

Executed at _____ on _____, _____
(City) (State)

_____
(Signature of Declarant)

(If executed other than in a state which permits verifications under penalty of perjury, attach a verification executed and sworn to before a Notary Public.)

.....

6. Name and address of officer or partner of petitioner who is to receive compliance and informational communications from the Department and who is responsible for disseminating the same within the petitioner's organization.

7. Set forth the grounds upon which the license, employment, or activity was suspended, revoked, or barred. Attach a copy of the decision, administrative record, and order suspending, revoking or barring petitioner.

8. Set forth the basis upon which petitioner believes that restoration is warranted.

9. Set forth the steps which petitioner has taken to prevent a recurrence of the grounds referred to in item 7, above, and any other information which petitioner believes to be relevant.

10. If the petitioner is a plan, is its application on file with the Department current without the need for any amendment?

[ ] Yes [ ] No

If "no," state the day on which petitioner will comply with subsection (c) of this section.

11. If the petitioner is a plan, attach as exhibits all current reports, information, and statements which are required to be filed under the Act or rules but which have not been filed to date.

12. If the petitioner is a solicitor firm, describe the organization of petitioner, identify its principle persons, and describe the manner in which it proposes to act as a solicitor firm.

13. If the petitioner is a solicitor firm, attach financial statements as required:

A. If petitioner is subject to the tangible net worth requirement of Section 1300.76.2, Title 28, Calif. Code of Regulations, attach a copy of petitioner's financial statement consisting of at least a balance sheet and statement reporting the results of operations for the petitioner, prepared as of a date within 30 days of the filing of this petition. Such financial statement need not be certified, but if not certified, also attach as an exhibit certified financial statements of the petitioner as of the close of its last fiscal year.

B. If petitioner is exempted from Section 1300.76.2, attach a statement to that effect and attach a copy of petitioner's financial statement, which need not be certified, consisting of at least a balance sheet and statement reporting the results of operations for the petitioner, prepared as of a date within 30 days of the filing of this petition.

C. If petitioner accepts no funds, in the form of; checks or otherwise, of plans, subscribers or other persons contracting with plans (exclusive of petitioner's compensation for its solicitation activities), attach a statement to that effect, and do not include financial statements of the petitioner as an exhibit to the petition.

14. If petitioner has applied for restoration previously and been denied, attach copies of all prior petitions, administrative records, and decisions on those petitions.

(c) If the petition provided in subsection (b) is filed by a plan, the plan shall file an amendment to its application on file with the Department which will bring that application current, or, if its application is current without the need for any amendment, it shall so allege.

(d) The Director may require additional information and/or undertakings as a condition of granting a petition for restoration. This requested material will be used to determine whether the petitioner, if restored, would engage in business in full compliance with the objectives and provisions of the Act and the applicable regulations. The Director, in evaluating the rehabilitation of the petitioner and his or her eligibility for a license or status as a solicitor, shall consider the following criteria:

(1) The nature and severity of the act(s) or offense(s).

(2) The administrative record applicable to the disciplinary proceedings.

(3) The time that has elapsed since commission of the act(s) or offense(s).

(4) Whether the petitioner has complied with any terms of parole, probation, restitution or any other sanctions imposed against him or her.

(5) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.

(6) Evidence, if any, of rehabilitation submitted by the petitioner.

(7) Any other information; or material that the Director deems to be appropriate and relevant.

NOTE: Authority cited; Section 1344, Health and Safety Code. Reference: Section 1389, Health and Safety Code.

History:

1. New section filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
3. Change without regulatory effect updating title reference on sample execution page filed 12-22-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 51).

4. Change without regulatory effect amending subsection (b) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).
5. Amendment filed 12-16-2002; operative 1-15-2003 (Register 2002, No. 51).

§ 1300.89.21. Rescissions.

(a) Definitions

(1) Rescission or rescind means a cancellation of coverage for fraud or intentional misrepresentation of material fact that has a retroactive effect. A cancellation of coverage with only a prospective effect is not a rescission.

(2) "Effective date of the rescission" in section 1389.21 subdivision (b) of the Health and Safety Code means the date on which the plan retroactively cancels coverage based on fraud or intentional misrepresentation of material fact.

