REVISED 12-6-02

DEPARTMENT OF MANAGED HEALTH CARE
PROPOSED REGULATIONS: FINANCIAL EXAMINATIONS

Section 1300.49.2 Exemptions.

New CCR Title 28, section 1300.49.2

For purposes of section 1349.2(a)(7) of the Act, "fiscally sound operation" means an operation maintaining a positive unrestricted fund balance; maintaining cash and cash equivalents sufficient to meet current obligations when they become due; and is issued a report, certificate, or opinion by an independent certified public accountant that is unqualified, and without reservation regarding future financial viability concerns.

NOTE: Authority cited: section 1344, Health and Safety Code. Reference: section 1349.2, Health and Safety Code.

Section 1300.75.1 Fiscal Soundness, Insurance, and Other Arrangements.

Amend section 1300.75.1(a)(1) and (a)(2). Add new subsections (a)(4) and (a)(5).

(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~~ sufficient to timely reimburse providers and enrollees for all claims and for retirement of existing and proposed indebtedness.

(2) Demonstrate that its working capital, cash, and cash generated by operations ~~is~~ are 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.

(4) Demonstrate that transactions with the plan's shareholders or any affiliates will not jeopardize the financial soundness of the plan by executing undertakings that meet the following minimum requirements:

(A) A plan will not declare or pay dividends, distribute or upstream cash, assets or property where such actions would result in noncompliance with the tangible net equity requirements of section 1300.76. Additionally, a plan shall not permit the distribution of cash, assets, or property that would result in insufficient working capital or cash flow necessary to provide for the retirement of existing or proposed indebtedness as it comes due, or adversely affects the ability of the plan to provide health care services required by the Act or these regulations.

(B) A plan shall file a written Notice of Material Modification pursuant to Health and Safety Code section 1352 and obtain prior approval of the Department for any loans or credit agreements entered into by the plan with shareholders or affiliates where the plan: cosigns or guarantees any portion of the loan or credit agreement, permits any portion of an existing loan or credit agreement to be assumed by the plan, or pledges plan assets or capital stock in support of the loan or credit agreement.

(C) A plan shall provide written notice of undertakings within the meaning of (A) and (B) to all current and future holders of any loans or credit agreements, or any shareholder or plan affiliates to the extent that plan assets or stock are involved in such loans or credit agreements to ensure that satisfaction of any obligations under such instruments is subordinated to the plan's obligations under the Act and these regulations.

(5) Ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations.

(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 the ~~it~~ provision of the health care services before the ~~y~~ services 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: ~~S~~section 1344, Health and Safety Code. Reference: ~~S~~section 1375.1, Health and Safety Code.

Section 1300.76 Plan Tangible Net Equity Requirement.

Amend section 1300.76

(a) ~~Except as provided in subsection (b) or (c), each~~ All full service health care service plans licensed pursuant to the provisions of the Act shall~~, at al times,~~ have and maintain at all times a tangible net equity at least equal to the greater of:

(1) $1 million; or

(2) the sum of ~~two~~ four percent of the first $150 million of annualized premium revenues plus ~~one~~ two percent of annualized premium revenues in excess of $150 million; or

(3) an amount equal to the sum of:

(A) ~~eight~~ twelve percent of the first $150 million of annualized health care expenditures except those paid on a capitated basis, ~~or~~ managed hospital payment basis, or per diem basis; plus

(B) ~~**four**~~ **six percent** of the annualized health care expenditures, except those paid on a capitated basis, ~~or~~ managed hospital payment basis, or per diem basis, which are in excess of $150 million; plus

(C) ~~**four**~~ **six percent** of annualized hospital expenditures paid on a managed hospital payment basis or per diem basis.

