DEPARTMENT OF MANAGED HEALTH CARE

BUDGET NO. 4150

REPORT NO. 1

HEALTH AND SAFETY CODE

DIVISION 2. LICENSING PROVISIONS [1200. - 1795.]
(Division 2 enacted by Stats. 1939, Ch. 60.)
CHAPTER 2.2. Health Care Service Plans [1340. - 1399.835.]
(Chapter 2.2 added by Stats. 1975, Ch. 941.)
ARTICLE 1. General [1340. - 1345.]
(Article 1 added by Stats. 1975, Ch. 941.)

1342.4.

(a) The Department of Managed Health Care and the Department of Insurance shall maintain a joint senior level working group to ensure clarity for health care consumers about who enforces their patient rights and consistency in the regulations of these departments.
(b) The joint working group shall undertake a review and examination of the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code as they apply to the Department of Managed Health Care and the Department of Insurance to ensure consistency in consumer protection.
(c) The joint working group shall review and examine all of the following processes in each department:
(1) Grievance and consumer complaint processes, including, but not limited to, outreach, standard complaints, including coverage and medical necessity complaints, independent medical review, and information developed for consumer use.
(2) The processes used to ensure enforcement of the law, including, but not limited to, the medical survey and audit process in the Health and Safety Code and market conduct exams in the Insurance Code.
(3) The processes for regulating the timely payment of claims.
(d) The joint working group shall report its findings to the Insurance Commissioner and the Director of the Department of Managed Health Care for review and approval. The commissioner and the director shall submit the approved final report under signature to the Legislature by January 1 of every year for five years.
(Added by Stats. 2002, Ch. 793, Sec. 1. Effective January 1, 2003.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
SB-1913	Committee on Insurance	Department of Managed Health Care and Department of Insurance: joint working group.	Chaptered 09/22/2002	09/22/2002 - Chaptered by Secretary of State. Chapter 793, Statutes of 2002. 09/22/2002 - Approved by Governor.	-		

COMMENTS/ RECOMMENDATIONS:

DMHC recommends eliminating this report requirement. The report requirement was valid for five years, with the last report required to be submitted on January 1, 2006. However, the LAO believes this information is of ongoing interest to the Legislature and recommends retaining the reporting requirement. The Legislature may wish to keep the requirement on the books.

REPORT NO. 2

HEALTH AND SAFETY CODE

DIVISION 2. LICENSING PROVISIONS [1200. - 1795.]
(Division 2 enacted by Stats. 1939, Ch. 60.)
CHAPTER 2.2. Health Care Service Plans [1340. - 1399.835.]
(Chapter 2.2 added by Stats. 1975, Ch. 941.)
ARTICLE 1. General [1340. - 1345.]
(Article 1 added by Stats. 1975, Ch. 941.)

1342.7.

(a) The Legislature finds that in enacting Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72, it did not intend to limit the department's authority to regulate the provision of medically necessary prescription drug benefits by a health care service plan to the extent that the plan provides coverage for those benefits.
(b) (1) Nothing in this chapter shall preclude a plan from filing relevant information with the department pursuant to Section 1352 to seek the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits. If the department approves an exclusion to a plan's prescription drug benefits, the exclusion shall not be subject to review through the independent medical review process pursuant to Section 1374.30 on the grounds of medical necessity. The department shall retain its role in assessing whether issues are related to coverage or medical necessity pursuant to paragraph (2) of subdivision (d) of Section 1374.30.
(2) A plan seeking approval of a copayment or deductible may file an amendment pursuant to Section 1352.1. A plan seeking approval of a limitation or exclusion shall file a material modification pursuant to subdivision (b) of Section 1352.
(c) Nothing in this chapter shall prohibit a plan from charging a subscriber or enrollee a copayment or deductible for a prescription drug benefit or from setting forth by contract, a limitation or an exclusion from, coverage of prescription drug benefits, if the copayment, deductible, limitation, or exclusion is reported to, and found unobjectionable by, the director and disclosed to the subscriber or enrollee pursuant to the provisions of Section 1363.
(d) The department in developing standards for the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits, shall consider alternative benefit designs, including, but not limited to, the following:
(1) Different out-of-pocket costs for consumers, including copayments and deductibles.
(2) Different limitations, including caps on benefits.
(3) Use of exclusions from coverage of prescription drugs to treat various conditions, including the effect of the exclusions on the plan's ability to provide basic health care services, the amount of subscriber or enrollee premiums, and the amount of out-of-pocket costs for an enrollee.
(4) Different packages negotiated between purchasers and plans.
(5) Different tiered pharmacy benefits, including the use of generic prescription drugs.
(6) Current and past practices.
(e) The department shall develop a regulation outlining the standards to be used in reviewing a plan's request for approval of its proposed copayment, deductible, limitation, or exclusion on its prescription drug benefits.
(f) Nothing in subdivision (b) or (c) shall permit a plan to limit prescription drug benefits provided in a manner that is inconsistent with Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72.

