1300.67.2.1 Geographic Accessibility Standards

Subject to subsections (a) and (b) of this section, a plan may rely, for the purposes of satisfying the requirements for geographic accessibility, on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2 .

(a)

If, given the facts and circumstances with regard to any portion of its service area, a plan's standards of accessibility adopted pursuant to Item H of Section 1300.51 and/or Section 1300.67.2 are unreasonably restrictive, or the service area is within a county with a population of 500,000 or fewer, and is within a county that, as of January 1, 2002, has two or fewer full service health care service plans in the commercial market, the plan may propose alternative standards of accessibility for that portion of its service area. The plan shall do so by including such alternative standards in writing in its plan license application or in a notice of material modification. The plan shall also include a description of the reasons justifying the less restrictive standards based on those facts and circumstances. If the Department rejects the plan's proposal, the Department shall inform the plan of the Department's reason for doing so.

(b)

If, in its review of a plan license application or a notice of material modification, the Department believes the accessibility standards set forth in Item H of Section 1300.51 and/or Section 1300.67.2 are insufficiently prescribed or articulated or

are inappropriate given the facts and circumstances with regard to a portion of a plan's service area, the Department shall inform the plan that the Department will not allow application of those standards to that portion of the plan's service area. The Department shall also inform the plan of the Department's reasons for rejecting the application of those standards.

(c)

The facts and circumstances to be included in a discussion of the reasons justifying the standards of accessibility proposed by the plan pursuant to subsection (a) or (b) of this section shall include, to the extent relevant, but shall not necessarily be limited to the following: (1) whether the plan contract involved is a group health care service plan contract or an individual health care service plan contract; (2) whether the plan contract is a full-service health care service plan contract or a specialized health care service plan contract, and if the latter, whether emergency services need not be covered; (3) the uniqueness of the services to be offered; (4) whether the portion of the service area involved is urban or rural; (5) population density in the portion of the service area, including whether the service area is within a county with a population of 500,000 or fewer; (6) whether, as of January 1, 2002, the county containing the service area had two or fewer full service health care service plans providing coverage to the entire county in the commercial market; (7) the distribution of enrollees in the portion of the service area; (8) the availability and distribution of primary care physicians; (9) the availability and distribution of other types of providers; (10) the existence of exclusive contracts in the provider community or other barriers to entry; (11) patterns of practice in the portion of the service area; (12) driving times; (13) waiting times for appointments; (14) whether the plan or any other health care service plan currently has significant operations in that portion of the service area;

and (15) other standards of accessibility that the Director deems necessary or appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.

(1)

whether the plan contract involved is a group health care service plan contract or an individual health care service plan contract;

(2)

whether the plan contract is a full-service health care service plan contract or a specialized health care service plan contract, and if the latter, whether emergency services need not be covered;

(3)

the uniqueness of the services to be offered;

(4)

whether the portion of the service area involved is urban or rural;

(5)

population density in the portion of the service area, including whether the service area is within a county with a population of 500,000 or fewer;

(6)

whether, as of January 1, 2002, the county containing the service area had two or fewer full service health care service plans providing coverage to the entire county in the commercial market;

(7)

the distribution of enrollees in the portion of the service area;

(8)

the availability and distribution of primary care physicians;

(9)

the availability and distribution of other types of providers;

(10)

the existence of exclusive contracts in the provider community or other barriers to entry;

(11)

patterns of practice in the portion of the service area;

(12)

driving times;

(13)

waiting times for appointments;

(14)

whether the plan or any other health care service plan currently has significant operations in that portion of the service area; and

(15)

other standards of accessibility that the Director deems necessary or appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.

(d)

At least 30 days before a health care service plan files a notice of material modification of its license with the department in order to withdraw from a county with a population of 500,000 or fewer, the health care service plan shall hold a public meeting at a time and place reasonably calculated to facilitate attendance by affected enrollees in the county from which it intends to withdraw, and shall do all of the following: (1) Provide notice announcing the public meeting at least 30 days prior to the public meeting to all affected enrollees, health care providers with which it contracts, the members of the board of supervisors of the affected

county, the members of the city councils of cities in the affected county, and the members of the Legislature who represent the affected county. (2) Provide notice announcing the public meeting at least 15 days prior to the public meeting in a newspaper of general circulation within the affected county. (3) At the public meeting, allow testimony, which may be limited to a certain length of time by the health care service plan, of all interested parties. (4) File with the department for review, no less than 30 days prior to the date of mailing or publication, the notices required under subparagraphs (1) and (2).

(1)

Provide notice announcing the public meeting at least 30 days prior to the public meeting to all affected enrollees, health care providers with which it contracts, the members of the board of supervisors of the affected county, the members of the city councils of cities in the affected county, and the members of the Legislature who represent the affected county.

(2)

Provide notice announcing the public meeting at least 15 days prior to the public meeting in a newspaper of general circulation within the affected county.

(3)

At the public meeting, allow testimony, which may be limited to a certain length of time by the health care service plan, of all interested parties.

(4)

File with the department for review, no less than 30 days prior to the date of mailing or publication, the notices required under subparagraphs (1) and (2).

(e)

The department may require a health care service plan that has filed to withdraw from a portion of a county with a population of fewer than 500,000 to hold a

hearing for affected enrollees.

(f)

A representative of the department shall attend the public meeting described in this section.