(b) General Requirements

(1) The health plan must provide the enrollee or subscriber with written notice of intent to rescind containing elements required under Health and Safety Code section 1389.21, as well as any and all requirements described in section 1300.65, of this title.

(2) If the enrollee or subscriber requests review of the rescission pursuant to Health and Safety Code section 1365, subdivision (b), the plan must continue or reinstate coverage as required by that section and section 1300.65 of this title.

(c) Enforcement

The failure of a plan to comply with the requirements of section 1389.21 and 1365 of the Act and this regulation may constitute a basis for disciplinary action against the plan. The Director shall have the civil, criminal, and administrative remedies available under the Act, including Health and Safety Code section 1394.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1365 and 1389.21, Health and Safety Code.

History:

1. New section filed 12-22-2014; operative 1-1-2015 pursuant to Government Code section 11343.4(b)(3) (Register 2014, No. 52).

§ 1300.99. Application to Surrender License.

An application to surrender a license as a health plan shall be filed with the Director, in the following form:

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

APPLICATION FOR SURRENDER OF LICENSE
PURSUANT TO
SECTION 1399, HEALTH AND SAFETY CODE

Date of Application _____ Dept. of Managed Care File No. _____

1. Name of Licensee (as appearing in license)

_____

2. Person to be contacted regarding this application.

Name _____

Address _____

_____

Telephone Number _____

3. Reason for Surrender of License (explain briefly):

4. Date upon which licensee proposes to terminate business:

_____

If the date is subject to contingencies or will be determined hereafter, explain briefly below:

5. Complete the following:

a. Attach a copy of the balance sheet and a statement of income and expense for the plan, prepared as of a datewithin 30 days of the filing of this application. Such financial statements need not be certified.

b. State whether the licensee is required to file certain reports pursuant to Section 1384 of the Knox-KeeneHealth Care Service Plan Act of 1975.

If so, state the date by which the licensee will forward such reports to the Director:

_____

c. Section 1300.85.1. of the rules pursuant to the Knox-Keene Health Care Service Plan Act of 1975 requires that the books and records of a plan be preserved for a period of five years. State the name and address of the custodian of the plan's books and records and the address at which such records will be located:

Custodian: ._____

_____

Location: _____

_____

d. Describe in an attachment hereto the licensee's plans for the termination of its business as a health care service plan or specialized health care service plan, including the following information:

1. The provision for payment of any amounts due to subscribers and enrollees and the aggregate amount owed thereto.

2. The provision for payment of any amounts due to providers of health care services, the aggregate owed thereto and a schedule showing the persons to whom such amounts are owed, the amount due each such person, and the date such liability first became due and payable.

3. The final date for payment of periodic payments by or on behalf of subscribers for health care services, and the final date which the plan will be obligated to furnish health care services by reason of such payments.

4. If an insurer assumes obligations as to the plans subscribers and enrollees, attach a detailed statement of the plan for the assumption of business by the subsequent provider or insurer, including the provision being made for notice to subscribers and enrollees, group representatives and providers of health care services who contract with the plan.

5. If the plan or any provider of health care services to the plan holds medical records as to any subscriber or enrollee, indicate the disposition to be made of such records, including the provision made for its subsequent availability to persons providing health care services to such subscribers and enrollees.

e. Is the plan's application pursuant to Section 1351 of the Knox-Keene Health Care Service Plan Act of 1975 current, reflecting all matters which require an amendment to such application pursuant to Rules 1300.52, 1300.52.1 or 1300.52.2?

Yes [ ] No [ ]

If "no" attach an amendment(s) to such application in conformance with such rules

f. Is the plan currently involved in any civil or administrative proceeding?

Yes [ ] No [ ]

If "yes" furnish full details, including the court or administrative action before which such matter is pending.

6. The licensee has duly caused this application to be signed on its behalf by the undersigned, thereunto duly authorized.

_____
(Licensee)

By _____

Title _____

I certify under penalty of perjury that I have read this application and the attachments hereto and know the contents thereof, and that the statements therein are true.

Executed at _____ on _____

_____
Signature of Declarant

If executed in a jurisdiction which does not permit verification under penalty of perjury, attach a verification executed and sworn to before a notary public.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1399, Health and Safety Code.

History:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Amendment filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).
3. Change without regulatory effect amending subsection (e) filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
4. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
5. Change without regulatory effect amending section filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.99.7. Application for Conversion or Restructuring.

An application for conversion or restructuring pursuant to Article 11 (commencing with Section 1399.70) of the Act shall be filed as a Notice of Material Modification pursuant to Rule 1300.52.1.

NOTE: Authority cited: Sections 1344 and 1399.74, Health and Safety Code. Reference: Sections 1352, 1399.70, 1399.71, 1399.72, 1399.73, 1399.74 and 1399.75, Health and Safety Code.

History:

1. New section filed 6-20-96 as an emergency; operative 6-20-96 (Register 96, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-18-96 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 10-15-96 as an emergency; operative 10-18-96 (Register 96, No. 42). A Certificate of Compliance must be transmitted to OAL by 2-12-97 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 10-15-96 order transmitted to OAL 2-3-97 and filed 2-24-97 (Register 97, No. 9).

ARTICLE 15
Charitable or Public Activities

Section
1300.824. Requirements Relating to Charitable or Public Activity Filings.
1300.824.1. Notices and Requests for Approval of Certain Transactions.
1300.826. Request for Ruling on Proposed Action or Article Amendment.

§ 1300.824. Requirements Relating to Charitable or Public Activity Filings.

NOTE: Authority cited: Sections 10824 and 10826, Corporations Code. Reference: Sections 7238, 10824 and 10826, Corporations Code.

History:
1. New Article 15 (Sections 1300.824-1300.826, not consecutive) filed 4-16-82; effective thirtieth day thereafter (Register 82, No. 16).
2. Change without regulatory effect repealing Section 1300.824 pursuant to Section 100, Title 1, California Code of Regulations filed 1-22-90 (Register 90, No. 11).

§ 1300.824.1. Notices and Requests for Approval of Certain Transactions.

NOTE: Authority cited: Section 10824, Corporations Code. Reference: Section 10824, Corporations Code.

History:
1. Change without regulatory effect repealing Section 1300.824.1 pursuant to Section 100, Title 1, California Code of Regulations filed 1-22-90 (register 90, No. 11).

§ 1300.826. Request for Ruling on Proposed Action or Article Amendment.

NOTE: Authority cited: Section 10824, Corporations Code. Reference: Section 10826, Corporations Code.

History:
1. Change without regulatory effect repealing Section 1300.826 pursuant to Section 100, Title 1, California Code of Regulations filed 1-22-90 (register 90, No. 11).

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Health care service plans, discontinuance and replacement of contracts, H&S §1399.61.
Individual access to contracts for health care, H&S §1399.801.

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Dependent —Cont'd
Individual access to health insurance, H&S §1399.845.
Nongrandfathered small employer health plan, H&S §1357.500.
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Department of Managed Health Care, consumer participation program, 28 CCR §1010.
Disclosure forms.
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Discontinuance.
Health care service plans, discontinuance and replacement of contracts, H&S §1399.61.
Disputed health care services.
Independent medical review, H&S §1374.30.
Dosage form.
Health care service plans, prescription drug formulary template, 28 CCR §1300.67.205.
Drugs.
Health care service plans, prescription drug formulary template, 28 CCR §1300.67.205.
Drug tier.
Health care service plans, prescription drug formulary template, 28 CCR §1300.67.205.
Dues.
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Department of Managed Health Care, electronic filing, 28 CCR §1300.41.8.
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Department of Managed Health Care, electronic filing, 28 CCR §1300.41.8.
Eligible employee.
Grandfathered small employer health plan, H&S §1357.600.
Nongrandfathered small employer health plan, H&S §1357.500.
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Employees.
Health care service plans, discontinuance and replacement of contracts, H&S §1399.61.
Employee welfare benefit plan.
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Employer.
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Enrollee.
Health care service plans, H&S §1345.
Prescription drug formulary template, 28 CCR §1300.67.205.