(g) Nothing in this section shall be construed to require or authorize a plan that contracts with the State Department of Health Services to provide services to Medi-Cal beneficiaries or with the Managed Risk Medical Insurance Board to provide services to enrollees of the Healthy Families Program to provide coverage for prescription drugs that are not required pursuant to those programs or contracts, or to limit or exclude any prescription drugs that are required by those programs or contracts.
(h) Nothing in this section shall be construed as prohibiting or otherwise affecting a plan contract that does not cover outpatient prescription drugs except for coverage for limited classes of prescription drugs because they are integral to treatments covered as basic health care services, including, but not limited to, immunosuppressives, in order to allow for transplants of bodily organs.
(i) (1) The department shall periodically review its regulations developed pursuant to this section.
(2) On or before July 1, 2004, and annually thereafter, the department shall report to the Legislature on the ongoing implementation of this section.
(j) This section shall become operative on January 2, 2003, and shall only apply to contracts issued, amended, or renewed on or after that date.
(Added by Stats. 2002, Ch. 791, Sec. 1. Effective January 1, 2003. Section operative January 2, 2003, by its own provisions.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
SB-842	Speier	Health care: prescription drug benefits.	Chaptered 09/22/2002	09/22/2002 - Chaptered by Secretary of State. Chapter 791, Statutes of 2002. 09/22/2002 - Approved by Governor.	-		

COMMENTS/ RECOMMENDATIONS:

DMHC recommends eliminating this report as implementation, by way of regulations, was completed in 2006.

REPORT NO. 3

HEALTH AND SAFETY CODE

DIVISION 2. LICENSING PROVISIONS [1200. - 1795.]
(Division 2 enacted by Stats. 1939, Ch. 60.)
CHAPTER 2.2. Health Care Service Plans [1340. - 1399.835.]
(Chapter 2.2 added by Stats. 1975, Ch. 941.)
ARTICLE 2. Administration [1346. - 1348.9.]
(Article 2 added by Stats. 1975, Ch. 941.)

1348.9.

(a) On or before July 1, 2003, the director shall adopt regulations to establish the Consumer Participation Program, which shall allow for the director to award reasonable advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of any regulation or to an order or decision made by the director if the order or decision has the potential to impact a significant number of enrollees.
(b) The regulations adopted by the director shall include specifications for eligibility of participation, rates of compensation, and procedures for seeking compensation. The regulations shall require that the person or organization demonstrate a record of advocacy on behalf of health care consumers in administrative or legislative proceedings in order to determine whether the person or organization represents the interests of consumers.
(c) This section shall apply to all proceedings of the department, but shall not apply to resolution of individual grievances, complaints, or cases.
(d) Fees awarded pursuant to this section may not exceed three hundred fifty thousand dollars ($350,000) each fiscal year.
(e) The fees awarded pursuant to this section shall be considered costs and expenses pursuant to Section 1356 and shall be paid from the assessment made under that section. Notwithstanding the provisions of this subdivision, the amount of the assessment shall not be increased to pay the fees awarded under this section.
(f) The department shall report to the appropriate policy and fiscal committees of the Legislature before March 1, 2004, and annually thereafter, the following information:
(1) The amount of reasonable advocacy and witness fees awarded each fiscal year.
(2) The individuals or organization to whom advocacy and witness fees were awarded pursuant to this section.
(3) The orders, decisions, and regulations pursuant to which the advocacy and witness fees were awarded.
(g) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.
(Amended by Stats. 2011, Ch. 31, Sec. 14. Effective June 29, 2011. Repealed as of January 1, 2018, by its own provisions.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-119	Committee on Budget	State government.	Chaptered 06/29/2011	06/28/2011 - Chaptered by Secretary of State - Chapter 31, Statutes of 2011.	Secretary of State-Chaptered	Yes	Majority

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-1806	Committee on Budget	State government.	Chaptered 07/12/2006	07/12/2006 - Chaptered by Secretary of State - Chapter 69, Statutes of 2006. 07/12/2006 - Approved by the Governor.	-	Yes	Two Thirds
SB-1092	Sher	Health care service plans.	Chaptered 09/22/2002	09/22/2002 - Chaptered by Secretary of State. Chapter 792, Statutes of 2002. 09/22/2002 - Approved by Governor.	-		

COMMENTS/ RECOMMENDATIONS:

DMHC recommends eliminating this report as the information contained in the report is posted on DMHC's webpage. The LAO believes this information to be of ongoing interest to the Legislature. The Legislature may wish to continue receiving, and therefore requiring, this report.

