WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 8. Prepaid Plans [14200 - 14499.77] *(Chapter 8 added by Stats. 1972, Ch. 1366.)*

ARTICLE 4. Enrollment and Disenrollment [14400 - 14413] *(Article 4 added by Stats. 1974, Ch. 983.)*

14400. Every prepaid health plan shall have an open enrollment period at least once every year. During the open enrollment period the plan shall accept up to the limit of its capacity or the limit of its contract, without restrictions, other than those which may be required by the director, Medi-Cal beneficiaries who are eligible to enroll in such plans. Eligible enrollees shall be accepted in the order in which they apply for enrollment.

(Amended by Stats. 1977, Ch. 1036.)

14401. No Medi-Cal beneficiary shall be enrolled in a prepaid health plan prior to the time a contract under this chapter is signed by the department and such prepaid health plan is approved by the appropriate state agencies.

(Added by Stats. 1974, Ch. 983.)

14402. The prepaid health plan shall enroll only those Medi-Cal beneficiaries who reside within the contract service area. Prepaid health plans shall use a standard application form prescribed by the department which is readily understandable to the enrollees. A beneficiary shall be enrolled in the prepaid health plan when the beneficiary voluntarily signs the enrollment application agreeing to utilize the health services provided by the prepaid plan and his eligibility for enrollment in that plan is verified by validation of the application by the department.

Notwithstanding the provisions of this section requiring voluntary enrollment, the department may approve the transfer of the enrollees of one or more prepaid health plans to another prepaid health plan in accordance with the terms of a merger or reorganization approved by the department pursuant to the conditions set forth in Sections 14303.1 and 14303.2.

(Amended by Stats. 1977, Ch. 1036.)

14403. No Medi-Cal beneficiary shall be enrolled in more than one prepaid health plan at any time.

(Added by Stats. 1974, Ch. 983.)

14406. (a) Within seven days after the effective date of enrollment, the prepaid health plan shall provide in writing the following information to a new enrollee or the family unit of the new enrollee:

(1) An appropriate document identifying the enrollee and authorizing the services or benefits to which that person is entitled under the plan subject to verification of eligibility.

(2) A description of all services and benefits provided by the plan.

(3) An explanation of the procedure for obtaining these services and benefits, including in the case of medical foundations or independent practice associations, the address and telephone number of each primary care physician, dentist, optometrist, psychologist, and in the case of other plans, the address and telephone number of each service site and the location of primary care physicians, dentists, optometrists and psychologists, and in the case of all prepaid health plans, the address and telephone numbers of each hospital, pharmacy, and skilled nursing facility where health care benefits may be obtained. In addition, the explanation shall state the hours and days where each of these facilities are open and the services and benefits available.

(4) The location, telephone number, and procedure for securing 24-hour emergency care and an explanation of and procedure for obtaining out-of-area emergency coverage.

(5) Information setting forth the term of enrollment in the prepaid health plan including the causes for which an enrollee shall lose eligibility in the prepaid health plan.

(6) The procedure for processing and resolving any grievance by enrollees. Such information shall include the name, address, and telephone number of the person responsible for resolving grievances or initiating a grievance procedure.

(7) The procedure by which enrollees may request disenrollment.

(8) Any other information essential to the use of the prepaid health plan as may be required by the department.

(b) The information made available under this section shall be revised and distributed annually to each enrollee or enrollee's family unit and whenever there is a change in the services provided or the location where they may be obtained. Except for a change which is unforeseeable, all enrollees affected by the change in service or the location of services shall be notified at least 14 days prior to such a change.

(Amended by Stats. 1979, Ch. 1061.)

14407. Enrollment in a prepaid health plan shall be voluntary and a prepaid health plan shall not use false advertising or false statements to induce enrollment. No solicitation of enrollees shall include the granting or offering of any monetary or other valuable consideration for enrollment.

(Amended by Stats. 1977, Ch. 1036.)

14407.1. (a) A contractor that has entered into a contract with the department under this chapter, or under another Medi-Cal managed care contracting authority, may offer nonmonetary incentives to promote good health practices by its existing Medi-Cal enrollees.

(b) No Medi-Cal managed care contractor may offer an incentive to promote good health practices by its Medi-Cal enrollees prior to written approval by the department. In the absence of other countervailing considerations, the department shall approve, to the extent permitted by federal law, the use by health plans of nonmonetary incentives to enhance health education program efforts to increase member participation, learning, and motivation to do any of the following:

(1) Effectively use managed health care services, including preventive and primary care services, obstetric care, and health education services.