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Enrollee —Cont'd
Health care service plans —Cont'd
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Enrollee transfer notice.
Health care service plans, block transfer filings, 28 CCR §1300.67.1.3.
Enrollment.
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Essential health benefits.
Health care service plans, H&S §1367.005.
Established name.
Health care service plans, prescription drug formulary template, 28 CCR §1300.67.205.
Evidence of coverage.
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Exception.
Health care service plans, solicitation and enrollment, H&S §1362.
Exception request.
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Health care service plans, individual access to contracts, H&S §1399.805.
Individual access to health insurance, H&S §1399.845.
Nongrandfathered small employer health plan, H&S §1357.500.
Exigent circumstances.
Health care service plans, H&S §1367.241.
Prescription drug formulary template, 28 CCR §1300.67.205.
Extended care facilities.
Medicare supplement insurance, policy definitions, H&S §1358.5.
Extension of benefits.
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External party.
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Facility.
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Family unit.
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Former spouse.
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Health care service plans.
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Generally accepted accounting principles.
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Medical supplemental policies, H&S §1358.24.
Geographic region.
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Global risk.
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Individual access to contracts, H&S §§1399.805, 1399.810.
Underwriting practices, H&S §1389.4.
Individual access to health insurance, H&S §1399.845.
Grandfathered small employer health care service plan contract, H&S §1357.600.
Grievance.
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Group contract holder.
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Nongrandfathered small employer health plan, H&S §1357.500.
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Habilitative services.
Health care service plans, H&S §1367.005.
Health benefit plan.
Health care service plans, H&S §§1357.50, 1365.
Individual access to health insurance, H&S §1399.845.
Nongrandfathered small employer health plan, H&S §1357.500.
Health benefits.
Health care service plans, H&S §1367.005.
Health care expenses.
Medicare supplement insurance, policy definitions, H&S §1358.5.
Health care provider.
Health care providers' bill of rights, H&S §1375.7.
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Insolvent plans, replacement coverage by other carriers, H&S §1394.7.
Health maintenance organization.
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HIV.
Health care service plans, standing referral to HIV/AIDS specialist, 28 CCR §1300.74.16.

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HIV/AIDS specialist.
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Home health aide services.
Health care service plans, hospice services, 28 CCR §1300.68.2.
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Hospice.
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Hospice agency.
Health care service plans, 28 CCR §1300.68.2.
Hospice program.
Health care service plans, 28 CCR §1300.68.2.
Hospice service.
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Hospital based plan.
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Hospitals.
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HTML.
Health care service plans, web site filing of grievances, H&S §1368.015.
Hyperlink.
Health care service plans, web site filing of grievances, H&S §1368.015.
In a manner that does not adversely affect the integrity of the contract negotiation process.
Health care service plans, risk-bearing organizations, 28 CCR §1300.75.4.
Individual.
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Individual grandfathered plan coverage.
Health care service plans, H&S §1399.825.
Individual practice association.
Health care service plans, H&S §1373.
Individual provider.
Health care service plans, completion of coverage, H&S §1373.96.
In force business.
Grandfathered small employer health plan, H&S §1357.600.
Individual access to contracts for health care, H&S §1399.801.

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In force business —Cont'd
Nongrandfathered small employer health plan, H&S §1357.500.
Small employer health care service plans, H&S §1357.
Information necessary to determine payer liability.
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In-network coverage or services.
Point-of-service health care service plan contracts, H&S §1374.60.
Insolvency.
Insolvent plans, replacement coverage by other carriers, H&S §§1394.7, 1394.8.
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Institutional risk.
Health care service plans, general licensure requirements, 28 CCR §1300.49.
Interdisciplinary team.
Health care service plans, hospice services, 28 CCR §1300.68.2.
Interim advocacy award.
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Issuer.
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Issuer of a medicare supplement contract.
Medical supplemental policies, H&S §1358.24.
Large group health care service plan contract.
Health care service plans, H&S §§1367.010, 1385.01.
Late enrollee.
Grandfathered small employer health plan, H&S §1357.600.
Health care service plans, H&S §1399.825.
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Limitation.
Health care service plans, solicitation and enrollment, H&S §1362.

