

Knox-Keene Protections

Quick Reference

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Know-Keene Protections Quick Reference

The Knox-Keene Health Care Service Plan Act of 1975 and accompanying laws regulate managed care plans. Checking the Act and the regulations in Chapter 28 of the California Code of Regulations can help to see what services and protections a client may have. All citations are to the California Health & Safety Code, unless otherwise noted.

Subject Area	H&S Code Section	Description
Consumer Protections		
Confidentiality	§§1364.5, 1374.8, 1375.7(b)(5).	Requires written confidentiality policy that is available upon request. Release of information to an employer only with the employee's consent. Confidentiality of medical records.
Non-Discrimination	§§1365.5, 1367.4, 1367.8, 1373(f), 1374.7, 1374.75, 1399.804(c), (d)	Non-discrimination provisions in health plan contracting related to race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, blindness or partial blindness, physical or mental impairment, genetic disability characteristics, or conditions arising out of acts of domestic violence.
Discrimination based on genetic characteristics	§§1374.7, 1374.9	Plans may not discriminate based on a person's genetic characteristics. Administrative penalties for violations.
Right to Assistance in Enrollee's Primary Language	§§1367(e)(3), 1367.04	DMHC to develop standards for services in languages other than English by 1/1/06. Thresholds for providing translations of vital documents; standards for interpretation assistance.
Premium or Coverage Changes	§§1374.20-1374.29	Limits to when a plan may change premiums or co-payments during the contract period. Plans must give 30-day notice prior to contract renewal effective date of changes in the amount of premiums or coverage.
Enrollment Protections	§1365	Enrollment cannot be cancelled and cannot refuse to renew, except under limited circumstances.
Availability of Services	§1367(e)(1), 1367.03	Plan must ensure that all services are available at reasonable times to each enrollee consistent with good professional practice. Develop and adopt thresholds for reasonable times in accessing care.

Right to Select Primary Care Provider	§1373.3	Right to select any primary care provider who is available and in the network.
Right to Standing Referral to a Specialist	§1374.16	Right to a standing referral for specialist for series of visits; right to an HIV specialist.
Individuals' Access to Contracts for Health Services	§§1399.801-1399.818	Fair and affirmative offers of health plan contracts, limitations on premiums and premium increases, renewals, limitations on exclusions.
Contracts in Compliance with the Law	§1367(h)	Contracts with enrollees and providers are on terms that are fair, reasonable, and consistent with the Knox-Keene protections. Contracts must include dispute resolution mechanisms.
Enrollee Participation	§1369	Plans must permit enrollee participation in plan's public policy.
Reasonable advocacy and witness fees for substantial contribution to consumers	§1348.9	Person or organization representing consumers that makes a substantial contribution to adoption of regulation, order or decision on behalf of consumers is entitled to advocacy and witness fees.
Delegation of responsibilities is not a waiver	§1367(j)	A plan's responsibility to comply with standards in §1367 is not waived by contracting to medical groups or other entities.
Billing by non-contracting hospital for post-stabilization care	§1371.4(j), 1262.8(c)	A non-contracting hospital may not bill the patient for post-stabilization care if the hospital has not contacted the patient's health plan prior to that care.
Telephone Medical Advice Services	§1348.8	Requirements and standards for telephone medical advice services offered by health plans.
Discharge planning policy and process	§§1262.5, 1367.5	Hospitals must have a written discharge planning policy and process requiring, and inform patients of continuing health care requirements.
Access to Care		
Availability of services	§1367(e)(1)	Plan must ensure that all services are available at reasonable times to each enrollee consistent with good professional practice.

Telephone Medical Advice Services	§1348.8	Staff providing telephone medical advice must be properly licensed; must provide a physician and surgeon on call; must maintain records of medical advice conversations.
Right to Select Primary Care Provider	§1373.3	Right to select any primary care provider who is available and in the network.
Right to Specialist Referral	§1374.16	Right to a standing referral for specialist for series of visits; right to an HIV specialist.
Newborn Coverage	§1373(c)	Coverage for spouse or dependents includes immediate accident and sickness coverage for an infant born to a subscriber or spouse.
Children not living in the home	§1374.57(a)	Group health plans cannot exclude a child dependent solely because the dependent child does not live with the insured.
Pre-existing Illness and Late Enrollees	§§1357.50-1357.54	Special provision for health plans regarding pre-existing illness exclusions and late enrollment; definitions of “pre-existing condition,” “late enrollee,” and “creditable coverage.”
OB/GYN	§1367.69	Right to select OB/GYN as primary care provider.
OB/GYN	§1367.695	Right to seek OB/GYN services without prior approval.
Reproductive Health	§1363.02	Required information on reproductive health services, required notice when providers do not offer reproductive health services.
Adequate capacity	§1367(g)	Plans must be sure that providers have the organizational and administrative capacity to provide the services for which the plan is obligated.
Provider Lists	§1367.26	Upon request, plans must provide lists of providers with certain information about the providers.
Domestic Partners	§1374.58	Plans deemed to provide coverage to registered domestic partners equal to spouse coverage.

