INSURANCE CODE - INS

DIVISION 2. CLASSES OF INSURANCE [1880 - 12880.8] *(Division 2 enacted by Stats. 1935, Ch. 145.)*

PART 6.2. HEALTHY FAMILIES [12693 - 12694.2] *(Part 6.2 added by Stats. 1997, Ch. 623, Sec. 2.)*

CHAPTER 4. Administration [12693.25 - 12693.55] *(Chapter 4 added by Stats. 1997, Ch. 623, Sec. 2.)*

12693.25. The board may use a purchasing pool model, issuance of purchasing credits, supplemental coverage, or other means as appropriate to meet the purposes of this part.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.26. (a) The board shall establish a purchasing pool for coverage of program subscribers to enable applicants without access to affordable and comprehensive employer-sponsored dependent coverage to provide their eligible children with health, dental, and vision benefits. The board shall negotiate separate contracts with participating health, dental, and vision plans for each of the benefit packages described in Chapters 5 (commencing with Section 12693.60), 6 (commencing with Section 12693.63), and 7 (commencing with Section 12693.65).

(b) Notwithstanding any other provision of law, on and after January 1, 2011, the board may negotiate contracts with entities that are not participating health, dental, or vision plans, including, but not limited to, interagency agreements with the State Department of Health Care Services, to provide or pay for benefits to subscribers under this part, if necessary for any of the following purposes:

(1) To comply with Section 403 of the federal Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3) by applying paragraph (4) of subsection (a) of Section 1932 of the federal Social Security Act.

(2) To comply with Section 503 of the federal Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3) by applying subsection (bb) of Section 1902 of the federal Social Security Act.

(3) To ensure that subscribers have adequate access to benefits under this part.

(c) Any interagency agreement entered into by a state agency with the board pursuant to subdivision (b), and any other contract or contract amendment necessary to implement that agreement, shall be exempt from any provision of law relating to competitive bidding and from the review or approval of any division of the Department of General Services in the same manner as contracts entered into by the board are exempt pursuant to Section 12693.54.

(Amended by Stats. 2010, Ch. 717, Sec. 28. (SB 853) Effective October 19, 2010.)

12693.27. (a) The board shall develop a purchasing credit mechanism to enable applicants with access to affordable and comprehensive employer-sponsored dependent coverage to have an eligible child enrolled in the employer's health plan. Children enrolled in the purchasing credit mechanism may receive dental and vision benefits through the purchasing pool component of the program.

(b) In order to be eligible for a purchasing credit, the employer shall make a meaningful contribution toward the cost of coverage for an employee's dependents for whom an application is made for a purchasing credit. An employer's contribution, including any increases or decreases in the contribution made after the effective date of this part, may not vary among employees based on wage base or job classification.

(c) The board shall adopt appropriate mechanisms to recoup purchasing credit expenditures from an employer plan when the employees or dependents on behalf of whose coverage the payments are made are no longer enrolled in that plan.

(d) An employer utilizing a purchasing credit arrangement and a participating health plan receiving a purchasing credit must use 100 percent of the funds for the purchase of coverage for purchasing credit members including dependent coverage.

(e) A participating plan shall not assess the board for any portion of late fees, returned checks, or other fees in connection with an employer with group coverage who is also participating in the purchasing credit arrangement.

(f) An applicant may begin coverage for dependents using a purchasing credit arrangement at any time. Purchasing credit members enrolling in employer-sponsored coverage shall not be considered late enrollees for the purposes of subdivision (d) of Section 1357 and subdivision (b) of Section 1357.50 of the Health and Safety Code, and subdivision (b) of Section 10198.6 and subdivision (l) of Section 10700.

(g) Under no circumstances shall the employee's share of cost, including, deductibles, copayments, and coinsurance, for dependent coverage, including any supplemental coverage necessary to meet the 95 percent actuarial standard established in Section 12693.15 be more than that required as the employee's share of premium if the employee's children were enrolled in the purchasing pool component of the program.

(h) The board may limit participation in the purchasing credit program to those employers that provide employee health benefits through participation in public or private purchasing cooperatives.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.271. (a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to reduce General Fund expenditures.

(b) Notwithstanding any other provision of law, beginning the first day of the fifth month following the enactment of the 2008–09 Budget Act, the rates for the participating health, dental, and vision plans shall be set by reducing the rates that were in effect on July 1, 2007, by 5 percent, and by adjusting the July 1, 2007, rates downward to account for any reduction in the actuarial value of the benefits provided to subscribers as of the first day of the fifth month following the enactment of the 2008–09 Budget Act, associated with annual limitations on dental benefits. This requirement does not preclude the board from making other downward adjustments that it deems appropriate as a result of its annual rate negotiation process.