(b) ~~Except as provided in subsection (c), each~~ All specialized health care service plans licensed pursuant to the provisions of the Act ~~and which only offers specialized health care service contracts~~ shall~~, at all times,~~ have and maintain at all times a tangible net equity at least equal to the greater of:

(1) ~~$50,000~~ $200,000; or

(2) the sum of ~~two~~ four percent of the first ~~$7,500,000~~ $7.5 million of annualized premium revenues plus ~~one~~ two percent of annualized premium revenues in excess of ~~$7,500,000~~ $7.5 million; or

(3) an amount equal to the sum of:

(A) ~~eight~~ twelve percent of the first ~~$7,500,000~~ $7.5 million of annualized health care expenditures, except those paid on a capitated, ~~or~~ managed hospital payment, ~~basis~~ or per diem basis; plus

(B) ~~**four**~~ **six percent** of the annualized health care expenditures, except those paid on a capitated basis, ~~or~~ managed hospital payment basis or per diem basis, which are in excess of ~~$7,500,000~~; $7.5 million plus

(C) ~~**four**~~ **six percent** of annualized hospital expenditures paid on a managed hospital payment basis or per diem basis.

~~(c) Each plan pursuant to the provisions of the Act prior to the effective date of this section must maintain a minimum tangible net equity of:~~

~~(1) 20 percent of the amount required by subsection (a) or (b), as applicable within 6 months of the effective date of this section.~~

~~(2) 36 percent of the amount required by subsection (a) or (b), as applicable within 12 months of the effective date of this section.~~

~~(3) 52 percent of the amount required by subsection (a) or (b), as applicable within 18 months of the effective date of this section.~~

~~(4) 68 percent of the amount required by subsection (a) or (b), as applicable within 24 months of the effective date of this section.~~

~~(5) 84 percent of the amount required by subsection (a) or (b), as applicable within 30 months of the effective date of this section.~~

~~(6) 100 percent of the amount required by subsection (a) or (b), as applicable within 36 months of the effective date of this section.~~

~~(d) The Director may extend the time periods noted in subsection (c) if the Director determines that such extension is in the best interests of the plan and its enrollees and it will not cause the plan to operate in a manner that may be hazardous to its enrollees.~~

~~(e)~~(c) All licensed health plans shall meet and maintain the tangible net equity requirements specified in subsections (a) and (b) on or before July 1, 2003.

(d) For the purpose of this section "net equity" means the excess of total assets over total liabilities, excluding liabilities ~~which~~ 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; organization expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except ~~short term~~ obligations less than 30 days past due of affiliates for goods or services arising in the normal course of business that ~~which~~ are payable on the same terms as equivalent transactions with nonaffiliates ~~and which are not past due~~; long term prepayments of deferred charges, long term deferred tax assets, and nonreturnable deposits. ~~An obligation is fully secured for the purposes of this~~

~~subsection if it is secured by tangible collateral, by securities of the plan or an affiliate with an equity of at least 110 per cent of the amount owing.~~

~~(f)~~(e) For ~~the~~ purposes 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.

~~(g)~~(f) For ~~the~~ purposes 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.

(g) For purposes of this section, an obligation is fully secured in a manner acceptable to the Director, if it is secured by tangible collateral, other than by securities of the plan or an affiliate, with an equity of at least 110 percent of the amount owing, with security documents filed with the Department.

(h) For purposes of this section, a liability is subordinated if a written agreement is executed that meets all of the following requirements:

(1) Lender irrevocably and fully subordinates all rights and title to, and interest in repayment of the loan as evidenced by a note to all other present and future creditors of the plan.

(2) Lender agrees that the payment by the plan of principal and interest of the loan under the terms of the note will be suspended and will not mature when, if after giving effect to the payment, the plan would not retain the required tangible net equity as defined in and calculated under the Act and these regulations.

(3) Lender agrees that, in the event of the liquidation or dissolution of the plan, the payment by the plan of principal and interest on the note is fully subordinated and subject to the prior payment or provision for payment in full of all claims of all other present and future creditors of the plan.

(4) The terms of the note are subject to the terms of the subordination agreement. To the extent that the terms of the note are in conflict with the subordination agreement, the terms of the subordination agreement will control.