(2) Modify personal health behaviors, achieving and maintaining healthy lifestyles and treatment therapies and positive health outcomes.

(3) Follow self-care regimens and treatment therapies for existing medical conditions, chronic diseases, or health conditions.

(c) If a contractor is a publicly operated entity, the offering of a department-approved, nonmonetary incentive to promote good health practices by enrollees shall not constitute a gift of public funds.

(d) Violations of this section shall be subject to the requirements and penalties set forth in Sections 14408 and 14409, and any regulations adopted by the department pursuant to this article.

(e) The department shall develop and publish written guidelines for the appropriate use of nonmonetary incentives that may be offered to Medi-Cal enrollees.

(Amended by Stats. 2008, Ch. 179, Sec. 248. Effective January 1, 2009.)

14407.6. (a) Notwithstanding Section 14407.5, the department shall, to the extent permitted by federal law or under federal waivers which the department may obtain, establish a minimum enrollment period for Medi-Cal beneficiaries enrolling in managed care plans under any of the following:

(1) This chapter.

(2) Any of the following provisions of Chapter 7 (commencing with Section 14000):

(A) Article 2.7 (commencing with Section 14087.3).

(B) Article 2.9 (commencing with Section 14088).

(C) Article 2.91 (commencing with Section 14089).

(b) (1) Except as otherwise required by federal law, disenrollment during the minimum enrollment period shall only be for good cause.

(2) For purposes of this section, the meaning of “good cause” shall be as defined in subdivision (b) of Section 14407.8, and shall include “good cause” as defined by federal laws or regulations governing Medi-Cal managed care contracting.

(Added by Stats. 1991, Ch. 95, Sec. 12. Effective June 30, 1991.)

14408. (a) Except as otherwise prohibited by law, a contractor that has entered into a contract with the department pursuant to this chapter may make the benefits known to potential enrollees by methods approved by the department.

(b) No prepaid health plan, marketing representative, or marketing organization shall engage in marketing activities prior to written submittal to and approval by the department. All marketing activities, procedures, methods, and places in which any activities will be conducted shall be explicitly described in a marketing plan and approved by the department prior to being used by a prepaid health plan, marketing representative, or marketing organization. The marketing plan shall be updated and submitted for renewed approval on an annual basis. The department may approve, disapprove, or withdraw approval of any marketing activity or procedure. The department shall require the discontinuance of any marketing activity or procedure for which the department withdraws approval. The conduct of activities or procedures not included in an approved marketing plan shall constitute a violation of this article and be subject to sanctions in accordance with Section 14409.

The prepaid health plan shall be responsible for all presentations by its marketing representatives and for their ethical and professional conduct. The department may withdraw certification for participation in the program from, and impose marketing sanctions specified in Section 14409, as applicable, on marketing representatives.

(c) The marketing plan shall meet the standards established by the department. The marketing plan shall include, but not be limited to, an explicit description of the specific marketing activities, the method of identifying individual enrollments by marketing representative, and formal measures to monitor performance of marketing representatives and verify both of the following:

(1) The prepaid health plan’s marketing activities and practices do not violate subdivision (a) of Section 14409.

(2) Beneficiaries receive complete and accurate information about the benefits and limitations of receiving health care services through the prepaid plan in a manner that considers the beneficiary’s level of comprehension.

(d) Each time a marketing representative presents information about the benefits of prepaid health plan enrollment to a beneficiary in order to encourage the beneficiary to enroll, the marketing representative shall leave with the beneficiary printed information identifying the marketing representative by name and prepaid health plan represented.

(e) All printed or illustrated material prepared by the prepaid health plan for dissemination to enrollees or to prospective enrollees shall be submitted to the department prior to dissemination. The department shall acknowledge receipt of the printed or illustrated material within five days, and shall approve or disapprove the material for dissemination within 60 days after the date of notification that the material has been received. The department may withdraw approval of the material previously approved and order its dissemination discontinued. If the department notifies the prepaid health plan of its disapproval or withdrawal of approval, the prepaid health plan shall have the right to meet and confer with the director or his or her designee and demonstrate the purpose and reasonable basis for the distribution of the material to enrollees and potential enrollees.

(f) (1) Any form of door-to-door or in-person marketing that coerces or misleads beneficiaries or selectively enrolls beneficiaries on the basis of their health status is unlawful. In addition, on or after July 1, 1996, door-to-door solicitation of Medi-Cal enrollees shall not be permitted.