(Added by Stats. 2008, Ch. 758, Sec. 16. Effective September 30, 2008.)

12693.28. The program shall be administered without regard to gender, gender identity, gender expression, race, creed, color, sexual orientation, health status, disability, or occupation.

(Amended by Stats. 2011, Ch. 719, Sec. 28. (AB 887) Effective January 1, 2012.)

12693.29. (a) The board shall use appropriate and efficient means to notify families of the availability of health coverage from the program.

(b) The State Department of Health Services in conjunction with the board shall conduct a community outreach and education campaign in accordance with Section 14067 of the Welfare and Institutions Code to assist in notifying families of the availability of health coverage for their children.

(c) The board shall use appropriate materials, which may include brochures, pamphlets, fliers, posters, and other promotional items, to notify families of the availability of coverage through the program.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.30. (a) The board shall assure that written enrollment information issued or provided by the program is available to program subscribers and applicants in each of the languages identified pursuant to Chapter 17.5 (commencing with Section 7290) of Division 7 of Title 1 of the Government Code.

(b) The board shall assure that phone services provided to program subscribers and applicants by the program are available in all of the languages identified pursuant to Chapter 17.5 (commencing with Sec. 7290) of Division 7 of Title 1 of the Government Code.

(c) The board shall assure that interpreter services are available between subscribers and contracting plans. The board shall assure that subscribers are provided information within provider network directories of available linguistically diverse providers.

(d) The board shall assure that participating health, dental, and vision plans provide documentation on how they provide linguistically and culturally appropriate services, including marketing materials, to subscribers.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.31. No participating health, dental, or vision plan shall, in an area served by the program, directly, or through an employee, agent, or contractor, provide an applicant, or a child with any marketing material relating to benefits or rates provided under the program unless the material has been both reviewed and approved by the board.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.32. (a) The board may pay designated individuals or organizations an application assistance fee, if the individual or organization assists an applicant to complete the program application, and the applicant is enrolled in the program as a result of the application.

(b) The board may establish the list of eligible individuals, or categories of individuals and organizations, the amount of the application assistance payment, and rules necessary to assure the integrity of the payment process.

(c) The board, as part of its community outreach and education campaign, may include community-based face-to-face initiatives to educate potentially eligible applicants about the program and to assist potential applicants in the application process. Those entities undertaking outreach efforts shall not include as part of their responsibilities the selection of a health plan and provider for the applicant. Participating plans shall be prohibited from directly, indirectly, or through their agents conducting in-person, door-to-door, mail, or telephone solicitation of applicants for enrollment except through employers with employees eligible to participate in the purchasing credit mechanism. However, information approved by the board on the providers and plans available to prospective subscribers in their geographic areas shall be distributed through any door-to-door activities for potentially eligible applicants and their children.

(d) (1) All assistance offered to an individual applying to the program shall be free of charge. Except as provided in subdivision (a) or by a regulation adopted by the board, no individual or organization offering or providing assistance to an applicant to complete the program application shall solicit or receive any fee or remuneration from the applicant or subscriber for offering or providing that service.

(2) A person who violates this subdivision or a regulation adopted by the board pursuant to this subdivision, shall be assessed a civil penalty of five hundred dollars ($500) for each violation. For this purpose, a violation occurs each day a solicitation is published on an Internet Web site or is otherwise circulated to the public. This penalty is in addition to any other remedy or penalty provided by law. All penalties collected under this paragraph shall be deposited in the State Treasury to the credit of the Healthy Families Fund.

(3) A civil or administrative action brought under this article at the request of the board may be brought by the Attorney General in the name of the people of the State of California in a court of competent jurisdiction, or in a hearing through the Office of Administrative Hearings conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that when a civil action is to be filed in small claims court, the board may bring the action. The action shall be filed within three years of the date the board discovered the facts indicating a violation of this subdivision.

(Amended by Stats. 2004, Ch. 234, Sec. 1. Effective January 1, 2005.)

12693.325. (a) (1) Notwithstanding any provision of this chapter, a participating health, dental, or vision plan that is licensed and in good standing as required by subdivision (b) of Section 12693.36 may provide application assistance directly to an applicant acting on behalf of an eligible person who telephones, writes, or contacts the plan in person at the plan's place of business, or at a community public awareness event that is open to all participating plans in the county, or at any other site approved by the board, and who requests application assistance.

(2) A participating health, dental, or vision plan may also provide application assistance directly to an applicant only under the following conditions:

(A) The assistance is provided upon referral from a government agency, school, or school district.