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Limited English proficient or LEP enrollee.
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Limited health care service plan.
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Loss of minimum essential coverage.
Individual access to health insurance, H&S §1399.849.
Major health care provider contracts.
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Termination date of major health care provider contracts, availability to subscribers, H&S §1366.2.
Market rate.
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Marriage and family therapists.
Health care service plans, H&S §1373.
Material.
Health care providers' bill of rights, H&S §1375.7.
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Material change.
Health care service plans, H&S §1399.3.
Material familial affiliation.
Independent medical review of disputed health care services and coverage decisions, contracting with medical review organizations, H&S §1374.32.
Material financial affiliation.
Independent medical review of disputed health care services and coverage decisions, contracting with medical review organizations, H&S §1374.32.
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Independent medical review of disputed health care services and coverage decisions, contracting with medical review organizations, H&S §1374.32.
Maternal mental health.
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Medical direction.
Health care service plans, hospice services, 28 CCR §1300.68.2.
Medi-Cal managed care health care service plan contract.
Health care service plans, H&S §1367.24.
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Medicare advantage plan.
Medicare supplement policies, H&S §1358.4.
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Medicare supplement insurance, policy definitions, H&S §1358.5.

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Medicare eligible expenses.
Medicare supplement insurance, policy definitions, H&S §1358.5.
Medicare rate.
Health care service plans, average contract rate methodology, 28 CCR §1300.71.31.
Medicare supplement contract, H&S §1358.4.
Member.
Consumer operated and oriented health care service plans, H&S §1399.80.
Member services portal.
Health care service plans, web site filing of grievances, H&S §1368.015.
Members of a guaranteed association.
Grandfathered small employer health plan, H&S §1357.600.
Nongrandfathered small employer health plan, H&S §1357.500.
Small employer health care service plans, H&S §1357.
Minimum essential coverage.
Health care service plans, H&S §1345.5.
Individual access to health insurance, H&S §1399.849.
New business.
Individual access to contracts for health care, H&S §1399.801.
Nongrandfathered small employer health plan, H&S §1357.500.
Small employer health care service plans, H&S §1357.
1990 plan.
Medicare supplement policies, H&S §1358.4.
1990 standardized benefit plan.
Medicare supplement policies, H&S §1358.4.
1990 standardized Medicare supplement benefit plan.
Medicare supplement policies, H&S §1358.4.
Non-contracted provider dispute.
Health care service plans, fast, fair and cost-effective dispute resolution mechanism, 28 CCR §1300.71.38.
Noncore coverage.
Cal-COBRA, H&S §1366.21.
Nonformulary drugs.
Health care service plans, prescription drug formulary template, 28 CCR §1300.67.205.
Nongrandfathered health benefit plan, H&S §1357.50.
Nongrandfathered small employer health care service plan contract, H&S §§1357.500, 1357.600.
Nonparticipating providers.
Health care service plans, completion of coverage, H&S §1373.96.
Nonpayment of premiums.
Health care service plans, cancellation, rescissions and nonrenewals of enrollment or subscription, 28 CCR §1300.65.

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Nonprofit member corporation.
Consumer operated and oriented health care service plans, H&S §1399.80.
Nonprofit member organization.
Consumer operated and oriented health care service plans, H&S §1399.80.
Non-suspension QHP issuer.
Health care service plans, cancellation, rescissions and nonrenewals of enrollment or subscription, 28 CCR §1300.65.
Notice of cancellation, rescission or nonrenewal.
Health care service plans, cancellation, rescissions and nonrenewals of enrollment or subscription, 28 CCR §1300.65.
Notice of end of coverage.
Health care service plans, cancellation, rescissions and nonrenewals of enrollment or subscription, 28 CCR §1300.65.
Notice of start of federal grace period.
Health care service plans, cancellation, rescissions and nonrenewals of enrollment or subscription, 28 CCR §1300.65.
Notice of start of grace period.
Health care service plans, cancellation, rescissions and nonrenewals of enrollment or subscription, 28 CCR §1300.65.
Open enrollment period.
Health care service plans, H&S §1399.825.
Operational board.
Consumer operated and oriented health care service plans, H&S §1399.80.
Organization.
Health care service plans, risk-bearing organizations, 28 CCR §1300.75.4.
Out-of-area coverage.
Health care service plans, H&S §1345.
Out-of-network coverage or services.
Point-of-service health care service plan contracts, H&S §1374.60.
Out-of-pocket costs.
Health care service plans, prescription drug formulary template, 28 CCR §1300.67.205.
Outstanding premium.
Health care service plans, cancellation, rescissions and nonrenewals of enrollment or subscription, 28 CCR §1300.65.
Participant.
Department of Managed Health Care, consumer participation program, 28 CCR §1010.
Patient's personal representative.
Medical records, patient access, H&S §1367.243.
Payor.
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Person.
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Pervasive developmental disorder or autism.
Point-of-service health care service plan contracts, H&S §1374.73.
Petition to participate.
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Pharmacy benefit manager.
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Physicians.
Medicare supplement insurance, policy definitions, H&S §1358.5.
Plan.
Health care service plans, H&S §1345.
Cancellation, rescissions and nonrenewals of enrollment or subscription, 28 CCR §1300.65.
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Plan contract.
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Plan of care.
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Plan year.
Grandfathered small employer health plan, H&S §1357.600.
Health care service plans, H&S §§1367.010, 1374.255.
Nongrandfathered small employer health plan, H&S §1357.500.
Point of contact.
Health care service plans, language assistance programs, 28 CCR §1300.67.04.
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Point-of-service health care service plan contracts, H&S §1374.60.
Policy year.
Individual access to health insurance, H&S §1399.845.
Postclaims underwriting.
Health care service plans, H&S §1389.3.
PPACA.
Consumer operated and oriented health care service plans, H&S §1399.80.
Grandfathered small employer health plan, H&S §1357.600.
Health care service plans, H&S §§1357.50, 1363.06, 1363.07, 1366.35, 1367.005, 1367.007, 1367.009, 1373.6, 1373.620, 1385.01, 1399.811, 1399.815, 1399.825.
Underwriting practices, H&S §1389.4.
Health care service plans, individual access to contracts, H&S §§1399.805, 1399.810.

