HEALTH AND SAFETY CODE - HSC

DIVISION 2. LICENSING PROVISIONS [1200 - 1796.70] *(Division 2 enacted by Stats. 1939, Ch. 60.)*

CHAPTER 2.2. Health Care Service Plans [1340 - 1399.874] *(Chapter 2.2 added by Stats. 1975, Ch. 941.)*

ARTICLE 9. Miscellaneous [1395 - 1399.5] *(Article 9 added by Stats. 1975, Ch. 941.)*

1395. (a) Notwithstanding Article 6 (commencing with Section 650) of Chapter 1 of Division 2 of the Business and Professions Code, any health care service plan or specialized health care service plan may, except as limited by this subdivision, solicit or advertise with regard to the cost of subscription or enrollment, facilities and services rendered, provided, however, Article 5 (commencing with Section 600) of Chapter 1 of Division 2 of the Business and Professions Code remains in effect. Any price advertisement shall be exact, without the use of such phrases as “as low as,” “and up,” “lowest prices” or words or phrases of similar import. Any advertisement that refers to services, or costs for the services, and that uses words of comparison must be based on verifiable data substantiating the comparison. Any health care service plan or specialized health care service plan so advertising shall be prepared to provide information sufficient to establish the accuracy of the comparison. Price advertising shall not be fraudulent, deceitful, or misleading, nor contain any offers of discounts, premiums, gifts, or bait of similar nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

(b) Plans licensed under this chapter shall not be deemed to be engaged in the practice of a profession, and may employ, or contract with, any professional licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code to deliver professional services. Employment by or a contract with a plan as a provider of professional services shall not constitute a ground for disciplinary action against a health professional licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code by a licensing agency regulating a particular health care profession.

(c) A health care service plan licensed under this chapter may directly own, and may directly operate through its professional employees or contracted licensed professionals, offices and subsidiary corporations, including pharmacies that satisfy the requirements of subdivision (d) of Section 4080.5 of the Business and Professions Code, as are necessary to provide health care services to the plan’s subscribers and enrollees.

(d) A professional licensed pursuant to the provisions of Division 2 (commencing with Section 500) of the Business and Professions Code who is employed by, or under contract to, a plan may not own or control offices or branch offices beyond those expressly permitted by the provisions of the Business and Professions Code.

(e) Nothing in this chapter shall be construed to repeal, abolish, or diminish the effect of Section 129450 of the Health and Safety Code.

(f) Except as specifically provided in this chapter, nothing in this chapter shall be construed to limit the effect of the laws governing professional corporations, as they appear in applicable provisions of the Business and Professions Code, upon specialized health care service plans.

(g) No representative of a participating health, dental, or vision plan or its subcontractor representative shall in any manner use false or misleading claims to misrepresent itself, the plan, the subcontractor, or the Healthy Families or Medi-Cal program while engaging in application assistance activities that are subject to this section. Notwithstanding any other provision of this chapter, any representative of the health, dental, or vision care plan or of the health, dental, or vision care plan’s subcontractor who violates any of the provisions of Section 12693.325 of the Insurance Code shall only be subject to a fine of five hundred dollars ($500) for each of those violations.

(h) A health care service plan shall comply with Section 12693.325 of the Insurance Code and Section 14409 of the Welfare and Institutions Code. In addition to any other disciplinary powers provided by this chapter, if a health care service plan violates any of the provisions of Section 12693.325 of the Insurance Code, the department may prohibit the health care service plan from providing application assistance and contacting applicants pursuant to Section 12693.325 of the Insurance Code.

(Amended by Stats. 2001, Ch. 171, Sec. 2. Effective August 10, 2001.)

1395.5. (a) Except as provided in subdivisions (b) and (c), no contract that is issued, amended, renewed, or delivered on or after January 1, 1999, between a health care service plan, including a specialized health care service plan, and a provider shall contain provisions that prohibit, restrict, or limit the health care provider from advertising.

(b) Nothing in this section shall be construed to prohibit plans from establishing reasonable guidelines in connection with the activities regulated pursuant to this chapter, including those to prevent advertising that is, in whole or in part, untrue, misleading, deceptive, or otherwise inconsistent with this chapter or the rules and regulations promulgated thereunder. For advertisements mentioning a provider's participation in a plan, nothing in this section shall be construed to prohibit plans from requiring each advertisement to contain a disclaimer to the effect that the provider's services may be covered for some, but not all, plan contracts, or that plan contracts may cover some, but not all, provider services.