(2) On or after July 1, 1996, the health care options presentation required by Sections 14016.5 and 14016.6 or the health care options information required by Sections 14087.305 and 14089 shall be fully operational in counties specified by the director for expansion of the Medi-Cal managed care program or in counties where prepaid health plans are contracting with the department pursuant to Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, 14087.96, 14089, and 14089.05. In these counties, on or after July 1, 1996, no enrollment of beneficiaries by prepaid health plans shall occur during in-person marketing activities or during health fairs pursuant to paragraph (5) of subdivision (f). Enrollment shall be exclusively performed and transmitted pursuant to the program required by Sections 14016.5, 14016.6, 14087.305, and 14089.

(3) In the event the health care options presentation required by Sections 14016.5 and 14016.6 is not fully operational or the health care options information required by Sections 14087.305 and 14089 is not fully available, as specified in paragraph (2) of subdivision (f), the department shall perform the enrollment-only functions until the health care options presentation or information is fully operational or available.

(4) Nothing in this section shall preclude a prepaid health plan from responding to inquiries initiated by beneficiaries or potential beneficiaries.

(5) Until July 1, 1996, a prepaid health plan may participate in an organized community or neighborhood health fair in a public place only if two or more prepaid health plans are participating, or if the plan is invited by the sponsor of the fair. If there are not two or more prepaid health plans providing services to Medi-Cal beneficiaries in a prepaid health plan's service area, this subdivision shall not apply. On or after July 1, 1996, a prepaid health plan may participate in an organized community or neighborhood health fair in a public place for marketing purposes.

(g) Any prepaid health plan, marketing representative, or marketing organization that violates subdivision (f) shall be subject to the sanctions set forth in subdivision (b) of Section 14409 and shall be guilty of a misdemeanor and subject to a fine of five hundred dollars ($500) or imprisonment in a county jail for six months, or both, for each violation.

(h) The department shall certify each marketing representative prior to participation in the program in accordance with standards established by the department. Continuing certification for participation in the program shall be contingent upon compliance with this article, as well as guidelines and standards adopted by the department, and may be withdrawn upon their violation, as determined by the department. The department may temporarily decertify any marketing representative when that action is necessary to protect the public welfare or the interests of the Medi-Cal program. Temporary decertification shall be effective immediately upon written notice to the marketing representative and the managed care contractor, and shall remain in effect until the department has made a determination on the merits. Temporary decertification shall be canceled unless the department acts to permanently withdraw certification within 60 days.

(i) No prepaid health plan shall employ in any capacity relating to the marketing operations of the plan a marketing representative whose certification has been withdrawn. Marketing representatives shall not be recertified for participation until the cause for withdrawal of certification has been corrected to the satisfaction of the department. Proof of correction shall be the sole responsibility of the marketing representative.

(Amended by Stats. 2004, Ch. 183, Sec. 389. Effective January 1, 2005.)

14408.5. A prepaid health plan that contracts with Medi-Cal managed care or contracts with the Healthy Families Program may provide application assistance pursuant to Section 12693.325 of the Insurance Code during the eligibility redetermination process in order to allow persons to retain coverage.

(Added by Stats. 2000, Ch. 93, Sec. 97. Effective July 7, 2000.)

14409. (a) No prepaid health plan, marketing representative, or marketing organization shall in any manner misrepresent itself, the plans it represents, or the Medi-Cal program. A violation of this section shall include, but is not limited to, all of the following:

(1) False or misleading claims that marketing representatives are employees or representatives of the state, county, or anyone other than the prepaid health plan or the organization by whom they are reimbursed.

(2) False or misleading claims that the prepaid health plan is recommended or endorsed by any state or county agency, or by any other organization which has not certified its endorsement in writing to the prepaid health plan.

(3) False or misleading claims that the state or county recommends that a Medi-Cal beneficiary enroll in a prepaid health plan.

(4) Claims that a Medi-Cal beneficiary will lose their benefits under the Medi-Cal program or any other health or welfare benefits to which they are legally entitled, if they do not enroll in a prepaid health plan.

(b) Violations of this article or regulations adopted by the department pursuant to this article shall result in one or more of the following sanctions that are appropriate to the specific violation, considering the nature of the offense and frequency of occurrence within the prepaid health plan:

(1) Revocation of one or more permitted methods of marketing.

(2) Termination of authorization for a plan to provide application assistance.

(3) Refusal of the department to accept new enrollments for a period specified by the department.

(4) Refusal of the department to accept enrollments submitted by a marketing representative or organization.