Geographic Access in less populated counties	§1366.1	DMHC must develop regulations for geographic access in less populated counties. Plans intending to withdraw from these counties where two or fewer plans serve the county must hold public hearings.
Specific Services Coverage		
Basic Services	§1367(i)	Unless exempted, plans must provide basic health care services as defined in §1345(b).
Children's Preventive Care	§§1367.3, 1367.35	Provide preventative care for children through age 18 (some exceptions) and communicate the availability of the care to enrollees.
Pediatric Asthma	§ 1367.06	Plans covering prescription drugs must also cover inhaler spacers, nebulizers, and peak flow meters for pediatric asthma.
Maternity, Labor & Delivery	§1367.62	Cover inpatient hospital care for at least 48 hours following normal vaginal delivery, 96 hours after a Cesarean Section. Inpatient hospital care may be for a shorter period only if certain conditions in the statute are met.
Maternity Care Cost sharing (Maternity Parity Act)	§1373.4	Limits on co-payments and deductibles for maternity care. Prohibits exclusion of involuntary complications, unless the provisions apply generally to all benefits paid under the plan.
OB/GYN	§1367.69	Right to select OB/GYN as primary care provider.
OB/GYN	§1367.695	Right to seek OB/GYN services without prior approval.
Reproductive Health	§1363.02	Required information on reproductive health services, required notice when providers do not offer reproductive health services.
Sterilization restrictions	§1373(b)	Plans that cover sterilizations cannot place restrictions on coverage based on the patient's reasons for the procedure.

Preventive Care Services	§§1367.3, 1367.35	Group health plans must cover preventive services for children through age 18, including lead screening.
Diabetes Coverage	§1367.51	Plans must cover prescription and over-the-counter equipment and supplies for management of diabetes.
Mammography	§1367.65	
Breast Cancer Treatment	§1367.6	Conditions under which breast cancer treatment must be covered.
Cervical Cancer Screening Coverage	§1367.66	Conditions under which cervical cancer screening must be covered. Must cover annual screening.
Prostate cancer screening	§1367.64	
Other cancer screening tests	§1367.665	Plans deemed to provide coverage for all generally medically accepted cancer screening tests, subject to all terms and conditions that would otherwise apply.
Osteoporosis	§1367.67	Diagnosis and treatment covered.
Jawbone Surgical Procedures	§1367.68	
Routine patient care costs related to clinical trial for cancer patients	§1370.6	Health plans must cover routine patient care costs for enrollees with cancer who are in clinical trials.
Reconstructive Surgery	§§1367.63, 1367.635	Plans must also cover reconstructive surgery incident to mastectomies.
Orthotic and prosthetic devices	§§1367.18, 1367.19	
Severe mental illnesses and serious emotional disturbance	§1374.72	Mental health parity. Plans must cover diagnosis and medically necessary treatment of certain listed mental conditions.
Mental Health	§1373(h)	Mental health services are optional, but if covered, plan must make disclosures of limitations on outpatient services and must allow enrollees to access their preferred providers affiliated with the plan.
Mental Health	§1374.5	Lifetime waiver of mental health services coverage in nongroup health plans is unenforceable.