(c) Nothing in this section is intended to prohibit provisions or agreements intended to protect service marks, trademarks, trade secrets, or other confidential information or property. If a health care provider participates on a provider panel or network as a result of a direct contractual arrangement with a health care service plan that, in turn, has entered into a direct contractual arrangement with another person or entity, pursuant to which enrollees, subscribers, insureds, and other beneficiaries of that other person or entity may receive covered services from the health care provider, then nothing in this section is intended to prohibit reasonable provisions or agreements in the direct contractual arrangement between the health care provider and the health care service plan that protect the name or trade name of the other person or entity or require that the health care provider obtain the consent of the health care service plan prior to the use of the name or trade name of the other person or entity in any advertising by the health care provider.

(d) Nothing in this section shall be construed to impair or impede the authority of the director to regulate advertising, disclosure, or solicitation pursuant to this chapter.

(Amended by Stats. 1999, Ch. 525, Sec. 150. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1395.6. (a) In order to prevent the improper selling, leasing, or transferring of a health care provider's contract, it is the intent of the Legislature that every arrangement that results in a payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel shall be disclosed to the provider in advance and that the payor shall actively encourage beneficiaries to use the network, unless the health care provider agrees to provide discounts without that active encouragement.

(b) Beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor, as defined in subparagraph (A) of paragraph (3) of subdivision (d), or another contracting agent shall, upon entering or renewing a provider contract, do all of the following:

(1) Disclose to the provider whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents, and specify whether those payors or contracting agents include workers' compensation insurers or automobile insurers.

(2) Disclose what specific practices, if any, payors utilize to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate. For purposes of this paragraph, a payor is deemed to have actively encouraged its beneficiaries to use the list of contracted providers if one of the following occurs:

(A) The payor's contract with subscribers or insureds offers beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information to its beneficiaries, who are parties to the contract, or, in the case of workers' compensation insurance, the employer, advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to beneficiaries in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or Internet web site addresses supplied directly to every beneficiary. However, internet web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of a beneficiary.

(3) Disclose whether payors to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the payors' beneficiaries to use the list of contracted

providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.

(4) Disclose, upon the initial signing of a contract, and within 30 calendar days of receipt of a written request from a provider or provider panel, a payor summary of all payors currently eligible to claim a provider's contracted rate due to the provider's and payor's respective written agreement with any contracting agent.

(5) Allow providers, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care as described in paragraph (2). Each provider's election under this paragraph shall be binding on the contracting agent with which the provider has the contract and any contracting agent that buys, leases, or otherwise obtains the list of contracted providers. A provider shall not be excluded from any list of contracted providers that is sold, leased, transferred, or conveyed to payors that actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care, based upon the provider's refusal to be included on any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care.

(6) Nothing in this subdivision shall be construed to impose requirements or regulations upon payors, as defined in subparagraph (A) of paragraph (3) of subdivision (d).

(c) Beginning July 1, 2000, a payor, as defined in subparagraph (B) of paragraph (3) of subdivision (d), shall do all of the following:

(1) Provide an explanation of benefits or explanation of review that identifies the name of the network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered.

(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. The failure of a payor to make the demonstration within 30 business days shall render the payor responsible for the amount that the payor would have been required to pay pursuant to the applicable health care service plan contract, including a specialized health care service plan contract, covering the beneficiary, which amount shall be due and payable within 10 business days of receipt of written notice from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this paragraph. A payor shall be deemed to have demonstrated that it is entitled to pay a contracted rate if it complies with either of the following:

(A) Discloses the name of the network that has a written agreement with the provider whereby the provider agrees to accept discounted rates, and describes the specific practices the payor utilizes to comply with paragraph (2) of subdivision (b).

(B) Identifies the provider's written agreement with a contracting agent whereby the provider agrees to be included on lists of contracted providers sold, leased, transferred, or conveyed to payors that do not actively encourage beneficiaries to use the list of contracted providers pursuant to paragraph (5) of subdivision (b).

(d) For the purposes of this section, the following terms have the following meanings:

(1) "Beneficiary" means:

(A) For workers' compensation insurance, an employee seeking health care services for a work-related injury.

