

**ASSEMBLY BILL**

**No. 3251**

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**Introduced by Assembly Member Gallegos**

February 23, 1996

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An act to amend Section 1374.64 of the Health and Safety Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

AB 3251, as introduced, Gallegos. Health care service plans: point-of-service contracts.

Existing law provides for the licensure and regulation of health care service plans administered by the Commissioner of Corporations. Existing law authorizes a plan to offer a point-of-service plan contract, which means a contract whereby a plan assumes financial risk for both in-network coverage or services, as defined, and out-of-network coverage or services, as defined, if it meets several requirements, including that it has been licensed and in operation, or licensed or operating under a certificate of authority, in the state for 5 years. Under existing law, willful violation of any of these provisions is a misdemeanor.

This bill changes the requirement to 4 years. By changing the definition of a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 1374.64 of the Health and Safety  
2 Code is amended to read:

3 1374.64. (a) Only a plan that has been licensed under  
4 this chapter and in operation in this state for a period of  
5 ~~five~~ *four* years or more, or a plan licensed under this  
6 chapter and operating in this state for a period of ~~five~~ *four*  
7 or more years under a combination of (1) licensure under  
8 this chapter and (2) pursuant to a certificate of authority  
9 issued by the Department of Insurance may offer a  
10 point-of-service contract. A specialized health care  
11 service plan shall not offer a point-of-service plan  
12 contract unless this plan was formerly registered under  
13 the Knox-Mills Health Plan Act (Article 2.5 (commencing  
14 with Section 12530) of Chapter 6 of Part 2 of Division 3 of  
15 Title 2 of the Government Code), as repealed by Chapter  
16 941 of the Statutes of 1975, and offered point-of-service  
17 plan contracts previously approved by the commissioner  
18 on July 1, 1976, and on September 1, 1993.

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

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

28 (A) (i) Initial tangible net equity so that the plan is  
29 not required to file monthly reports with the  
30 commissioner as required by Section 1300.84.3(d)(1)(G)  
31 of Title 10 of the California Code of Regulations and then  
32 have and maintain adjusted tangible net equity to be  
33 determined pursuant to either of the following:



1 (I) In the case of a plan that is required to have and  
2 maintain a tangible net equity as required by Section  
3 1300.76(a)(1) or (2) of Title 10 of the California Code of  
4 Regulations, multiply 130 percent times the sum resulting  
5 from the addition of the plan's tangible net equity  
6 required by Section 1300.76(a)(1) or (2) of Title 10 of the  
7 California Code of Regulations and the number that  
8 equals 10 percent of the plan's annualized health care  
9 expenditures for out-of-network services for  
10 point-of-service enrollees.

11 (II) In the case of a plan that is required to have and  
12 maintain a tangible net equity as required by Section  
13 1300.76(a)(3) of Title 10 of the California Code of  
14 Regulations, recalculate the plan's tangible net equity  
15 under Section 1300.76(a)(3) of Title 10 of the California  
16 Code of Regulations excluding the plan's annualized  
17 health care expenditures for out-of-network services for  
18 point-of-service enrollees, add together the number  
19 resulting from this recalculation and the number that  
20 equals 10 percent of the plan's annualized health care  
21 expenditures for out-of-network services for point of  
22 services enrollees, and multiply this sum times 130  
23 percent, provided that the product of this multiplication  
24 must exceed 130 percent of the tangible net equity  
25 required by Section 1300.76(a)(3) of Title 10 of the  
26 California Code of Regulations so that the plan is not  
27 required to file monthly reports to the commissioner as  
28 required by Section 1300.84.3(d)(1)(G) of Title 10 of the  
29 California Code of Regulations.

30 (ii) The failure of a plan offering a point-of-service  
31 plan contract under this article to maintain adjusted  
32 tangible net equity as determined by this subdivision shall  
33 require the filing of monthly reports with the  
34 commissioner pursuant to Section 1300.84.3(d) of Title 10  
35 of the California Code of Regulations, in addition to any  
36 other requirements that may be imposed by the  
37 commissioner on a plan under this article and chapter.

38 (iii) The calculation of tangible net equity under any  
39 report to be filed by a plan offering a point-of-service plan  
40 contract under this article and required of a plan



1 pursuant to Section 1384, and the regulations adopted  
2 thereunder, shall be on the basis of adjusted tangible net  
3 equity as determined under this subdivision.