(B) The applicant has authorized the government agency, school, or school district to allow a health, dental, or vision plan to contact the applicant with additional information on enrolling in free or low-cost health care.

(C) The State Department of Health Care Services approves the applicant authorization form in consultation with the board.

(D) The plan may not actively solicit referrals and may not provide compensation for the referrals.

(E) If a family is already enrolled in a health plan, the plan that contacts the family cannot encourage the family to change health plans.

(F) The board amends its marketing guidelines to require that when a government agency, school, or school district requests assistance from a participating health, dental, or vision plan to provide application assistance, that all plans in the area shall be invited to participate.

(G) The plan abides by the board's marketing guidelines.

(b) A participating health, dental, or vision plan may provide application assistance to an applicant who is acting on behalf of an eligible or potentially eligible child in any of the following situations:

(1) The child is enrolled in a Medi-Cal managed care plan and the participating plan becomes aware that the child's eligibility status has or will change and that the child will no longer be eligible for Medi-Cal. In those instances, the plan shall inform the applicant of the differences in benefits and requirements between the Healthy Families Program and the Medi-Cal program.

(2) The child is enrolled in a Healthy Families Program managed care plan and the participating plan becomes aware that the child's eligibility status has changed or will change and that the child will no longer be eligible for the Healthy Families Program. When it appears a child may be eligible for Medi-Cal benefits, the plan shall inform the applicant of the differences in benefits and requirements between the Medi-Cal program and the Healthy Families Program.

(3) The participating plan provides employer-sponsored coverage through an employer and an employee of that employer who is the parent or legal guardian of the eligible or potentially eligible child.

(4) The child and his or her family are participating through the participating plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law and the group continuation coverage will expire within 60 days, or has expired within the past 60 days.

(5) The child's family, but not the child, is participating through the participating plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law, and the group continuation coverage will expire within 60 days, or has expired within the past 60 days.

(c) A participating health, dental, or vision plan employee or other representative that provides application assistance shall complete a certified application assistant training class approved by the State Department of Health Care Services in consultation with the board. The employee or other representative shall in all cases inform an applicant verbally of his or her relationship with the participating health plan. In the case of an in-person contact, the employee or other representative shall provide in writing to the applicant the nature of his or her relationship with the participating health plan and obtain written acknowledgment from the applicant that the information was provided.

(d) A participating health, dental, or vision plan that provides application assistance may not do any of the following:

(1) Directly, indirectly, or through its agents, conduct door-to-door marketing or telephone solicitation.

(2) Directly, indirectly, or through its agents, select a health plan or provider for a potential applicant. Instead, the plan shall inform a potential applicant of the choice of plans available within the applicant's county of residence and specifically name those plans and provide the most recent version of the program handbook.

(3) Directly, indirectly, or through its agents, conduct mail or in-person solicitation of applicants for enrollment, except as specified in subdivision (b), using materials approved by the board.

(e) A participating health, dental, or vision plan that provides application assistance pursuant to this section is not eligible for an application assistance fee otherwise available pursuant to Section 12693.32, and may not sponsor a person eligible for the program by paying his or her family contribution amounts or copayments, and may not offer applicants any inducements to enroll, including, but not limited to, gifts or monetary payments.

(f) A participating health, dental, or vision plan may assist applicants acting on behalf of subscribers who are enrolled with the participating plan in completing the program's annual eligibility review package in order to allow those applicants to retain health care coverage.

(g) Each participating health, dental, or vision plan shall submit to the board a plan for application assistance. All scripts and materials to be used during application assistance sessions shall be approved by the board and the State Department of Health Care Services.

(h) Each participating health, dental, or vision plan shall provide each applicant with the toll-free telephone number for the Healthy Families Program.

(i) When deemed appropriate by the board, the board may refer a participating health, dental, or vision plan to the Department of Managed Health Care or the State Department of Health Care Services, as applicable, for the review or investigation of its application assistance practices.

(j) The board shall evaluate the impact of the changes required by this section and shall provide a biennial report to the Legislature on or before March 1 of every other year. To prepare these reports, the State Department of Health Care Services, in cooperation with the board, shall code all the application packets used by a managed care plan to record the number of applications received that originated from managed care plans. The number of applications received that originated from managed care plans shall also be reported on the board's Web site. In addition, the board shall periodically survey those families assisted by plans to determine if

the plans are meeting the requirements of this section, and if families are being given ample information about the choice of health, dental, or vision plans available to them.

(k) Nothing in this section shall be seen as mitigating a participating health, dental, or vision plan's responsibility to comply with all federal and state laws, including, but not limited to, Section 1320a-7b of Title 42 of the United States Code.