(B) For automobile insurance, those persons covered under the medical payments portion of the insurance contract.

(C) For group or individual health services covered through a health care service plan contract, including a specialized health care service plan contract, or a policy of disability insurance that covers hospital, medical, or surgical benefits, a subscriber, an enrollee, a policyholder, or an insured.

(2) "Contracting agent" means a health care service plan, including a specialized health care service plan, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying, a provider or provider panel to payors to provide health care services to beneficiaries.

(3) (A) For the purposes of subdivision (b), "payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries.

(B) For the purposes of subdivision (c), "payor" means only a health care service plan, including a specialized health care service plan that has purchased, leased, or otherwise obtained the use of a provider or provider panel to provide health care

services to beneficiaries pursuant to a contract that authorizes payment at discounted rates.

(4) "Payor summary" means a written summary that includes the payor's name and the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan.

(5) "Provider" means any of the following:

(A) Any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) Any person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) Any person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200).

(E) Any entity exempt from licensure pursuant to Section 1206.

(e) This section shall become operative on July 1, 2000.

(Amended by Stats. 2000, Ch. 1069, Sec. 2. Effective January 1, 2001.)

1395.7. (a) A staff-model dental health care service plan that arranges for or establishes credit extended by a third party shall establish and comply with policies and procedures that ensure that its dentists, employees, and agents, and employees or agents of its dentists, comply with Section 654.3 of the Business and Professions Code.

(b) A staff-model dental health care service plan that arranges for or establishes credit extended by a third party shall establish and comply with policies and procedures that ensure that, within 15 business days of an enrollee's request, the plan refunds to a lender any payment received through that credit for treatment that has not been rendered or costs that have not been incurred.

(c) A staff-model dental health care service plan that directly extends credit or establishes a payment plan shall, at a minimum, establish and comply with policies and procedures that ensure that, within 15 business days of an enrollee's request, the plan refunds to the enrollee any payment received through that credit or payment plan for treatment that has not been rendered or costs that have not been incurred.

(d) For purposes of this section, the following definitions shall apply:

(1) "Staff-model dental health care service plan" means a specialized health care service plan that contracts to provide coverage for dental care services and that retains dentists as employees to care for its enrollees.

(2) "Enrollee" includes, but is not limited to, an enrollee's parent or other legal representative.

(Added by Stats. 2009, Ch. 418, Sec. 2. (AB 171) Effective January 1, 2010.)

1396. It is unlawful for any person willfully to make any untrue statement of material fact in any application, notice, amendment, report, or other submission filed with the director under this chapter or the regulations adopted thereunder, or willfully to omit to state in any application, notice, or report any material fact which is required to be stated therein.

(Amended by Stats. 1999, Ch. 525, Sec. 151. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1396.5. A nonprofit hospital corporation which substantially indemnified subscribers and enrollees and was operating in 1965 under Chapter 11A (commencing with Section 11490) of Part 2 of Division 2 of the Insurance Code and which is regulated under the Knox-Keene Health Care Service Plan Act shall enjoy the privileges under the act which would have been available to it had it been registered under the Knox-Mills Health Plan Act and applied for a license under the Knox-Keene Health Care Service Plan Act in 1976.

(Added by Stats. 1990, Ch. 1043, Sec. 10.)

1397. (a) Whenever reference is made in this chapter to a hearing before or by the director, the hearing shall be held in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and the director shall have all of the powers granted under that act.

(b) Every final order, decision, license, or other official act of the director under this chapter is subject to judicial review in accordance with the law.

(Amended by Stats. 1999, Ch. 525, Sec. 152. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1397.5. (a) The director shall make and file annually with the Department of Managed Health Care as a public record, an aggregate summary of grievances against plans filed with the director by enrollees or subscribers. This summary shall include at least all of the following information:

(1) The total number of grievances filed.

(2) The types of grievances.

(b) The summary set forth in subdivision (a) shall include the following disclaimer:

"THIS INFORMATION IS PROVIDED FOR STATISTICAL PURPOSES ONLY. THE DIRECTOR OF THE DEPARTMENT OF MANAGED CARE HAS NEITHER INVESTIGATED NOR DETERMINED WHETHER THE GRIEVANCES COMPILED WITHIN THIS SUMMARY ARE REASONABLE OR VALID."