(5) The subordination agreement is not subject to cancellation by either the plan or the lender, nor may the subordination agreement be terminated, rescinded or amended by mutual consent or otherwise without the prior written consent of the Director.

NOTE: Authority cited: ~~S~~section 1344, Health and Safety Code. Reference: ~~S~~section 1375.1, Health and Safety Code.

Section 1300.76.1. Deposits.

Amend section 1300.76.1

(a) ~~Except as provided in subsection (b), or (c) e~~ Each licensed full service health care service plan ~~licensed pursuant to the provisions of the Act~~ shall deposit with the Director, or at the Director's discretion, ~~of the Director~~ with any bank or savings and loan association authorized to do business in this state and insured by either 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 $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.~~ the amount indicated in the following schedule:

Plan enrollment	Amount Deposited
0 to 1,000,000	$500,000
over 1,000,000	$1,000,000

~~(b) Each plan licensed pursuant to the provisions of the Act prior to the effective date of this section, except any plan which only offers specialized health care services contracts, shall make a deposit of 50 percent of the amount required by subsection (a) within 12 months of the effective date of this section and 100 percent of the amount required by subsection (a) with 24 months of the effective date of this section.~~

~~(c) 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 40 percent of the amount required by subsection (a) within 12 months of the effective date of this section, 70 percent of the amount required by subsection (a) within 24 months of the effective date of this section and 100 percent of the amount required by subsection (a) within 36 months of the effective date of this section.~~

~~(d) The Director may extend the time periods noted in subsection (c) if the Director determines that such extension is in the best interests of the plan and its enrollees and if it will not cause the plan to be operated in a manner that may he hazardous to its enrollees.~~

(b) Each licensed specialized health care service plan shall deposit with the Director, or at the Director's discretion, with a bank or savings and loan association authorized to do business in this state, and insured by either the Federal Deposit Insurance Corporation

or the Savings Association Insurance Fund, an amount which shall have a value of not less than $150,000.

(c) All licensed health plans shall meet and maintain the deposit requirements specified in subsections (a) and (b) on or before July 1, 2003. The deposit may be in the form of cash, investment certificates, U.S. Government Treasury instruments held in a Trust Bank, accounts, or any combination of these. U.S. Government Treasury instruments must have a minimum market value of $500,000 or $1,000,000.

(d) The deposit shall be assigned to the Director, upon those terms as the Director may prescribe, until released by the Director.

(e) 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.

(f) 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. All plans shall annually report to the Director the location where the funds are deposited, and form of the deposited funds required by this section.

(g) The Director may utilize 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~~ or to cover the direct or indirect costs and expenses incurred by the Department whenever the Director has brought an action~~s~~ pursuant to sections 1386, 1392, 1393, 1393.5, 1393.6 or

1394.1 of the Health and Safety Code. ~~The Director may use the deposit for administrative costs directly attributable to a conservatorship, receivership or liquidation.~~

NOTE: Authority cited: ~~S~~section 1344, Health and Safety Code. Reference: ~~S~~section 1376, Health and Safety Code.

Section 1300.77.1 Estimated Liability for Reimbursement.

Amend section 1300.77.1

A plan subject to ~~subsection (b) of S~~section 1377(b) of the Act shall estimate its liability for incurred ~~and unreported~~ but not reported (IBNR) claims on a monthly basis. The estimate shall include the administrative cost of processing such claims and ~~record such estimate~~ be recorded as an accrual in ~~it's~~ the plan's books and records ~~at least monthly~~.

NOTE: Authority cited: ~~S~~section 1344, Health and Safety Code. Reference: ~~S~~sections 1375.1, 1376 and 1377 Health and Safety Code.

Section 1300.82 Examination Procedure.

