§ 1375.3. Meet and confer with director prior to filing petition for bankruptcy; Information to ensure continuity of care

(a) A health care service plan shall meet and confer with the director and his or her designated representatives at least 10 business days prior to filing a petition commencing a case for bankruptcy under Title 11 of the United States Code, except under extraordinary circumstances. If extraordinary circumstances preclude a meet and confer with the director within the 10-day time period prior to the filing of a petition for bankruptcy, the plan shall meet and confer with the department at least 24 hours prior to filing the petition. A plan

shall notify the department concurrently upon filing the petition. These meetings shall be deemed confidential.

(b) At the director's request, a plan shall provide within the time period specified by the department, information to assist in ensuring continuity of care and uninterrupted access to health care services for plan subscribers and enrollees. The information may include, but is not limited to, the following:

(1) A list of all providers with which the plan contracts and material information regarding the contracts including, but not limited to, the grounds for termination of the contract and the term remaining on the contract.

(2) A list of employer groups who subscribe with the plan.

(3) A list of the enrollees of the plan.

(4) A list of enrollees undergoing current treatment and a description of the authorized treatment for the enrollee.

(5) A list of all brokers and agents involved in the negotiation of subscriber contracts.

(6) A list of all enrollees who contract as individual subscribers for coverage by the plan.

(c) Notwithstanding subdivision (a), nothing in this section shall preclude the director from exercising powers and duties authorized under this chapter.

HISTORY:
Added Stats 2002 ch 928 § 2 (SB 398), effective January 1, 2003.

§ 1375.4. Required provisions for contract between health care service plan and risk-bearing organization; Regulations; Sanctions for plan's failure to comply with contractual requirements; Report; Exemption

(a) Every contract between a health care service plan and a risk-bearing organization that is issued, amended, renewed, or delivered in this state on or after July 1, 2000, shall include provisions concerning the following, as to the risk-bearing organization's administrative and financial capacity, which shall be effective as of January 1, 2001:

(1) A requirement that the risk-bearing organization furnish financial information to the health care service plan or the plan's designated agent and meet any other financial requirements that assist the health care service plan in maintaining the financial viability of its arrangements for the provision of health care services in a manner that does not adversely affect the integrity of the contract negotiation process.

(2) A requirement that the health care service plan disclose information to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the financial risk assumed under the contract.

(3) A requirement that the health care service plans provide payments of all risk arrangements, excluding capitation, within 180 days after close of the fiscal year.

(b) In accordance with subdivision (a) of Section 1344, the director shall adopt regulations on or before June 30, 2000, to implement this section which shall, at a minimum, provide for the following:

(1)(A) A process for reviewing or grading risk-bearing organizations based on the following criteria:

(i) The risk-bearing organization meets criterion 1 if it reimburses, contests, or denies claims for health care services it has provided, arranged, or for which it is otherwise financially responsible in accordance with the timeframes and other requirements described in Section 1371 and in accordance with any other applicable state and federal laws and regulations.

(ii) The risk-bearing organization meets criterion 2 if it estimates its liability for incurred but not reported claims pursuant to a method that has not been held objectionable by the director, records the estimate at least quarterly as an accrual in its books and records, and appropriately reflects this accrual in its financial statements.

(iii) The risk-bearing organization meets criterion 3 if it maintains at all times a positive tangible net equity, as defined in subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.

(iv) The risk-bearing organization meets criterion 4 if it maintains at all times a positive level of working capital (excess of current assets over current liabilities).

(B) A risk-bearing organization may reduce its liabilities for purposes of calculating tangible net equity, pursuant to clause (iii) of subparagraph (A), and working capital, pursuant to clause (iv) of subparagraph (A), by the amount of any liabilities the payment of which is guaranteed by a sponsoring organization pursuant to a qualified guarantee. A sponsoring organization is one that has a tangible net equity of a level to be established by the director that is in excess of all amounts that it has guaranteed to any person or entity. A qualified guarantee is one that meets all of the following:

(i) It is approved by a board resolution of the sponsoring organization.

(ii) The sponsoring organization agrees to submit audited annual financial statements to the plan within 120 days of the end of the sponsoring organization's fiscal year.

(iii) The guarantee is unconditional except for a maximum monetary limit.

(iv) The guarantee is not limited in duration with respect to liabilities arising during the term of the guarantee.

(v) The guarantee provides for six months' advance notice to the plan prior to its cancellation.