Vision Services	§1373(h)	Vision services are optional, but if covered, plan must make disclosures of limitations on outpatient services and must allow enrollees to access their preferred providers affiliated with the plan.
Infertility Treatment	§1374.55	
Prenatal Genetic Disorder Testing of Fetus	§1367.7	Plans must include coverage for prenatal diagnosis of genetic disorders of the fetus in high-risk pregnancies.
Conditions attributable to DES Exposure	§1367.9	Plans must include coverage for conditions related to DES or exposure to DES.
Home Health Care	§1374.10	
Hospice Care	§ 1368.2	Plans must include coverage for hospice care at least to the same extent as Medicare provides.
Second Opinions	§§1383.1, 1383.15	Enrollees may request and receive a second opinion. Expedited authorization of second opinion available.
Transportation	§1367.11	Provision for direct payment to transportation providers.
AIDS Vaccine	§1367.45	Plans must cover the cost of an AIDS vaccine, when one is developed.
Prescription Drugs		
Drug Coverage	§1363.01	Evidence of coverage must include information on the health plan's drug formulary. Provide information upon request on whether specific drug is on the formulary.
Cost Sharing and Exclusions of Drugs	§ 1342.7(c)	Plans may charge co-payments or deductibles on drug coverage. Plans may impose limitations or exclusions.
Formulary Availability	§1367.20	Provide drug formulary to members of the public upon request.
Drugs removed from Formulary	§1367.22(a)(b)	Cannot cut coverage of prescription drug already approved by health plan as long as doctor prescribes as medically necessary. Applies to drugs that the health plan removes from drug formulary. Does not apply to "off-label" use.
Off-formulary Drugs	§1367.24	Have expeditious process for approving drugs that are not on the formulary.

DMHC approval of drug exclusion	§ 1342.7(b)(1)	If DMHC approves an exclusion to a plan's prescription drug benefits, the exclusion is not subject to an IMR process based on medical necessity.
Prescription Denials	§1367.24(b)	Provide written notice of denial of nonformulary drug, with explanation of the reason for denial & grievance right.
Off-label Prescriptions	§1367.21	Plans must cover a prescription drug that is prescribed for a purpose other than the FDA-approved purpose if certain statutory conditions are met.
Process for getting drugs not on the formulary	§1367.24(a), (d)	Plans must maintain an expeditious process for enrollees to get non-formulary drugs. Plans must advise enrollees of the process.
Contraceptives coverage	§1367.25	Plans must cover contraceptives and provide exception for and definition of religious employer.
Uniform card with uniform prescription drug information	§1363.03	Health plans must issue a uniform prescription drug benefits card (unless health plan card contains required information).
Experimental or investigational therapies	§1370.4	Plans must have an external, independent review process for experimental or investigational therapies. Criteria for that process.
Pain Management Medications for Terminally Ill Patients	§1367.215	Plans with a prescription drug benefit must cover pain management medications for terminally ill patients. Plan must approve or deny request within 72 hours.
Emergencies and Post-Emergency Care		
Twenty-four Hour Access to Authorization for emergency care	§1371.4(a)	Must provide 24 hour access for enrollees and providers to obtain timely authorizations for care where enrollee has received an emergency stabilization, but transfer or discharge cannot be done safely.
Emergency Services Reduction	§1364.1	Notice requirement for reduction or elimination of emergency services.
Emergency Care up to Stabilization of Enrollee's Condition	§1371.4(b), (j)	Health plan must reimburse a provider for emergency care rendered to an enrollee until the care results in stabilization of the enrollee's condition.

Contacting health plan before rendering post-stabilization services	§1371.4(j), 1262.8	A non-contracting hospital must contact the patient’s health plan before admitting patient for post-stabilization care or transferring patient to a non-contracting hospital for post-stabilization care. If the hospital fails to do this, it may not bill the enrollee for post-stabilization care.
Post-stabilization reimbursement to provider	§1371.4(c), (j)	Health plan may require prior authorization for care to an enrollee after stabilization of an emergency medical condition in order for a provider to receive reimbursement for those services.
Prudent layperson definition of an “Emergency”	§1371.5	Coverage for emergency medical conditions and ambulance services when an enrollee reasonably believed that an emergency existed.
Mexican prepaid health plans licensed in California	§ 1351.2(a)(2), (a)(4)	These health plans may pay for urgent and emergency care within California.
Continuing Coverage and Completion of Previously Covered Care		
Continuity of care	§1367(d)	Furnish services in a manner providing continuity of care and ready referral.
Conversion Privilege	§1373.6	Group health plans must offer a right to convert to an individual plan if an employer terminates the group plan.
Continuation for totally disabled	§1399.62(a)	Every contract shall contain a reasonable extension of benefits in the event of total disability while enrolled and upon a discontinuance of the insurance contract.
Extension for totally disabled	§1399.62(b)	Every contract is deemed to include a period of no less than 12 months of reasonable extension of benefits for a covered condition that causes total disability in the event of the discontinuance of the insurance contract.
Cal-COBRA	§§1366.20-1366.29	Cal-COBRA provisions. Continuing health care coverage for employees in businesses that are too small for federal COBRA coverage or after federal COBRA has run out. Qualified beneficiaries may extend health care coverage up to 36 months.