Amend section 1300.82

~~Regular and additional or nonroutine e~~Examinations conducted by the Department pursuant to ~~S~~section 1382 will ordinarily be commenced on an unannounced basis. To the extent feasible, deficiencies noted will be ~~called~~ brought to the attention of the responsible officers of the ~~company~~ plan ~~under examination~~ during the course of the examination~~., and in that event the company should take the~~ If the plan is notified of such deficiencies, the plan shall immediately commence the appropriate corrective action~~s. indicated.~~ When ~~deemed~~ appropriate, the ~~company~~ plan will be advised by letter of the deficiencies noted ~~upon~~ during the examination. ~~If t~~The deficiency letter may require~~s~~ a

report from the ~~company~~ plan~~, such report must~~ which shall be furnished within 15 working days, or after such additional time as may be allowed.

Follow-up examinations may be performed after each regular and additional or nonroutine examination to verify the plan's progress in correcting the deficiencies noted during the initial examination. The costs associated with performing follow-up examinations may be charged to the plan being examined.

NOTE: Authority cited: ~~S~~section 1344, Health and Safety Code. Reference: ~~S~~section 1382, Health and Safety Code.

Section 1300.82.1. Additional or Nonroutine Examinations and Surveys.

Amend subsection 1300.82.1(a)(2)

(a) An examination or survey is additional or nonroutine for good cause for the purposes of ~~S~~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 ~~S~~sections 1352,1370, 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1271.37, 1371.38, 1371.4, 1375.1, 1375.4 1376, 1384 and 1385 of the Act and ~~S~~sections 1300.71, 1300.71.38, 1300.75.4, 1300.75.4.1, 1300.75.4.3, 1300.75.4.5, 1300.77.4, 1300.76, 1300.80.10, 1300.81, 1300.8~~2~~4(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 ~~S~~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 Health & Safety Code ~~S~~section 1382(b).

NOTE: Authority cited: ~~S~~section 1344, Health and Safety Code. Reference: ~~S~~sections 1352, 1370, 1371, 1371.35, 1371.4, 1375.1, 1376, 1380, 1382, 1384, 1385, and 1386, Health and Safety Code.

Section 1300.84 Financial Statements.

Amend subsection 1300.84(a), 1300.84(b) and 1300.84(c)(2)

(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 ~~S~~section 1384 of the Act shall be audited by an independent accountant in accordance with section 1300.45(e).

(1) The contract or engagement letter between the plan and independent accountant shall contain a provision to provide the independent accountant's working papers to the Director.

(2) Upon demand, the Director will have reasonable access to the accountant's working papers relating to the completion of the audit required by section 1384 of the Act.

(c) Except as provided in subsection (d), financial statements of a plan required pursuant to these ~~rules~~ regulations 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~~ shall be combined, regardless of its form of organization, if the ~~following conditions exist:~~

~~(1)~~ ~~T~~the affiliate controls, is controlled by, or is under common control with, the plan, either directly or indirectly (~~see~~ as defined by 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 the plan's financial statements required pursuant to these ~~rules~~ regulations. 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) consolidat~~ing~~ed 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~~ that is a public entity or political subdivision.

(h) All filings of financial statements required pursuant to these ~~rules~~ regulations must include an original and one copy.

NOTE: Authority cited: ~~S~~section 1344, Health and Safety Code. Reference: ~~S~~section~~s~~ 1384, Health and Safety Code.

Section 1300.84.06 Plan Annual Report.

Amend subsections 1300.84.06(a) and (b). Add new subsections 1300.84.06(b)(10), 1300.84.06(b)(11) and 1300.84.06(c)

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 Health Maintenance Organization Financial Report of Affairs and Conditions Form" as adopted by the National Association of Insurance Commissioners commonly known as the "HMO Annual Reporting Form" and the "Orange Blank" published by the Brandon Insurance Service Company. The "HMO Annual Reporting Form", revised 1989, is incorporated by reference.~~ The DMHC Annual Financial Reporting Form, publication date 2002, available from the Department. Pursuant to section 1300.41.8, Title 28 of the California Code of Regulations, plans shall electronically file their annual report with the Department.