(Amended by Stats. 2007, Ch. 483, Sec. 38. Effective January 1, 2008.)

12693.326. Notwithstanding any other provision of this part, a new subscriber in the program shall be allowed to switch his or her choice of plans once within the first three months of coverage for any reason.

(Amended by Stats. 2004, Ch. 234, Sec. 3. Effective January 1, 2005.)

12693.33. To the extent feasible and permissible under federal law and with receipt of necessary federal approvals, the State Department of Health Services and the board shall develop a joint Medi-Cal and program application and enrollment form for children. The department shall seek any federal approval necessary to implement a combined application form.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.34. (a) The board may establish geographic areas within which participating health, dental, and vision plans may offer coverage to subscribers.

(b) Nothing in this section shall restrict a county organized health system or a local initiative from providing service to program subscribers in their licensed geographic service area.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.35. Participating health, dental, and vision plans shall have, but need not be limited to, all of the following operating characteristics satisfactory to the board in consultation with the plan's licensing or regulatory oversight agency:

(a) Strong financial condition, including the ability to assume the risk of providing and paying for covered services. A participating plan may utilize reinsurance, provider risk sharing, and other appropriate mechanisms to share a portion of the risk.

(b) Adequate administrative management.

(c) A satisfactory grievance procedure.

(d) Participating plans that contract with or employ health care providers shall have mechanisms to accomplish all of the following, in a manner satisfactory to the board:

(1) Review the quality of care covered.

(2) Review the appropriateness of care covered.

(3) Provide accessible health care services.

(e) (1) Before the effective date of the contract, the participating health plan shall have devised a system for identifying in a simple and clear fashion both in its own records and in the medical records of subscribers the fact that the services provided are provided under the program.

(2) Throughout the duration of the contract, the plan shall use the system described in paragraph (1).

(f) Plans licensed by the Department of Managed Health Care shall be deemed to meet the requirements of subdivisions (a) to (d), inclusive, of this section.

(Amended by Stats. 2015, Ch. 190, Sec. 67. (AB 1517) Effective January 1, 2016.)

12693.36. (a) Notwithstanding any other provision of law, the board shall not be subject to licensure or regulation by the Department of Insurance or the Department of Managed Health Care, as the case may be.

(b) Participating health, dental, and vision plans that contract with the program and are regulated by either the Insurance Commissioner or the Department of Managed Health Care shall be licensed and in good standing with their respective licensing agencies. In their application to the program, those entities shall provide assurance of their standing with the appropriate licensing entity.

(Amended by Stats. 2005, Ch. 80, Sec. 4. Effective July 19, 2005.)

12693.37. (a) The board shall contract with a broad range of health plans in an area, if available, to ensure that subscribers have a choice from among a reasonable number and types of competing health plans. The board shall develop and make available

objective criteria for health plan selection and provide adequate notice of the application process to permit all health plans a reasonable and fair opportunity to participate. The criteria and application process shall allow participating health plans to comply with their state and federal licensing and regulatory obligations, except as otherwise provided in this chapter. Health plan selection shall be based on the criteria developed by the board.

(b) (1) In its selection of participating plans the board shall take all reasonable steps to assure the range of choices available to each applicant, other than a purchasing credit member, shall include plans that include in their provider networks and have signed contracts with traditional and safety net providers.

(2) Participating health plans shall be required to submit to the board on an annual basis a report summarizing their provider network. The report shall provide, as available, information on the provider network as it relates to:

(A) Geographic access for the subscribers.

(B) Linguistic services.

(C) The ethnic composition of providers.

(D) The number of subscribers who selected traditional and safety net providers.

(c) (1) The board shall not rely solely on the Department of Managed Health Care's determination of a health plan network's adequacy or geographic access to providers in the awarding of contracts under this part. The board shall collect and review demographic, census, and other data to provide to prospective local initiatives, health plans, or specialized health plans, as defined in this act, specific provider contracting target areas with significant numbers of uninsured children in low-income families. The board shall give priority to those plans, on a county-by-county basis, that demonstrate that they have included in their prospective plan networks significant numbers of providers in these geographic areas.

(2) Targeted contracting areas are those ZIP Codes or groups of ZIP Codes or census tracts or groups of census tracts that have a percentage of uninsured children in low-income families greater than the overall percentage of uninsured children in low-income families in that county.

(d) In each geographic area, the board shall designate a community provider plan that is the participating health plan which has the highest percentage of traditional and safety net providers in its network. Subscribers selecting such a plan shall be given a family contribution discount as described in Section 12693.43.