(2) The information required from risk-bearing organizations to assist in reviewing or grading these risk-bearing organizations, including balance sheets, claims reports, and designated annual, quarterly, or monthly financial statements prepared in accordance with generally accepted accounting principles, to be used in a manner, and to the extent necessary, provided to a single external party as approved by the director to the extent that it does not adversely affect the integrity of the contract negotiation process between the health care service plan and the risk-bearing organizations.

(3) Audits to be conducted in accordance with generally accepted auditing standards and in a manner that avoids duplication of review of the risk-bearing organization.

(4) A process for corrective action plans, as mutually agreed upon by the health care service plan and the risk-bearing organization and as approved by the director, for cases where the review or grading indicates deficiencies that need to be corrected by the risk-bearing organization, and contingency plans to ensure the delivery of health care services if the corrective action fails. The corrective action plan shall be approved by the director and standardized, to the extent possible, to meet the needs of the director and all health care service plans contracting with the risk-bearing organization. If the health care service plan and the risk-bearing organization are unable to determine a mutually agreeable corrective action plan, the director shall determine the corrective action plan.

(5) The disclosure of information by health care service plans to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the risk assumed under the contract, including:

(A) Enrollee information monthly.

(B) Risk arrangement information, information pertaining to any pharmacy risk assumed under the contract, information regarding incentive payments, and information on income and expenses assigned to the risk-bearing organization quarterly.

(6) Periodic reports from each health care service plan to the director that include information concerning the risk-bearing organizations and the type and amount of financial risk assumed by them, and, if deemed necessary and appropriate by the director, a registration process for the risk-bearing organizations.

(7) The confidentiality of financial and other records to be produced, disclosed, or otherwise made available, unless as otherwise determined by the director.

(c) The failure by a health care service plan to comply with the contractual requirements pursuant to this section shall constitute grounds for disciplinary action. The director shall, as appropriate, within 60 days after receipt of documented violation from a risk-bearing organization, investigate and take enforcement action against a health care service plan that fails to comply with these requirements and shall periodically evaluate contracts between health care service plans and risk-bearing organizations to determine if any audit, evaluation, or enforcement actions should be undertaken by the department.

(d) The Financial Solvency Standards Board established in Section 1347.15 shall study and report to the director on or before January 1, 2001, regarding all of the following:

(1) The feasibility of requiring that there be in force insurance coverage commensurate with the financial risk assumed by the risk-bearing organization to protect against financial losses.

(2) The appropriateness of different risk-bearing arrangements between health care service plans and risk-bearing organizations.

(3) The appropriateness of the four criteria specified in paragraph (1) of subdivision (b).

(e) This section shall not apply to specialized health care service plans.

(f) For purposes of this section, “provider organization” means a medical group, independent practice association, or other entity that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a plan.

(g)(1) For purposes of this section, a "risk-bearing organization" means a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (*l*) of Section 1206, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a health care service plan, and that does all of the following:

(A) Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees.

(B) Receives compensation for those services on any capitated or fixed periodic payment basis.

(C) Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization. Nothing in this subparagraph in any way limits, alters, or abrogates any responsibility of a health care service plan under existing law.

(2) Notwithstanding paragraph (1), risk-bearing organizations shall not be deemed to include a provider organization that meets either of the following requirements:

(A) The health care service plan files with the department consolidated financial statements that include the provider organization.

(B) The health care service plan is the only health care service plan with which the provider organization contracts for arranging or providing health care services and, during the previous and current fiscal years, the provider organization's maximum potential expenses for providing or arranging for health care services did not exceed 115 percent of its maximum potential revenue for providing or arranging for those services.

(h) For purposes of this section, "claims" include, but are not limited to, contractual obligations to pay capitation or payments on a managed hospital payment basis.

HISTORY:

Added Stats 1999 ch 529 § 3 (SB 260). Amended Stats 2000 ch 1067 § 14 (SB 2094); Stats 2009 ch 298 § 6 (AB 1540), effective January 1, 2010.

§ 1375.5. Contract provision requiring risk-bearing organization to be at financial risk for provision of health care services

No contract between a risk-bearing organization and a health care service plan that is issued, amended, delivered, or renewed in this state on or after July 1, 2000, shall include any provision that requires the risk-bearing organization to be at financial risk for the provision of health care services, unless the provision has first been negotiated and agreed to between the health care service plan and the risk-bearing organization.

This section shall not prevent a risk-bearing organization from accepting the financial risk pursuant to a contract that meets the requirements of Section 1375.4.

HISTORY:

Added Stats 1999 ch 529 § 4 (SB 260). Amended Stats 2002 ch 798 § 1 (AB 2420), effective January 1, 2003.