(5) Forfeiture by the plan of all or part of the capitation payments for persons enrolled as a result of such violations.

(6) Requirement that the prepaid health plan in violation of this article personally contact each enrollee enrolled to explain the nature of the violation and inform the enrollee of their right to disenroll.

(7) Application of sanctions as provided in Section 14197.7.

(8) Temporarily suspend capitation payments for beneficiaries enrolled in violation of this article, or regulations adopted thereunder, until the prepaid health plan is in substantial compliance with the statutory and regulatory requirements.

(c) Any marketing representative who violates subdivision (a) while engaged in door-to-door solicitation is guilty of a misdemeanor, and shall be subject to a fine of five hundred dollars ($500) or imprisonment in a county jail for six months, or both.

(Amended by Stats. 2019, Ch. 465, Sec. 9. (AB 1642) Effective January 1, 2020.)

14410. No prepaid health plan or marketing representative shall adopt or utilize any procedure to identify prospective enrollees with medical or psychiatric problems in order to exclude them from enrollment in the prepaid health plan, other than medical conditions specifically excluded from coverage by the contract.

(Added by Stats. 1974, Ch. 983.)

14411. (a) No prepaid health plan or marketing organization shall solicit prospective enrollees on county premises for benefits or services available pursuant to this chapter except under any one of the following conditions:

(1) Such marketing activities are performed by a county employee under an agreement between the county and the prepaid health plan, and all marketing presentations and materials to be used have been approved by the department.

(2) Such marketing activities are performed by a state employee under an agreement between the department, county, and the prepaid health plan, and all marketing presentations and materials to be used have been approved by the department.

(3) Such marketing activities are performed by a marketing representative of a prepaid health plan under an agreement between the county, the prepaid health plan and the department, and all marketing presentations and materials to be used have been approved by the department.

(b) No prepaid health plan or marketing organization shall solicit prospective enrollees on state premises for benefits or services available pursuant to this chapter, except under any one of the following conditions:

(1) Such marketing activities are performed by a state employee under an agreement between the department, the Department of General Services, and the prepaid health plan, and all marketing presentations and materials to be used have been approved by the department.

(2) Such marketing activities are performed by a marketing representative of a prepaid health plan under an agreement between the department, the Department of General Services, and the prepaid health plan, and all marketing presentations and materials to be used have been approved by the department.

(Amended by Stats. 1977, Ch. 1036.)

14412. (a) The enrollment of a Medi-Cal beneficiary in the prepaid health plan shall not be terminated except for loss of eligibility, for good cause as determined by the department, or at the request of the beneficiary.

(b) Enrollment shall be terminated at the request of the Medi-Cal beneficiary, to the extent required by federal law.

(c) Any Medi-Cal beneficiary enrolled in a prepaid health plan who would remain eligible for Medi-Cal program benefits for three additional months pursuant to Section 14005.8 shall remain enrolled in the prepaid health plan and shall not receive a Medi-Cal card unless disenrollment is requested by the beneficiary, and the request is submitted in accordance with state and federal law.

(d) It is the intent of the Legislature that the department shall develop such policies and procedures to maximize continuity of care for persons enrolled in prepaid health plans and to insure that the eligibility determination or redetermination process does not unnecessarily interfere with such enrollment or create gaps in the delivery of health services.

(Amended by Stats. 1983, Ch. 822, Sec. 1.)

14413. (a) Requests for disenrollment shall be made to an authorized representative of the prepaid health plan or to the department. All requests for disenrollment, except those submitted pursuant to subdivision (c) of Section 14303.1, subdivision (c) of Section 14303.2, or paragraph (6) of subdivision (b) of Section 14409, or for other good cause as determined by the director, shall be processed through the prepaid health plan's grievance procedure as approved by the department. Disenrollment requests received by the prepaid health plan shall be submitted to the department, on standard disenrollment forms prescribed by the

department, within a reasonable time following the date of such signed request, as determined by the director, to permit the department to terminate enrollment effective the beginning of the first calendar month following a full calendar month after the request is made.

(b) All applications for disenrollment shall be processed by the department, and where Medi-Cal eligibility continues or Medi-Cal coverage is extended under Section 14005.8, a Medi-Cal card shall be issued effective not later than the beginning of the first calendar month following a full calendar month after the request for disenrollment is made. Submittal of a request for disenrollment for processing through the grievance procedure of a prepaid health plan shall not be deemed to infringe on this entitlement.

(Amended by Stats. 2020, Ch. 370, Sec. 287. (SB 1371) Effective January 1, 2021.)