(e) The board shall establish reasonable limits on health plan administrative costs.

(Amended by Stats. 2000, Ch. 857, Sec. 75. Effective January 1, 2001.)

12693.38. (a) The board shall contract with a sufficient number of dental and vision plans to assure that dental and vision benefits are available to all subscribers. The board shall develop and make available objective criteria for dental and vision plan selection and provide adequate notice of the application process to permit all dental and vision plans a reasonable and fair opportunity to participate. The criteria and application process shall allow participating dental and vision plans to comply with their state and federal licensing and regulatory obligations, except as otherwise provided in this part. Dental and vision plan selection shall be based on the criteria developed by the board.

(b) Participating dental plans shall be required to submit to the board on an annual basis a report summarizing their provider network. The report shall provide, as available, information on the provider network as it relates to each of the following:

(1) Geographic access for the subscribers.

(2) Linguistic services.

(3) The ethnic composition of providers.

(c) The board shall establish reasonable limits on dental plan administrative costs.

(Amended by Stats. 1998, Ch. 285, Sec. 1. Effective August 13, 1998.)

12693.39. The board shall establish a process for determining which employer-sponsored health plans are eligible to receive a purchasing credit issued by the program. The process shall assure that the benefits, copayments, coinsurance, and deductibles are no less than 95 percent actuarially equivalent to those provided to program subscribers enrolled in the purchasing pool.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.40. The board shall contract with health plans to provide coverage supplemental to that provided by an applicant's or applicant's spouse's employer-sponsored health plan for the purchasing credit member, if the employer-sponsored plan's benefits

are not 95 percent actuarially equivalent to those provided to subscribers. If supplemental coverage is available and provided, the plan may then, notwithstanding Section 12693.39, become eligible to receive purchasing credits.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.41. (a) The board shall consult and coordinate with the State Department of Health Services in implementing a preenrollment program into the Healthy Families Program or the Medi-Cal program pursuant to subdivision (b) of Section 14011.7 of the Welfare and Institutions Code. The board shall accept the followup application provided for in Section 14011.7 of the Welfare and Institutions Code as an application for the Healthy Families Program. Preenrollment shall be administered by the State Department of Health Services to provide full-scope benefits pursuant to Medi-Cal program requirements, at no cost to the applicant.

(b) The board may use the state fiscal intermediary for medicaid to process the eligibility determinations and payments required pursuant to Section 14011.7 of the Welfare and Institutions Code.

(c) The board shall be exempt from the requirements of Chapter 7 (commencing with Section 11700) of Division 3 of Title 2 of the Government Code and Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code as those requirements apply to the use of processing services by the state fiscal intermediary.

(d) The board may adopt emergency regulations to implement preenrollment into the Healthy Families Program or the Medi-Cal program pursuant to Section 14011.7 of the Welfare and Institutions Code. The emergency regulations shall include, but not be limited to, regulations that implement any changes in rules relating to eligibility, enrollment, and disenrollment in the programs pursuant to Sections 12693.45 and 12693.70. The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and one readoption of those regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and each shall remain in effect for no more than 180 days.

(e) This section shall become operative on April 1, 2003.

(Repealed (in Sec. 19) and added by Stats. 2002, Ch. 1161, Sec. 20. Effective September 30, 2002. Section operative April 1, 2003, by its own provisions.)

12693.42. Any purchasing credit issued by the board, or a contractor acting on behalf of the board, pursuant to this part shall have an overall cost to the program no greater than the cost to the program to enroll the subscriber in the lowest cost plan available to the subscriber through the purchasing pool. Administrative costs and the cost to the program of any supplemental product shall be included in the calculation of the cost of the purchasing credit program and deducted from the amount of the purchasing credit.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.43. (a) Applicants applying to the purchasing pool shall agree to pay family contributions, unless the applicant has a family contribution sponsor. Family contribution amounts consist of the following two components:

(1) The flat fees described in subdivision (b) or (d).

(2) Any amounts that are charged to the program by participating health, dental, and vision plans selected by the applicant that exceed the cost to the program of the highest cost Family Value Package in a given geographic area.

(b) In each geographic area, the board shall designate one or more Family Value Packages for which the required total family contribution is:

(1) Seven dollars ($7) per child with a maximum required contribution of fourteen dollars ($14) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) (A) Nine dollars ($9) per child with a maximum required contribution of twenty-seven dollars ($27) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(B) Commencing the first day of the fifth month following the enactment of the 2008–09 Budget Act, the family contribution pursuant to this paragraph shall be twelve dollars ($12) per child with a maximum required contribution of thirty-six dollars ($36) per month per family.

