§ 1377. Reserves or insurance to be maintained by certain plans for payments to subscribers or providers

(a) Every plan which reimburses providers of health care services that do not contract in writing with the plan to provide health care services, or which reimburses its subscribers or enrollees for costs incurred in having received health care services from providers that do not contract in writing with the

plan, in an amount which exceeds 10 percent of its total costs for health care services for the immediately preceding six months, shall comply with the requirements set forth in either paragraph (1) or (2):

(1)(A) Place with the director, or with any organization or trustee acceptable to the director through which a custodial or controlled account is maintained, a noncontracting provider insolvency deposit consisting of cash or securities that are acceptable to the director that at all times have a fair market value in an amount at least equal to 120 percent of the sum of the following:

(i) All claims for noncontracting provider services received for reimbursement, but not yet processed.

(ii) All claims for noncontracting provider services denied for reimbursement during the previous 45 days.

(iii) All claims for noncontracting provider services approved for reimbursement, but not yet paid.

(iv) An estimate of claims for noncontracting provider services incurred, but not reported.

(B) Each plan licensed pursuant to this chapter prior to January 1, 1991, shall, upon that date, make a deposit of 50 percent of the amount required by subparagraph (A), and shall maintain additional cash or cash equivalents as defined by rule of the director, in the amount of 50 percent of the amount required by subparagraph (A), and shall make a deposit of 100 percent of the amount required by subparagraph (A) by January 1, 1992.

(C) The amount of the deposit shall be reasonably estimated as of the first day of the month and maintained for the remainder of the month.

(D) The deposit required by this paragraph is in addition to the deposit that may be required by rule of the director and is an allowable asset of the plan in the determination of tangible net equity as defined in subdivision (b) of Section 1300.76 of Title 28 of the California Code of Regulations. All income from the deposit shall be an asset of the plan and may be withdrawn by the plan at any time.

(E) A health care service plan that has made a deposit may withdraw that deposit or any part of the deposit if (i) a substitute deposit of cash or securities of equal amount and value is made, (ii) the fair market value exceeds the amount of the required deposit, or (iii) the required deposit under this paragraph is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the director, but approval shall not be required for the withdrawal of earned income.

(F) The deposit required under this section is in trust and may be used only as provided by this section. The director or, if a receiver has been appointed, the receiver shall use the deposit of an insolvent health care service plan, as defined in Sections 1394.7 and 1394.8, for payment of covered claims for services rendered by noncontracting providers under circumstances covered by the plan. All claims determined by the director or receiver, in his or her discretion, to be eligible for reimbursement under this section shall be paid on a pro rata basis based on assets available from the deposit to pay the ultimate liability for incurred expenditures. Partial

distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health care service plan. The director may also use the deposit of an insolvent health care service plan for payment of any administrative costs associated with the administration of this section. The department, the director, and any employee of the department shall not be liable, as provided by Section 820.2 of the Government Code, for an injury resulting from an exercise of discretion pursuant to this section. Nothing in this section shall be construed to provide immunity for the acts of a receiver, except when the director is acting as a receiver.

(G) The director may, by regulation, prescribe the time, manner, and form for filing claims.

(H) The director may permit a plan to meet a portion of this requirement by a deposit of tangible assets acceptable to the director, the fair market value of which shall be determined on at least an annual basis by the director. The plan shall bear the cost of any appraisal or valuations required hereunder by the director.

(2) Maintain adequate insurance, or a guaranty arrangement approved in writing by the director, to pay for any loss to providers, subscribers, or enrollees claiming reimbursement due to the insolvency of the plan.

(b) Whenever the reimbursements described in this section exceed 10 percent of the plan's total costs for health care services over the immediately preceding six months, the plan shall file a written report with the director containing the information necessary to determine compliance with subdivision (a) no later than 30 business days from the first day of the month. Upon an adequate showing by the plan that the requirements of this section should be waived or reduced, the director may waive or reduce these requirements to an amount as the director deems sufficient to protect subscribers and enrollees of the plan consistent with the intent and purpose of this chapter.

(c) Every plan which reimburses providers of health care service on a fee-for-services basis; or which directly reimburses its subscribers or enrollees, to an extent exceeding 10 percent of its total payments for health care services, shall estimate and record in the books of account a liability for incurred and unreported claims. Upon a determination by the director that the estimate is inadequate, the director may require the plan to increase its estimate of incurred and unreported claims. Every plan shall promptly report to the director whenever these reimbursables exceed 10 percent of its total expenditures for health care services.

As used herein, the term "fee-for-services" refers to the situation where the amount of reimbursement paid by the plan to providers of service is determined by the amount and type of service rendered by the provider of service.

(d) In the event an insolvent plan covered by this section fails to pay a noncontracting provider sums for covered services owed, the provider shall first look to the uncovered expenditures insolvency deposit or the insurance or guaranty arrangement maintained by the plan for payment. When a plan becomes insolvent, in no event shall a noncontracting provider, or agent, trustee, or assignee thereof, attempt to collect from the subscriber or enrollee sums owed for covered services by the plan or maintain any action at law against a subscriber or enrollee to collect sums owed by the plan for covered

services without having first attempted to obtain reimbursement from the plan.

HISTORY:

Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1985 ch 908 § 2; Stats 1990 ch 1043 § 7 (SB 785); Stats 1991 ch 422 § 2 (SB 244); Stats 1999 ch 525 § 124 (AB 78), operative July 1, 2000; Stats 2009 ch 298 § 8 (AB 1540), effective January 1, 2010.