COBRA-type coverage for individual health coverage	§ 1366.3	Health plans that cease to offer individual health insurance must offer extended coverage to current subscribers. Does not apply to PPOs.
HIPAA implementation (Cannot impose a pre-existing illness exclusion on certain individuals who had continuous coverage.)	§§1366.35,1373.621, 1399.801	Provisions implementing federal HIPAA and providing for availability of continued coverage after COBRA and Cal-COBRA exhausted.
Conversion Rights after loss of employment or group membership	§§1373.1, 1373.2, 1373.6	Right to convert coverage after termination of employment or group membership.
Contract Termination Notice	§1373.65	If a plan terminates a contract with a provider group or a general acute care hospital, it must give 60 days notice to enrollees receiving services from that provider group or hospital.
Completion of Care for New and Continuing Enrollees with an Acute Condition	§1373.96(c)(1)	Health plan responsible for completion of covered services for an acute condition of limited duration for new enrollees or enrollees receiving services from a terminated provider or nonparticipating provider.
Completion of Care for New and Continuing Enrollees with a Serious Chronic Condition	§1373.96(c)(2)	Health plan responsible for completion of covered services (up to 12 months) for a serious chronic condition for new enrollees or enrollees receiving services from a terminated provider or nonparticipating provider.
Completion of Care for New and Continuing Enrollees with a Terminal Condition	§1373.96(c)(4)	Health plan responsible for completion of covered services to a new enrollee or enrollee receiving services from a terminated or nonparticipating provider where the enrollee has a terminal illness. Coverage continues for duration of terminal illness.

Completion of Care for Authorized Surgery	§1373.96(c)(6)	Health plan responsible for covering surgery or other procedure to an enrollee or new enrollee receiving services from a terminated or nonparticipating provider where the services were authorized to occur within 180 days of the termination date for enrollees or within 180 days of the effective date of coverage for a newly covered enrollee.
Completion of Care for New and Continuing Pregnant Enrollees	§1373.96(c)(3)	Health plan responsible for completion of covered services for a pregnant enrollee or enrollee receiving services from a terminated or nonparticipating provider. Coverage continues through pregnancy and immediate postpartum period.
Completion of Care for Child between birth and 36 months	§1373.96(c)(5)	Health plan responsible for completion of covered services (up to 12 months) to a new enrollee or enrollee receiving services from a terminated or nonparticipating provider where the services are for care of a child between birth and 36 months.
Enrollee's cost-sharing during period of completing continuing services	§1373.96(f)	If a new or continuing enrollee receives the continuing services under one of the provisions above, the enrollee's cost-sharing is the same as if the provider were employed by or contracting with the health plan.
Completion of care coverage not required for certain newly covered enrollees	§1373.96(j)	A plan need not pay for completion of care if a newly covered enrollee has an out-of-network option or could have remained with previous health plan but voluntarily changed plans.
Continuity of care for new and continuing enrollees receiving mental health services	§1373.95	Health plan must file a written policy concerning how it will facilitate continuity of care for new or continuing enrollees, receiving mental health services. Enrollees have a right to review the policy.
Grievances and Other Dispute Resolution		
Internal Grievance Procedure	§1368(a)	Every plan must have an internal grievance procedure; inform enrollees upon enrollment and annually thereafter of the grievance procedure; provide grievance forms.

