**§ 1374.64. Plan criteria**

(a) Only a plan that has been licensed under this chapter and in operation in this state for a period of five years or more, or a plan licensed under this chapter and operating in this state for a period of five or more years under a combination of (1) licensure under this chapter and (2) pursuant to a certificate of authority issued by the Department of Insurance may offer a point-of-service contract. A specialized health care service plan shall not offer a point-of-service plan contract unless this plan was formerly registered under the Knox-Mills Health Plan Act (Article 2.5 (commencing with Section 12530) of Chapter 6 of Part 2 of Division 3 of Title 2 of the Government Code), as repealed by Chapter 941 of the Statutes of 1975, and offered point-of-service plan contracts previously approved by the director on July 1, 1976, and on September 1, 1993.

(b) A plan may offer a point-of-service plan contract only if the director has not found the plan to be in violation of any requirements, including administrative capacity, under this chapter or the rules adopted thereunder and the plan meets, at a minimum, the following financial criteria:

(1) The minimum financial criteria for a plan that maintains a minimum net worth of at least five million dollars ($5,000,000) shall be:

(A)(i) Initial tangible net equity so that the plan is not required to file monthly reports with the director as required by Section

1300.84.3(d)(1)(G) of Title 28 of the California Code of Regulations and then have and maintain adjusted tangible net equity to be determined pursuant to either of the following:

(I) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(1) or (2) of Title 28 of the California Code of Regulations, multiply 130 percent times the sum resulting from the addition of the plan's tangible net equity required by Section 1300.76(a)(1) or (2) of Title 28 of the California Code of Regulations and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees.

(II) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(3) of Title 28 of the California Code of Regulations, recalculate the plan's tangible net equity under Section 1300.76(a)(3) of Title 28 of the California Code of Regulations excluding the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees, add together the number resulting from this recalculation and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees, and multiply this sum times 130 percent, provided that the product of this multiplication must exceed 130 percent of the tangible net equity required by Section 1300.76(a)(3) of Title 28 of the California Code of Regulations so that the plan is not required to file monthly reports to the director as required by Section 1300.84.3(d)(1)(G) of Title 28 of the California Code of Regulations.

(ii) The failure of a plan offering a point-of-service plan contract under this article to maintain adjusted tangible net equity as determined by this subdivision shall require the filing of monthly reports with the director pursuant to Section 1300.84.3(d) of Title 28 of the California Code of Regulations, in addition to any other requirements that may be imposed by the director on a plan under this article and chapter.

(iii) The calculation of tangible net equity under any report to be filed by a plan offering a point-of-service plan contract under this article and required of a plan pursuant to Section 1384, and the regulations adopted thereunder, shall be on the basis of adjusted tangible net equity as determined under this subdivision.

(B) Demonstrates adequate working capital, including (i) a current ratio (current assets divided by current liabilities) of at least 1:1, after excluding obligations of officers, directors, owners, or affiliates, or (ii) evidence that the plan is now meeting its obligations on a timely basis and has been doing so for at least the preceding two years. Short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates shall not be excluded. For purposes of this subdivision, an obligation is considered short term if the repayment schedule is 30 days or fewer.

(C) Demonstrates a trend of positive earnings over the previous eight fiscal quarters.

(2) The minimum financial criteria for a plan that maintains a minimum net worth of at least one million five hundred thousand dollars ($1,500,000) but less than five million dollars ($5,000,000) shall be:

(A)(i) Initial tangible net equity so that the plan is not required to file monthly reports with the director as required by Section 1300.84.3(d)(1)(G) of Title 28 of the California Code of Regulations and then have and maintain adjusted tangible net equity to be determined pursuant to either of the following:

(I) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(1) or (2) of Title 28 of the California Code of Regulations, multiply 130 percent times the sum resulting from the addition of the plan's tangible net equity required by Section 1300.76(a)(1) or (2) of Title 28 of the California Code of Regulations and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees.

(II) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(3) of Title 28 of the California Code of Regulations, recalculate the plan's tangible net equity under Section 1300.76excluding the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees, add together the number resulting from this recalculation and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees, and multiply this sum times 130 percent, provided that the product of this multiplication must exceed 130 percent of the tangible net equity required by Section 1300.76(a)(3) of Title 28 of the California Code of Regulations so that the plan is not required to file monthly reports to the director as required by Section 1300.84.3(d)(1)(G) of Title 28 of the California Code of Regulations.

(ii) The failure of a plan offering a point-of-service plan contract under this article to maintain adjusted tangible net equity as determined by this subdivision shall require the filing of monthly reports with the director pursuant to Section 1300.84.3(d) of Title 28 of the California Code of Regulations, in addition to any other requirements that may be imposed by the director on a plan under this article and chapter.

(iii) The calculation of tangible net equity under any report to be filed by a plan offering a point-of-service plan contract under this article and required of a plan pursuant to Section 1384, and the regulations adopted thereunder, shall be on the basis of adjusted tangible net equity as determined under this subdivision.

(B) Demonstrates adequate working capital, including (i) a current ratio (current assets divided by current liabilities) of at least 1:1, after excluding obligations of officers, directors, owners, or affiliates or (ii) evidence that the plan is now meeting its obligations on a timely basis and has been doing so for at least the preceding two years. Short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions

with nonaffiliates shall not be excluded. For purposes of this subdivision, an obligation is considered short term if the repayment schedule is 30 days or fewer.

(C) Demonstrates a trend of positive earnings over the previous eight fiscal quarters.

(D) Demonstrates to the director that it has obtained insurance for the cost of providing any point-of-service enrollee with out-of-network covered health care services, the aggregate value of which exceeds five thousand dollars ($5,000) in any year. This insurance shall obligate the insurer to continue to provide care for the period in which a premium was paid in the event a plan becomes insolvent. Where a plan cannot obtain insurance as required by this subparagraph, then a plan may demonstrate to the director that it has made other arrangements, acceptable to the director, for the cost of providing enrollees out-of-network health care services; but in this case the expenditure for total out-of-network costs for all enrollees in all point-of-service contracts shall be limited to a percentage, acceptable to the director, not to exceed 15 percent of total health care expenditures for all its enrollees.

(c) Within 30 days of the close of each month a plan offering point-of-service plan contracts under paragraph (2) of subdivision (b) shall file with the director a monthly financial report consisting of a balance sheet and statement of operations of the plan, which need not be certified, and a calculation of the adjusted tangible net equity required under subparagraph (A). The financial statements shall be prepared on a basis consistent with the financial statements furnished by the plan pursuant to Section 1300.84.2 of Title 28 of the California Code of Regulations. A plan shall also make special reports to the director as the director may from time to time require. Each report to be filed by a plan pursuant to this subdivision shall be verified by a principal officer of the plan as set forth in Section 1300.84.2(e) of Title 28 of the California Code of Regulations.

(d) If it appears to the director that a plan does not have sufficient financial viability, or organizational and administrative capacity to ensure the delivery of health care services to its enrollees, the director may, by written order, direct the plan to discontinue the offering of a point-of-service plan contract. The order shall be effective immediately.

**HISTORY:**

Added Stats 1993 ch 987 § 3 (SB 1221). Amended Stats 1999 ch 525 § 116 (AB 78), operative July 1, 2000; Stats 2009 ch 298 § 5 (AB 1540), effective January 1, 2010.