REPORT NO. 4

HEALTH AND SAFETY CODE

DIVISION 2. LICENSING PROVISIONS [1200. - 1795.]
(Division 2 enacted by Stats. 1939, Ch. 60.)
CHAPTER 2.2. Health Care Service Plans [1340. - 1399.835.]
(Chapter 2.2 added by Stats. 1975, Ch. 941.)
ARTICLE 3.1. Small Employer Group Access to Contracts for Health Care Services [1357. - 1357.17.]
(Article 3.1 added by Stats. 1992, Ch. 1128, Sec. 5.)

1357.16.

(a) Health care service plans may enter into contractual agreements with qualified associations, as defined in subdivision (b), under which these qualified associations may assume responsibility for performing specific administrative services, as defined in this section, for qualified association members. Health care service plans that enter into agreements with qualified associations for assumption of administrative services shall establish uniform definitions for the administrative services that may be provided by a qualified association or its third-party administrator. The health care service plan shall permit all qualified associations to assume one or more of these functions when the health care service plan determines the qualified association demonstrates the administrative capacity to assume these functions.
For the purposes of this section, administrative services provided by qualified associations or their third-party administrators shall be services pertaining to eligibility determination, enrollment, premium collection, sales, or claims administration on a per-claim basis that would otherwise be provided directly by the health care service plan or through a third-party administrator on a commission basis or an agent or solicitor workforce on a commission basis.
Each health care service plan that enters into an agreement with any qualified association for the provision of administrative services shall offer all qualified associations with which it contracts the same premium discounts for performing those services the health care service plan has permitted the qualified association or its third-party administrator to assume. The health care service plan shall apply these uniform discounts to the health care service plan's risk adjusted employee risk rates after the health plan has determined the qualified association's risk adjusted employee risk rates pursuant to Section 1357.12. The health care service plan shall report to the Department of Managed Health Care its schedule of discount for each administrative service.
In no instance may a health care service plan provide discounts to qualified associations that are in any way intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association. In addition to any other remedies available to the director to enforce this chapter, the director may declare a contract between a health care service plan and a qualified association for administrative services pursuant to this section null and void if the director determines any discounts provided to the qualified association are intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association.
(b) For the purposes of this section, a qualified association is a nonprofit corporation comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, that conforms to all of the following requirements:
(1) It accepts for membership any individual or small employer meeting its membership criteria.
(2) It does not condition membership directly or indirectly on the health or claims history of any person.

(3) It uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association.
(4) It is organized and maintained in good faith for purposes unrelated to insurance.
(5) It existed on January 1, 1972, and has been in continuous existence since that date.
(6) It has a constitution and bylaws or other analogous governing documents that provide for election of the governing board of the association by its members.
(7) It offered, marketed, or sold health coverage to its members for 20 continuous years prior to January 1, 1993.
(8) It agrees to offer only to association members any plan contract.
(9) It agrees to include any member choosing to enroll in the plan contract offered by the association, provided that the member agrees to make required premium payments.
(10) It complies with all provisions of this article.
(11) It had at least 10,000 enrollees covered by association sponsored plans immediately prior to enactment of Chapter 1128 of the Statutes of 1992.
(12) It applies any administrative cost at an equal rate to all members purchasing coverage through the qualified association.
(c) A qualified association shall comply with Section 1357.52.
(d) The department shall monitor compliance with this section and report the impact of any noncompliance to the Assembly Insurance Committee and the Senate Insurance Committee on January 1, 2002.
(Amended by Stats. 2002, Ch. 227, Sec. 1. Effective January 1, 2003.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-78	Gallegos	Health care coverage: Department of Managed Health Care.	Chaptered 09/28/1999	09/28/1999 - Chaptered by Secretary of State - Chapter 525, Statutes of 1999.	-		
AB-112		Health.	Chaptered 07/06/1998		-		
AB-1360		Health insurance.	Chaptered 09/19/1996		-		
AB-2903	Committee on Health	Health care coverage: telephone medical advice services.	Chaptered 09/29/2000	09/29/2000 - Chaptered by Secretary of State - Chapter 857, Statutes of 2000.	-		
SB-420	Figueroa	Managed care.	Amended Senate 04/14/1999	02/01/2000 - Returned to Secretary of Senate pursuant to Joint Rule 56.	-	Yes	Majority
SB-578		Health care coverage.	Chaptered 08/21/1997		-		
SB-1877	Johnson	Health care.	Chaptered 08/16/2002	08/16/2002 - Chaptered by Secretary of State. Chapter 227, Statutes of 2002.	-		

COMMENTS/ RECOMMENDATIONS:
DMHC recommends eliminating this report. The report was a one-time report requirement completed on January 1, 2002.