Acknowledgement and logging of grievances	§§1368(a)(4), (a)(6)	Plans must send an acknowledgement of receiving a grievance and must maintain a record of grievances.
Online grievance forms and filing	§1368.015	Among other requirements, plans must maintain a Web site and allow for online grievance submission.
Primary Language Assistance in Grievance Process	§1367.04(b)(1)(B)(iv), (b)(1)(C)(iii)	Enrollees' right to notices in primary language; interpretation assistance with grievances.
Normal timeframe for resolving a grievance	§1368.01(a)	Plans must resolve grievances within 30 days.
Expedited timeframe for resolving a grievance	§1368.01(b)	For grievances in cases involving imminent and serious threat to the patient's health, plan must resolve grievance within 3 days.
Written response to grievance	§1368(a)(5)	The plan must respond to a grievance in writing, citing authority for the response.
Untimely resolution of grievances	§1368(c)	Report grievances pending or unresolved after 30 days; director of grievances must make reports available to the public.
Exhaustion of process	§1368(d)	Internal grievance procedures need not be exhausted before pursuing other remedies.
DMHC Review of Grievances	§1368(b)	Consumer may seek DMHC review after grievance completed or after 30 days in the grievance process without resolution. DMHC review allowed in less than 30 days if exigent circumstances. Process of DMHC review.
Appeals	§1370.2	Appeal of a plan decision must be reviewed by the Medical Director or a licensed provider who is competent to evaluate the specific clinical issues of the appealed claim, including medical necessity.
Arbitration Access and Fees	§1373.20	Timely access to arbitration; waiver of arbitration fees in hardship cases.
Arbitration Process and Written Decision	§§1373(i), 1373.19, 1373.20, 1373.21	Plan must describe arbitration process, if any. Selection process for arbitrator. Written arbitration decision required.

Required disclosures for binding arbitration	§1363.1	Plans that require binding arbitration or waiving right to jury trial must make certain disclosures.
Independent Medical Review	§§1374.30-1374.35	Process and standards for an external, independent medical review system for services denied, modified, or delayed by a managed care plan. Consumer must file internal grievance first. If grievance is unresolved, consumer can request an independent review. Expedited timeframes for urgent cases. Consumer has 6 months to file.
Prompt Implementation of Independent Medical Review Decision	§1374.34	Health plans must promptly implement IMR decision; time periods for implementing, including reimbursements to enrollee.
Independent Review Process for Experimental or Investigational Drugs	§1370.4	Plans must have an external, independent review process to review a plan's decisions regarding experimental or investigational drugs. Criteria for the process and procedure.
DMHC approval of drug exclusion	§1342.7(b)(1)	If DMHC approves an exclusion to a plan's prescription drug benefits, the exclusion is not subject to an IMR process based on medical necessity.
Dispute Resolution	§1367(h), 1371.38	Plans must establish dispute resolution procedures for enrollees and providers and annually report on the dispute resolution mechanism for providers. Dispute resolution mechanism must be included in contracts.
Expedited Review	§1367.215	Expedited review for pain medication for terminally ill patients.
Annual Grievance Report	§1397.5	Annual public record summary of number and types of grievances.
Advocacy fees not available for individual grievances or complaints	§1348.9(c)	Advocacy fees are not available for resolution of individual grievances, complaints or cases.
Utilization Review & Claims Processing		
Medical Decisions	§1367(g)	Medical decisions must be made by qualified medical providers, unhindered by fiscal and administrative management.

Authorization and Denial	§1363.5(a)	Plans must have criteria and a process for authorization and denial of claims.
Appropriate Criteria for Authorization Denial or Modification of Services	§1363.5(b)	Use providers and clinical judgment in developing the criteria and the process and keep criteria current.
Disclosure of Authorization Criteria	§1363.5(a),(b)	Plans must disclose the authorization and denial criteria to providers. Must disclose to enrollees and to the public upon request or when used as the basis of a specific denial.
Appropriate Procedures for reviewing health care providers' service requests	§1367.01(a),(b),(e)	Must have written policies and procedures for prospective, retrospective, or concurrent reviews, approvals, modifications, delays or denials of requests for services. Only licensed, competent medical personnel may deny or modify requests based on medical necessity. Applies to health plans and subcontractors.
Medical Director	§1367.01(c)	A plan must have a medical director who is licensed to practice in California.
Medical Directors of Mexican Health Plans	§§ 1351.2(a)(11), 1367.01 (c)	Medical director need not be licensed in California if health care services wholly provided in Mexico. Special requirements in effect until 1/1/08.
Utilization Review for Medical Necessity	§1367.01(f), (h)	Utilization review must be consistent with clinical principles and processes and based on medical necessity.
No Rescission of Authorization after Treatment	§ 1371.8	See U.C. Regents v. Principal Financial, 412 F. Supp. 2d 1037 (N.D. Cal. 2006).
Normal Timeframes for Review	§1367.01(h)(1)	Reviews done within 5 business days.
Expedited Review of Service Requests	§§1367.01(h)(2)	72 hour timeframe for review when enrollee faces an imminent and serious threat to his/her health.
Communicating Review Decisions to Enrollees and Providers	§§1367.01(h)(3), (h)(4)	Decisions must be communicated to provider within 24 hours of being made. Explanations of reasons for the decision and grievance rights are included in the response.