(C) Commencing November 1, 2009, the family contribution pursuant to this paragraph shall be sixteen dollars ($16) per child with a maximum required contribution of forty-eight dollars ($48) per month per family.

(D) Subject to prior federal authorization, the family contribution pursuant to this paragraph shall be thirty dollars ($30) per child with a maximum required contribution of ninety dollars ($90) per month per family, or any lesser increase in family contributions as is authorized by the federal Department of Health and Human Services. The family contribution required by this subparagraph shall commence the first day of the third month following the later of the following:

(i) The effective date of the act adding this subparagraph.

(ii) Receipt of federal authorization for the contribution in the form of an approved amendment to California's state plan under Title XXI of the federal Social Security Act or a waiver of one or more requirements of Title XXI of the federal Social Security Act.

(3) (A) On and after July 1, 2005, fifteen dollars ($15) per child with a maximum required contribution of forty-five dollars ($45) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this subparagraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this subparagraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(B) Commencing the first day of the fifth month following the enactment of the 2008–09 Budget Act, the family contribution pursuant to this paragraph shall be seventeen dollars ($17) per child with a maximum required contribution of fifty-one dollars ($51) per month per family.

(C) Commencing November 1, 2009, the family contribution pursuant to this paragraph shall be twenty-four dollars ($24) per child with a maximum required contribution of seventy-two dollars ($72) per month per family.

(D) Subject to prior federal authorization, the family contribution pursuant to this paragraph shall be forty-two dollars ($42) per child with a maximum required contribution of one hundred twenty-six dollars ($126) per month per family, or any lesser increase in family contributions as is authorized by the federal Department of Health and Human Services. The family contribution required by this subparagraph shall commence the first day of the third month following the later of the following:

(i) The effective date of the act adding this subparagraph.

(ii) Receipt of federal authorization for the contribution in the form of an approved amendment to California's state plan under Title XXI of the federal Social Security Act or a waiver of one or more requirements of Title XXI of the federal Social Security Act.

(c) Combinations of health, dental, and vision plans that are more expensive to the program than the highest cost Family Value Package may be offered to and selected by applicants. However, the cost to the program of those combinations that exceeds the price to the program of the highest cost Family Value Package shall be paid by the applicant as part of the family contribution.

(d) The board shall provide a family contribution discount to those applicants who select the health plan in a geographic area that has been designated as the Community Provider Plan. The discount shall reduce the portion of the family contribution described in subdivision (b) to the following:

(1) A family contribution of four dollars ($4) per child with a maximum required contribution of eight dollars ($8) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) (A) Six dollars ($6) per child with a maximum required contribution of eighteen dollars ($18) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(B) Commencing the first day of the fifth month following the enactment of the 2008–09 Budget Act, the family contribution pursuant to this paragraph shall be nine dollars ($9) per child with a maximum required contribution of twenty-seven dollars ($27) per month per family.

(C) Commencing November 1, 2009, the family contribution pursuant to this paragraph shall be thirteen dollars ($13) per child with a maximum required contribution of thirty-nine dollars ($39) per month per family.

(D) Subject to prior federal authorization, the family contribution pursuant to this paragraph shall be twenty-seven dollars ($27) per child with a maximum required contribution of eighty-one dollars ($81) per month per family, or any lesser increase in

family contributions as is authorized by the federal Department of Health and Human Services. The family contribution required by this subparagraph shall commence the first day of the third month following the later of the following:

(i) The effective date of the act adding this subparagraph.

(ii) Receipt of federal authorization for the contribution in the form of an approved amendment to California's state plan under Title XXI of the federal Social Security Act or a waiver of one or more requirements of Title XXI of the federal Social Security Act.

(3) (A) On and after July 1, 2005, twelve dollars ($12) per child with a maximum required contribution of thirty-six dollars ($36) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this subparagraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this subparagraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(B) Commencing the first day of the fifth month following the enactment of the 2008–09 Budget Act, the family contribution pursuant to this paragraph shall be fourteen dollars ($14) per child with a maximum required contribution of forty-two dollars ($42) per month per family.

(C) Commencing November 1, 2009, the family contribution pursuant to this paragraph shall be twenty-one dollars ($21) per child with a maximum required contribution of sixty-three dollars ($63) per month per family.

(D) Subject to prior federal authorization, the family contribution pursuant to this paragraph shall be thirty-nine dollars ($39) per child with a maximum required contribution of one hundred seventeen dollars ($117) per month per family, or any lesser increase in family contributions as is authorized by the federal Department of Health and Human Services. The family contribution required by this subparagraph shall commence the first day of the third month following the later of the following:

(i) The effective date of the act adding this subparagraph.