(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~~ but not reported claims.

(2) Accounts 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~~ regulations. 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~~ Four percent of the first $150 million for full service health plans, or $7.5 million for specialized plans, of annualized premium revenues;

2. ~~One~~ Two percent of annualized premium revenues in excess of $150 million for full service health plans, or $7.5 million for specialized plans;

3. Sum of 1. and 2. above.

(B) Healthcare Expenditures

1. ~~Eight~~ Twelve percent of the first $150 million for full service health plans, or ~~$7,500,00~~ $7.5 million for specialized plans of annualized health care expenditures except those paid on a capitated basis or managed hospital payment basis, or per diem.

2. ~~**Four**~~ **six percent** of the annualized health care expenditures for full service health plans, except those paid on a capitated basis, ~~**or**~~ managed hospital payment basis, or per diem, which are in excess of $150 million, or ~~$7,500,000~~ $7.5 million for specialized plans;

3. ~~**Four**~~ **six percent** of annualized hospital expenditures paid on a managed hospital payment basis, or per diem.

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 ~~s~~section 1377(a) as determined in accordance with such section.

(10) At the request of the Director, plans will file paid claims data in a format, and for the time period, prescribed by the Director.

(c) Schedule L in the DMHC Annual Financial Reporting Form, shall be treated as confidential by the Department. However, the Department may publish aggregate information relating to individual lines of business in a format that does not permit identification of plan specific information.

NOTE: Authority cited: ~~S~~sections 1344 and 1384, Health and Safety Code. Reference: ~~S~~sections 1384, Health and Safety Code.

Section 1300.84.2 Quarterly Financial Reports.

Amend subsection 1300.84.2(a)

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) known as the DMHC Annual Financial Reporting Form, identified in section 1300.84.06(a) of these regulations for the period covered by the report, prepared in accordance with generally accepted accounting principles, prepared on a basis consistent with the certified financial report furnished by the plan pursuant to ~~S~~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. Pursuant to section 1300.41.8 of Title 28, California Code of Regulations, plans shall electronically file their quarterly report with the Department. ~~The financial statements shall include the following statements, reports and schedules contain in the "HMO Annual 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 Revenues 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 ~~S~~section 1300.84.06 (b) of these ~~rules~~ regulations for the period covered by the report, except as otherwise specified.

NOTE: Authority cited: ~~S~~sections 1344 and 1384, Health and Safety Code. Reference: ~~S~~sections 1384, Health and Safety Code.

Section 1300.84.3 Monthly Financial Reports.

Amend subsection 1300.84.3(d) and (d)(1). (No changes to subsections 1300.84.3(a), (b) and (c))

(a) Each plan shall maintain internal procedures ~~which~~ that 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~~ regulation.

(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~~ that:

(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~~ regulations.

(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, statement of cash flows, 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~~ regulations, and the verification required by subsection (e) of this ~~rule~~ regulation. 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~~ regulations. 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~~ regulation1300.84(c)), is less than ~~the following:~~

~~(A) 200% of the minimum tangible net equity required by section 1300.76(c)(1);~~

~~(B) 155% of the minimum tangible net equity required by section 1300.76(c)(2);~~

~~(C) 148% of the minimum tangible net equity required by section 1300.76(c)(3);~~

~~(D) 137% of the minimum tangible net equity required by section 1300.76(c)(4);~~

~~(E) 136% of the minimum tangible net equity required by section 1300.76(c)(5);~~

~~(F) 130% of the minimum tangible net equity required by section 1300.76(c)(6);~~

~~(C)~~ 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~~ regulation 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 ~~S~~section 1300.76 of these ~~rules~~ regulations.

(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~~ regulation shall be verified by a principal officer of the plan in accordance with section 1004 of these regulations. ~~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)*~~

NOTE: Authority cited: ~~S~~section 1344 and 1384, Health and Safety Code. Reference: ~~S~~section~~s~~ 1384, Health and Safety Code.