Review when additional information or tests are required	§1367.01(h)(5)	If a plan cannot make a decision on time because of a need for information or a specific test, the plan should inform the enrollee and offer a timetable for the decision to be made.
Hearing for Untimely Utilization Review	§1367.01(h)(6)	Hearing right for reviews that are not completed in a timely manner.
Administrative Penalties for failure to meet timeframes	§1367.01(h)(6)	DMHC may assess administrative penalties for failure to meet the timeframes or other requirements of this section.
Claims Processing	§§1371, 1371.1, 1371.2, 1371.35, 1371.4	Generally 30 days to reimburse claims.
Denial of Claim Payment	§1371.36	Prohibited circumstances for denying a claim.
Unfair Payment Pattern	§§1371.37, 1371.39	Prohibition on and definition of unfair payment pattern. Reporting, enforcement and penalties.
Claims Dispute Resolution	§1371.38	DMHC must develop regulations to require plans to have mechanisms to resolve claims disputes with contracting and non-contracting providers.
Claims Review	§§1399.55-1399.57	A rejected claim must include the specific rationale for the rejection. Claims reviewers cannot be paid according to how many claims they reject. These provisions do not apply to Medi-Cal.
Experimental or investigational therapies	§1370.4	Plans must have an external, independent review process for experimental or investigational therapies. Criteria for that process.
Claims for Psychiatric Inpatient Admissions	§1374.51	Claim reimbursement for psychiatric inpatient services may not be based on whether the admission was voluntary or involuntary.
Financial Protections and Solvency		
Financial Solvency	§§1347.15, 1375.1-1375.6, 1384	Requirements of fiscal solvency of risk-bearing health care provider entities, including independent practice associations and medical groups.
Disclosure of Financial Records	§1351.1	Application for licensure includes authorization for disclosure of financial records to DMHC.

Contracts between plans and risk-bearing organizations	§§1375.4, 1375.5, 1375.6	Requirements to ensure that the risk-bearing organization has sufficient administrative and financial capacity.
Limits on assigning financial risk to providers	§1375.8	Contracts may not make providers assume financial risk for adult vaccines and other injectable medications.
Insolvency	§§1394.7, 1394.8	Procedures for moving members to other plans when a plan becomes insolvent.
Meeting with Director prior to filing for bankruptcy	§1375.3	At least 10 days prior to filing for bankruptcy, a plan must meet with the director in order to ensure continuity of care and uninterrupted access to care for subscribers.
Marketing/Advertising		
Marketing and Advertising	§§1358.20, 1359-1366.4, 1388, 1389, 1395, 13.95.5, 1395.6	Marketing, advertising, and disclosure requirements and prohibitions. Deceptive practices. Discipline of illegal marketing.
Disclosure Forms	§1363, 1363.05	Requirements for disclosure forms, uniform matrix for displaying major provisions of a plan. Including disclosure of cost sharing, limitations on choosing a care provider, and limitations on covered services.
Restrictions on Application Assistants for Healthy Families or Medi-Cal	§1395(g)	Representatives of health, dental, or vision plans in the HFP or Medi-Cal may not make false or misleading claims.
Comparative benefits matrix	§§1363.06, 1363.07	DMHC and Dept. of Insurance to develop matrices showing a summary of a health plan or insurer's benefits in order to aid in comparing plans. Solicitors must provide a copy of the matrix to potential customers.
Health Care Provider Advertising	§1395.5	Contracts with providers may not restrict a provider's advertising.
Medi-Cal and Medicare		
Reduction in coverage	§1373(a)	Cannot reduce group coverage based upon an enrollee's entitlement to Medi-Cal.
Exclusions	§1373(a)	Cannot use Medi-Cal as an "other coverage" exclusion.
Medicare Supplement Contracts	§§1358.1-1358.23, 1363.05	Special rules and definitions for plans offering Medicare supplemental contracts.
Prohibited contract provisions in Medi-gap policies	§1358.6	