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Health insurance.
Individual coverage, H&S §§1367.006, 1367.008.
Individual access to health insurance, H&S §1399.845.
Nongrandfathered small employer health plan, H&S §1357.500.
Preexisting condition exclusion.
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Preexisting condition provision.
Grandfathered small employer health plan, H&S §1357.600.
Health care service plans, H&S §1357.50.
Individual access to contracts for health care, H&S §1399.801.
Individual access to health insurance, H&S §1399.845.
Nongrandfathered small employer health plan, H&S §1357.500.
Small employer health care service plans, H&S §1357.
Premium payment threshold policy.
Health care service plans, cancellation, rescissions and nonrenewals of enrollment or subscription, 28 CCR §1300.65.
Prepaid or periodic charge.
Health care service plans, general licensure requirements, 28 CCR §1300.49.
Prescribing provider.
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Prescription drug formulary template, 28 CCR §1300.67.205.
Prescription drugs.
Health care service plans, prescription drug formulary template, 28 CCR §1300.67.205.
Prescriptions.
Health care service plans, prescription drug formulary template, 28 CCR §1300.67.205.
Presenting for examination or sale.
Health care service plans, solicitation and enrollment, H&S §1362.
Primary care physician.
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Principal creditor.
Health care service plans, 28 CCR §1300.45.
Principal officer.
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Professional clinical counselors.
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Professional risk.
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Provider.
Health care service plans, H&S §§1345, 1367.49.
Health care service plans, completion of coverage, H&S §1373.96.
Provider contract.
Health care service plans, block transfer filings, 28 CCR §1300.67.1.3.
Provider groups.
Health care service plans.
Termination date of major health care provider contracts, availability to subscribers, H&S §1366.2.
Health care service plans, block transfer filings, 28 CCR §1300.67.1.3.
Health care service plans, completion of coverage, H&S §1373.96.
Purchaser.
Health care service plans, H&S §1367.49.
QHP.
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Qualified autism service paraprofessional.
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Qualified autism service professional.
Point-of-service health care service plan contracts, H&S §1374.73.
Qualified autism service provider.
Point-of-service health care service plan contracts, H&S §1374.73.
Qualified beneficiary.
Cal-COBRA, H&S §1366.21.
Qualified beneficiary eligible for premium assistance under ARRA.
Cal-COBRA, H&S §1366.21.
Qualified health plan.
Health care service plans, H&S §1366.6.
Cancellation, rescissions and nonrenewals of enrollment or subscription, 28 CCR §1300.65.
Qualifying event.
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Quantity limits.
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Rating period.
Grandfathered small employer health plan, H&S §1357.600.
Individual access to health insurance, H&S §1399.845.
Nongrandfathered small employer health plan, H&S §1357.500.
Small employer health care service plans, H&S §1357.
Reasonably relevant information.
Health care service plans, claims settlement, 28 CCR §1300.71.
Receiving provider group.
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Reduction.
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Registered domestic partner.
Grandfathered small employer health plan, H&S §1357.600.
Individual access to health insurance, H&S §1399.845.
Nongrandfathered small employer health plan, H&S §1357.500.
Reimbursement of claim.
Health care service plans, claims settlement, 28 CCR §1300.71.
Replacement coverage.
Health care service plans, discontinuance and replacement of contracts, H&S §1399.61.
Represents the interests of consumers.
Department of Managed Health Care, consumer participation program, 28 CCR §1010.
Rescind.
Health care service plans, cancellation, rescissions and nonrenewals of enrollment or subscription, 28 CCR §1300.65.
Rescission.
Health care service plans, cancellation, rescissions and nonrenewals of enrollment or subscription, 28 CCR §1300.65.
Responsible party for a child.
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Restricted health care service plans.
Health care service plans, general licensure requirements, 28 CCR §1300.49.
Risk adjusted employee risk rate.
Grandfathered small employer health plan, H&S §1357.600.
Small employer health care service plans, H&S §1357.
Risk adjustment factor.
Grandfathered small employer health plan, H&S §1357.600.
Small employer health care service plans, H&S §1357.
Risk arrangement.
Health care service plans, risk-bearing organizations, 28 CCR §1300.75.4.