(ii) Receipt of federal authorization for the contribution in the form of an approved amendment to California's state plan under Title XXI of the federal Social Security Act or a waiver of one or more requirements of Title XXI of the federal Social Security Act.

(e) Applicants, but not family contribution sponsors, who pay three months of required family contributions in advance shall receive the fourth consecutive month of coverage with no family contribution required.

(f) Applicants, but not family contribution sponsors, who pay the required family contributions by an approved means of electronic fund transfer shall receive a 25-percent discount from the required family contributions.

(g) It is the intent of the Legislature that the family contribution amounts described in this section comply with the premium cost-sharing limits contained in Section 2103 of Title XXI of the Social Security Act. If the amounts described in subdivision (a) are not approved by the federal government, the board may adjust these amounts to the extent required to achieve approval of the state plan.

(h) The adoption and one readoption of regulations to implement paragraph (3) of subdivision (b) and paragraph (3) of subdivision (d) shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health, and safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe specific facts showing the need for immediate action and from review by the Office of Administrative Law. For purpose of subdivision (e) of Section 11346.1 of the Government code, the 120-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to 180 days.

(i) The board may adopt, and may only one time readopt, regulations to implement the changes to this section that are effective the first day of the fifth month following the enactment of the 2008–09 Budget Act. The adoption and one-time readoption of a regulation authorized by this section is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted for this purpose from the requirements of subdivision (b) of Section 11346.1 of the Government Code.

(j) The program shall provide prior notice to any applicant for a subscriber whose premium will increase as a result of amendments made to this section and shall provide the applicant with an opportunity to demonstrate that, based on reduced family income, the

subscriber is subject to a lower premium pursuant to this section.

(k) The adoption and readoption, by the board, of regulations to implement the changes made to this section by the act that added this subdivision shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(Amended by Stats. 2011, Ch. 3, Sec. 1. (AB 97) Effective March 24, 2011.)

12693.44. (a) The board shall establish family contribution amounts for purchasing credit members that are equivalent to the amounts charged to subscribers participating in the purchasing pool portion of the program. Purchasing credit members shall not be required to pay family contribution amounts greater than the cost to the applicant if the purchasing credit members were enrolled in the purchasing pool component of the program. When calculating the cost to the applicant to participate in the purchasing pool, the family contribution discounts provided in subdivisions (c), (d), and (e) of Section 12693.34 shall not be considered. Purchasing credit members shall be eligible for dental and vision coverage through the purchasing pool at no additional premium charge.

(b) The family contribution amounts paid on behalf of a purchasing credit member may be paid directly to the applicant's employer through a payroll deduction or other mechanism.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.45. (a) After two consecutive months of nonpayment of family contributions by an applicant, and a reasonable written notice period of no less than 30 days is provided to the applicant, subscribers or purchasing credit members may be disenrolled for an applicant's failure to pay family contributions. The board may impose or contract for collection actions to collect unpaid family contributions.

(b) Subject to any additional requirements of federal law, disenrollments shall be effective at the end of the second consecutive month of nonpayment.

(Amended by Stats. 2002, Ch. 1161, Sec. 22. Effective September 30, 2002.)

12693.46. The board may prohibit applicants who drop coverage after enrolling in the pool from reenrollment in the program for up to six months.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.47. The program may place a lien on compensation or benefits, recovered or recoverable by a subscriber or applicant from any party or parties responsible for the compensation or benefits for which benefits have been provided under a policy issued under this part.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.48. The board may adjust payments made to a participating health plan if the board finds that the plan has a significantly disproportionate share of high- or low-risk subscribers. Prior to making this finding, the program shall obtain validated data from participating health plans. Reporting requirements shall be administratively compatible with the methods of operation of the health plans. Any adjustments to payments shall utilize demographic and other factors which are actuarially related to risk.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.49. (a) When an applicant is dissatisfied with any action or inaction of a participating plan in which a subscriber is enrolled through the purchasing pool, the applicant shall first attempt to resolve the dispute with the participating plan according to its established policies and procedures.

(b) The board shall assure that all participating health, dental, and vision plans make subscribers aware of the regulatory oversight available to the applicant by the participating health, dental, or vision plan's licensing or state oversight entity.

(c) The board shall assure that all participating health, dental, and vision plans report to the board, at least once a year, the number and types of benefit grievances filed by applicants on behalf of subscribers in the program. This information shall be available to applicants upon request in a format determined by the board.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.50. (a) The board shall consult and coordinate with the State Department of Health Services to implement the Medi-Cal to Healthy Families Accelerated Enrollment program pursuant to Section 14011.65 of the Welfare and Institutions Code.