Renewal or continuation of Medi-gap policies, required disclosures	§§1358.17, 1358.18	
Advertising and Marketing of Medi-gap policies	§§1358.19, 1358.20, 1358.21	
Medicare Supplement Open Enrollment periods	§1358.11	
Prescription Drugs	§1342.7(g)	DMHC cannot require a plan to cover or authorize prescription drugs to Medi-Cal or Healthy Families beneficiaries beyond what those programs provide.
Managed Risk Medical Insurance Program (MRMIP)		
Continuation of MRMIP plan	§ 1373.622	Continuation of a MRMIP plan after program termination.
DMHC Structure and Enforcement		
Department of Managed Health Care	§1341 <i>et. seq.</i>	Department of Managed Health Care oversees managed care health plans under Knox-Keene.
DMHC Public Records	§1341.5	Provisions for public access to information filed with or obtained by the DMHC.
DMHC Conflict of Interest	§1341.7	Conflict of interest standards for DMHC.
Legislative Intent	§§1342, 1342.6, 1342.7	Legislature's intent for enacting Knox-Keene and establishing DMHC.
Applicability	§§1343, 1343.1, 1343.5, 1346.5	Listing of types of health plans covered under Knox-Keene and procedures for exemption from the Act.
Rulemaking	§1344	Director of DMHC's power to issue rules and opinions.
Definitions	§1345	Definitions of terms used in Knox-Keene Act.
Powers of Director	§§1346, 1353, 1357.10, 1368.04, 1386, 1390-1394.3, 1399	Enforcement powers of Director of DMHC, suspensions and revocations of licenses.
Power to regulate prescription drug benefits	§1342.7	DMHC has the power to regulate the provision of medically necessary prescription drugs when a plan offers drug coverage.

Power to develop standards for prescription drug benefits	§1342.7(d)	DMHC may develop standards for approval of co-payments, deductibles, limitations, and exclusions to a plan's drug benefit.
Financial Solvency Standards Board	§1347.15	
Patient Advocate	§1368.02	Establishment and duties of the Office of Patient Advocate.
Enforcement of Grievance Procedures	§ 1368.04	DMHC has power to investigate and enforce noncompliance with grievance procedure requirements. May levy administrative penalties.
Standards of timeliness of access to care, availability of physicians	§ 1367.03(a)-(f)	DMHC must develop regulations setting standards of timeliness of access to care, availability of physicians, specialists, and other health care.
Enforcement of timeliness of access to care standards	§1367.03(g)-(h)	Enforcement of the standards, notice and hearing, administrative penalties.
Onsite visits to health plans	§ 1367.24(f), 1380	DMHC shall conduct periodic (at least every 3 years) onsite medical surveys of plans' health delivery systems.
DMHC coordination with Dept. of Insurance	§§ 1342.4, 1342.5	Work group to coordinate the two departments and ensure consistency in consumer protections. Reports January 1 of each year.
Standards for Primary Language Access	§ 1367.04	DMHC must develop regulations on standards for translation and interpretation by 1/1/06.
Contracts with Providers		
Health Care Providers' Bill of Rights	§ 1375.7	Limits to changes in contracts. Limits to numbers of patients. Complying with quality improvement.
Limits on assigning financial risk to providers	§ 1375.8	Contracts may not make providers assume financial risk for adult vaccines and other injectable medications.
Adequate capacity	§1367(g)	Plans must be sure that providers have the organizational and administrative capacity to provide the services for which the plan is obligated.

Fairness of Contracts	§1367(h)(1)	Contracts with subscribers, enrollees, providers, and others must be fair, reasonable, and consistent with the objectives. Contracts must include dispute resolution mechanisms.
Illegal Incentives	§1348.6, 1367.62(a)(3)	Prohibited incentives in contracts which discourage care for people with particular medical conditions or which encourage an attending physician to discharge a woman prematurely from a hospital after giving birth.
Non-physician contracts	§§1366.4, 1367(h)(1)	Provisions for health plan contracts with licensed, non-physicians. Contracts must be fair, reasonable and consistent with the Act's objectives.
Provider Lists	§1367.10, 1367.26	Plans must provide lists of providers with certain information about the providers.
POS Plan Contracts	§§1374.60-1374.75	Provisions applying only to Point of Service Plan contracts.
Contracts may not interfere with discharge planning	§1367.5	Contracts may not prohibit or restrict a hospital's duty under §1262.5 to provide a discharge policy and process.
Compliance with timeliness of access to care standards	§ 1367.03(f)(1)	Contracts must ensure compliance with regulations on timeliness of access to care standards.
Nonwaiver of Responsibility when services delegated	§1367(j)	When a plan delegates services to medical groups and other contracting entities, it shall not waive its responsibilities under §1367.
Health Care Provider Advertising	§1395.5	Contracts with providers may not restrict a provider's advertising.
Financial risks for immunizations	§1367.36	Contracts cannot make providers bear the financial risk for the acquisition costs of children's immunizations.
Sale, lease or transfer of contracted providers lists	§1395.6	Limits on sale, lease, or transfer of lists of contracted providers.
Providing assistance in the enrollee's primary language	§1367.04(b), 1367(e)(3)	Thresholds triggering translations. Surveys of language needs. Access to interpretation services.
Changes to provider contracts for Medi-Cal and Healthy Families services	§ 1375.7(b)(1)(C)	Plans must give 90 days notice of material changes; provider has rights to negotiate or terminate the contract.