(c) Nothing in this section shall require or authorize the disclosure of grievances filed with or received by the director and made confidential pursuant to any other provision of law including, but not limited to, the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code) and the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code). Nothing in this section shall affect any other provision of law including, but not limited to, the California Public Records Act and the Information Practices Act of 1977.

(Amended by Stats. 2021, Ch. 615, Sec. 229. (AB 474) Effective January 1, 2022. Operative January 1, 2023, pursuant to Sec. 463 of Stats. 2021, Ch. 615.)

1397.6. The director may contract with necessary medical consultants to assist with the health care program. These contracts shall be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(Amended by Stats. 1999, Ch. 525, Sec. 154. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1398.5. All references to the Knox-Mills Health Plan Act (Article 2.5 (commencing with Section 12530) of Chapter 6 of Part 2 of Division 3 of the Government Code), which was repealed by Chapter 941 of the Statutes of 1975, shall be deemed to be references to the Knox-Keene Health Care Service Plan Act of 1975.

(Added by Stats. 1976, Ch. 490.)

1399. (a) Surrender of a license as a health plan becomes effective 30 days after receipt of an application to surrender the license or within a shorter period of time as the director may determine, unless a revocation or suspension proceeding is pending when the application is filed or a proceeding to revoke or suspend or to impose conditions upon the surrender is instituted within 30 days after the application is filed. If this proceeding is pending or instituted, surrender becomes effective at the time and upon the conditions as the director by order determines.

(b) If the director finds that any plan is no longer in existence, or has ceased to do business or has failed to initiate business activity as a licensee within six months after licensure, or cannot be located after reasonable search, the director may by order summarily revoke the license of the plan.

(c) The director may summarily suspend or revoke the license of a plan upon (1) failure to pay any fee required by this chapter within 15 days after notice by the director that the fee is due and unpaid, (2) failure to file any amendment or report required under this chapter within 15 days after notice by the director that the report is due, (3) failure to maintain any bond or insurance pursuant to Section 1376, (4) failure to maintain a deposit, insurance, or guaranty arrangement pursuant to Section 1377, or (5) failure to maintain a deposit pursuant to Section 1300.76.1 of Title 28 of the California Code of Regulations.

(Amended by Stats. 2009, Ch. 298, Sec. 9. (AB 1540) Effective January 1, 2010.)

1399.1. (a) All orders and other actions taken by the Commissioner of Corporations pursuant to the authority contained in subdivision (c) of Section 1350 on or before September 30, 1977, and all administrative or judicial decisions or orders relating to the same and all conditions imposed upon the same remain in effect against a plan holding a transitional license.

(b) The Knox-Mills Health Plan Act as in effect prior to its repeal continues to govern all suits, actions, prosecutions or proceedings which are pending or which may be initiated under subdivision (c) of Section 1350 on the basis of facts or circumstances occurring on or before September 30, 1977.

(Amended by Stats. 1999, Ch. 525, Sec. 157. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1399.3. (a) A material change made by a health care service plan, as defined in subdivision (f) of Section 1345, to the terms and conditions of a contract between the health care service plan and a solicitor shall not become effective until the health care service plan has delivered to the solicitor, at least 45 days prior to the effective date of the change, written or electronic notice indicating the

change or changes to the contract. For purposes of this section, a “material change” is a change made to a provision of the contract affecting any of the following:

(1) Commissions, bonuses, and incentives paid to the solicitor.

(2) Right of survivorship.

(3) Indemnification of the solicitor by the health care service plan.

(4) Errors and omissions coverage requirements for the solicitor.

(b) Subdivision (a) shall not apply under either of the following circumstances:

(1) The change to the contract is mutually agreed upon by the health care service plan and the solicitor.

(2) The change to the contract is required by state or federal law.

(Added by Stats. 2015, Ch. 482, Sec. 1. (AB 1163) Effective January 1, 2016.)

1399.5. It is the intent of the Legislature that the provisions of this chapter shall be applicable to any private or public entity or political subdivision which, in return for a prepaid or periodic charge paid by or on behalf of a subscriber or enrollee, provides, administers or otherwise arranges for the provision of health care services, as defined in this chapter, unless such entity is exempted from the provisions of this chapter by, or pursuant to, Section 1343.

(Amended by Stats. 1980, Ch. 628.)