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

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

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

22 (A) (i) Initial tangible net equity so that the plan is  
23 not required to file monthly reports with the  
24 commissioner as required by Section 1300.84.3(d)(1)(G)  
25 of Title 10 of the California Code of Regulations and then  
26 have and maintain adjusted tangible net equity to be  
27 determined pursuant to either of the following:

28 (I) In the case of a plan that is required to have and  
29 maintain a tangible net equity as required by Section  
30 1300.76(a)(1) or (2) of Title 10 of the California Code of  
31 Regulations, multiply 130 percent times the sum resulting  
32 from the addition of the plan's tangible net equity  
33 required by Section 1300.76(a)(1) or (2) of Title 10 of the  
34 California Code of Regulations and the number that  
35 equals 10 percent of the plan's annualized health care  
36 expenditures for out-of-network services for  
37 point-of-service enrollees.

38 (II) In the case of a plan that is required to have and  
39 maintain a tangible net equity as required by Section  
40 1300.76(a)(3) of Title 10 of the California Code of



1 Regulations, recalculate the plan's tangible net equity  
2 under Section 1300.76(a)(3) excluding the plan's  
3 annualized health care expenditures for out-of-network  
4 services for point-of-service enrollees, add together the  
5 number resulting from this recalculation and the number  
6 that equals 10 percent of the plan's annualized health care  
7 expenditures for out-of-network services for  
8 point-of-services enrollees, and multiply this sum times  
9 130 percent, provided that the product of this  
10 multiplication must exceed 130 percent of the tangible  
11 net equity required by Section 1300.76(a)(3) of Title 10  
12 of the California Code of Regulations so that the plan is  
13 not required to file monthly reports to the commissioner  
14 as required by Section 1300.84.3(d)(1)(G) of Title 10 of  
15 the California Code of Regulations.

16 (ii) The failure of a plan offering a point-of-service  
17 plan contract under this article to maintain adjusted  
18 tangible net equity as determined by this subdivision shall  
19 require the filing of monthly reports with the  
20 commissioner pursuant to Section 1300.84.3(d) of Title 10  
21 of the California Code of Regulations, in addition to any  
22 other requirements that may be imposed by the  
23 commissioner on a plan under this article and chapter.

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

30 (B) Demonstrates adequate working capital,  
31 including (i) a current ratio (current assets divided by  
32 current liabilities) of at least 1:1, after excluding  
33 obligations of officers, directors, owners, or affiliates or  
34 (ii) evidence that the plan is now meeting its obligations  
35 on a timely basis and has been doing so for at least the  
36 preceding two years. Short-term obligations of affiliates  
37 for goods or services arising in the normal course of  
38 business that are payable on the same terms as equivalent  
39 transactions with nonaffiliates shall not be excluded. For



1 purposes of this subdivision, an obligation is considered  
2 short term if the repayment schedule is 30 days or fewer.

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

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

23 (c) Within 30 days of the close of each month a plan  
24 offering point-of-service plan contracts under paragraph  
25 (2) of subdivision (b) shall file with the commissioner a  
26 monthly financial report consisting of a balance sheet and  
27 statement of operations of the plan, which need not be  
28 certified, and a calculation of the adjusted tangible net  
29 equity required under subparagraph (A). The financial  
30 statements shall be prepared on a basis consistent with  
31 the financial statements furnished by the plan pursuant  
32 to Section 1300.84.2 of Title 10 of the California Code of  
33 Regulations. A plan shall also make special reports to the  
34 commissioner as the commissioner may from time to time  
35 require. Each report to be filed by a plan pursuant to this  
36 subdivision shall be verified by a principal officer of the  
37 plan as set forth in Section 1300.84.2(e) of Title 10 of the  
38 California Code of Regulations.

39 (d) If it appears to the commissioner that a plan does  
40 not have sufficient financial viability, or organizational



1 and administrative capacity to assure the delivery of  
2 health care services to its enrollees, the commissioner  
3 may, by written order, direct the plan to discontinue the  
4 offering of a point-of-service plan contract. The order  
5 shall be effective immediately.

6 SEC. 2. No reimbursement is required by this act  
7 pursuant to Section 6 of Article XIII B of the California  
8 Constitution because the only costs that may be incurred  
9 by a local agency or school district will be incurred  
10 because this act creates a new crime or infraction,  
11 eliminates a crime or infraction, or changes the penalty  
12 for a crime or infraction, within the meaning of Section  
13 17556 of the Government Code, or changes the definition  
14 of a crime within the meaning of Section 6 of Article  
15 XIII B of the California Constitution.

16 Notwithstanding Section 17580 of the Government  
17 Code, unless otherwise specified, the provisions of this act  
18 shall become operative on the same date that the act  
19 takes effect pursuant to the California Constitution.