(b) The state shall seek approval of any amendments to the state plan, necessary to implement Section 14011.65 of the Welfare and Institutions Code in accordance with Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.). Notwithstanding any other

provision of law, only when all necessary federal approvals have been obtained shall Section 14011.65 of the Welfare and Institutions Code be implemented.

(c) The board may adopt emergency regulations to implement the provision of accelerated eligibility benefits pursuant to this section and as described under Section 14011.65 of the Welfare and Institutions Code. The emergency regulations shall include, but not be limited to, regulations that implement any changes in rules relating to program eligibility, enrollment, and disenrollment. The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and one readoption of those regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations, and each shall remain in effect for no more than 180 days.

(Added by Stats. 2005, Ch. 80, Sec. 4.5. Effective July 19, 2005.)

12693.51. (a) A transfer of enrollment from one participating health plan to another may be made by a subscriber at times and under conditions as may be prescribed by regulations of the board.

(b) The board shall provide for the transfer of coverage of any subscriber to another participating plan (1) if a contract with any participating plan under which the subscriber receives coverage is canceled or not renewed and (2) at least once a year upon request in a manner as determined by the board, and (3) if a subscriber moves to an area that the current health plan does not serve.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.515. (a) Effective July 1, 2004, any subscriber who affirmatively selects, or is assigned by default to, a federally qualified health center, as defined by Section 1396(d)(l)(2) of Title 42 of the United States Code, a rural health clinic, as defined by Section 1396(d)(l)(1) of Title 42 of the United States Code, or a primary care clinic that is licensed under Section 1204 of the Health and Safety Code, or is exempt from licensure under subdivision (h) of Section 1206 of the Health and Safety Code, shall be deemed to have been assigned directly to the federally qualified health center, the rural health clinic, or the primary care clinic, and not to any individual provider who performs services on behalf of the federally qualified health center, the rural health clinic, or the primary care clinic.

(b) (1) When a subscriber is assigned, from any source, to a physician who is an employee of a federally qualified health center, a rural health clinic, or a primary care clinic, the assignment shall constitute an assignment to that federally qualified health center, rural health clinic, or primary care clinic for purposes of the subscriber's health care coverage.

(2) When a subscriber is assigned, from any source, to a dentist who is an employee of a federally qualified health center, a rural health clinic, or a primary care clinic, the assignment shall constitute an assignment to that federally qualified health center, rural health clinic, or primary care clinic for purposes of the subscriber's dental coverage.

(3) When a subscriber is assigned, from any source, to an optometrist who is an employee of a federally qualified health center, a rural health clinic, or a primary care clinic, the assignment shall constitute an assignment to that federally qualified health center, rural health clinic, or primary care clinic for purposes of the subscriber's vision coverage.

(c) This section shall not limit any rights a subscriber may have to select an available primary care physician within a health care service plan's service area pursuant to Section 1373.3 of the Health and Safety Code.

(Added by Stats. 2003, Ch. 139, Sec. 1. Effective January 1, 2004.)

12693.52. The board may negotiate or arrange for stop-loss insurance coverage that limits the program's fiscal responsibility for the total costs of health services provided to program subscribers, or arrange for participating health plans to share or assure the financial risk for a portion of the total cost of health care services to program subscribers, or both.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.53. The board shall develop and utilize appropriate cost containment measures to maximize the coverage offered under the program. Those measures may include limiting the expenditure of state funds for this purpose to the price to the state for the lowest cost plan contracting with the program and creation of program rules that restrict the ability of employers or applicants to drop existing coverage in order to qualify children for the program.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.54. A contract entered pursuant to this part shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The board shall not be required

to specify the amounts encumbered for each contract, but may allocate funds to each contract based on the projected or actual subscriber enrollments to a total amount not to exceed the amount appropriate for the program including family contributions.

(Added by Stats. 1997, Ch. 623, Sec. 2. Effective January 1, 1998.)

12693.55. (a) A health care provider who is furnished documentation of a person's enrollment in the program shall not seek reimbursement nor attempt to obtain payment for any covered services provided to that person other than from the participating health plan covering that person or from other entities that the board enters into contracts or interagency agreements with to provide or pay for benefits under this part pursuant to Section 12693.26.

(b) The provisions of subdivision (a) do not apply to any copayments required under this part for the covered services provided to the person.

(c) For purposes of this section, "health care provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(Amended by Stats. 2011, Ch. 29, Sec. 1. (AB 102) Effective June 29, 2011.)