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Risk category.
Grandfathered small employer health plan, H&S §1357.600.
Small employer health care service plans, H&S §1357.
Risk-shifting arrangement.
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Secure server.
Health care service plans, web site filing of grievances, H&S §1368.015.
Service area.
Health care service plans, H&S §1345.
Services most frequently subject to section 1371.9.
Health care service plans, average contract rate methodology, 28 CCR §1300.71.31.
Services subject to section 1371.9.
Health care service plans, average contract rate methodology, 28 CCR §1300.71.31.
Sickness.
Medicare supplement insurance, policy definitions, H&S §1358.5.
Skilled nursing facilities.
Medicare supplement insurance, policy definitions, H&S §1358.5.
Skilled nursing services.
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Small employer.
Grandfathered small employer health plan, H&S §1357.600.
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Contract, H&S §1357.500.
Nongrandfathered small employer health plan, H&S §1357.500.
Small employer health care service plans, H&S §1357.
Small employer health care service plan contract, H&S §1357.600.
Small group health care service plan contract.
Health care service plans, H&S §§1367.005, 1385.01.
Social service/counseling service.
Health care service plans, hospice services, 28 CCR §1300.68.2.
Solicitation.
Health care service plans, H&S §1345.
Solicitor.
Health care service plans, H&S §1345.
Solicitor firm.
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Solvency loan.
Consumer operated and oriented health care service plans, H&S §1399.80.
Solvency regulations.
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Specialized health care service plan.
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Insolvent plans, replacement coverage by other carriers, H&S §1394.8.
Specialized health care service plan contract.
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Specialty drugs.
Health care service plans, H&S §1385.045.
Sponsoring organization.
Health care service plans, risk-bearing organizations, 28 CCR §1300.75.4.
Staff-model dental health care service plan, H&S §1395.7.
Standard employee risk rate.
Grandfathered small employer health plan, H&S §1357.600.
Small employer health care service plans, H&S §1357.
Standard risk rate.
Health care service plans, H&S §1399.825.
Startup loan.
Consumer operated and oriented health care service plans, H&S §1399.80.
Step therapy.
Health care service plans, prescription drug formulary template, 28 CCR §1300.67.205.
Sterilization operations or procedures.
Health care service plans, H&S §1373.
Strength.
Health care service plans, prescription drug formulary template, 28 CCR §1300.67.205.
Structure, language, and format.
Medicare supplement policies, H&S §1358.91.
Sub-delegating organization.
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10 USCS § 1071 et seq., H&S §§1358.4, 1399.801.
22 USCS § 2504(e), H&S §1399.801.
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26 USCS § 4908B, H&S §1373.621.
29 USCS § 1002, H&S §§1366.35, 1399.801.
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HEALTH CARE SERVICE PLANS —Cont'd
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