Information about termination dates of major health care provider contracts	§ 1366.2	Group subscribers may request the termination dates of contracts between plans and local and major health care providers.
Contracts with Employers		
Health Plans & Small Employers	§§1357-1357.17	Health plans offering contracts to small employers (2-50 employees) and associations have additional requirements, including waiting periods, late enrollee, and pre-existing illness provisions.
Definitions of terms and rights under small group employer plans	§1357	
Licensing of Plans		
Health Plan Licensing	§§1349-1349.2, 1350, 1351.2, 1351.3, 1353, 1354,1355, 1356, 1367(i), 1386, 1389, 1399	Requirements for licensing and exemptions, revocation.
Schedule of costs of obtaining a license	§1356, 1356.1	License cost is a base amount plus an assessment based on the number of enrollees.
Nonprofit Health Plans	§§1399.70-76	Special provisions for nonprofit health plans, including nonprofits converting to for-profit status.
Licensed facilities	§1367(a)	Plans must use licensed facilities.
Licensed Personnel	§1367(b)	Must use licensed and/or certified personnel.
Allied Health	§1367(f)	Employ and utilize allied health professionals.
Suspension or revocation of licenses, discipline	§1386, 1393.5	Acts or omissions that can result in disciplinary action by DMHC, including suspension or revocation of license.
Licensure of Mexican health plans	§1351.2	Requirements for Mexican health plans to obtain licensure from DMHC to cover Mexican nationals in San Diego and Imperial counties for services provided wholly in Mexico.

Reporting by Health Plans		
Plan Reporting	§§1352, 1352.1	Requires plans to report certain changes to DMHC.
Disclosure of bonuses and incentives	§1367.10(b)	Plan disclosure statements must describe any bonus or financial incentive arrangements.
Dispute Resolution Reports	§1367(h)(3)	Health plans must annually report on dispute resolution procedures and outcomes with providers.
Compliance with timeliness of access to care standards	§§ 1367.03(f)(2), (h)	Plans must report on compliance with the timeliness of access to care standards. Compliance will be reported in the OPA's report cards.
Culturally appropriate care	§ 1367.07	Plans must report to DMHC on internal policies and procedures related to providing culturally appropriate care.
Quality Assurance		
Quality Assurance	§§1367.01, 1367.02, 1367.04, 1370, 1370.1	Plans must establish procedures for ensuring quality of services.
Quality Assurance	§§1367.03, 1380-1383	DMHC monitoring of health plan and provider quality.
Annual Grievance Report	§1397.5	Annual public record summary of number and types of grievances.
Liability		
Liability between plans, contractors, and providers	§1371.25	Plans, contractors, and providers are not liable for the others' acts or omissions.
Contracts between Plans and Providers	§1379	Contracts must provide that subscribers or enrollees are not liable for money the plan owes.

Health Plan Liability to Subscribers	Civil Code §3428	Health plans have duty of ordinary care to arrange for the provision of medically necessary services. Plan is liable for harm caused by negligence if it resulted in denial, delay, or modification of a health care service recommended for or furnished to an enrollee and the person suffers substantial harm. Consumer must exhaust other remedies (e.g. independent external review) before suing unless substantial harm occurs before exhaustion or will occur immediately.
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Table expanded from chart originally prepared by Protection & Advocacy, Inc. Additional analysis by Marjorie Swartz, Western Center on Law & Poverty. Chart expanded and updated by National Health Law Program, 2002, 2003, 2004, 2005, 2006, 2008.