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Knox-Keene Protections (Generally Health and Safety Code §§1340-1399.818 and Title 28 of the California Code of Regulations) 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. Provisions of the Knox Keene Act may be preempted by federal law.[1]

Consumer Protections

Access to Care

Specific Services Coverage

Prescription Drugs

Emergencies and Post-Emergency Care

Continuing Coverage and Completion of Previously Covered Care

Grievances and Other Dispute Resolution

Utilization Review & Claims Processing

Financial Protections and Solvency

Marketing/Advertising

Medi-Cal & Medicare

Managed Risk Medical Insurance Program (MRMIP)

DMHC Structure and Enforcement

Contracts with Providers

Contracts with Employers

Licensing Of Plans

Reporting By Health Plans

Quality Assurance

Liability

Compliance with the Patient Protection and Affordable Care Act

Subject Area	H&S Code Section(s)	Description	Implementing Regulations (California Code of Regulations Title 28)	Case Law
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.		*Rakestraw v. California Physicians' Serv.*, 81 Cal. App. 4th 42 (2000). Copayments for maternity services do not violate the Knox-Keene Act's prohibition against charging a copayment "because of sex."
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.	§1300.67.04	
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.	§§1300.65, 1300.65.1	
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. Adopt thresholds for reasonable times in accessing care.	§§1300.67.01, 1300.67.02, 1300.67.2.2 (timely access to non-emergency health care services)	
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.	§ 1300.74.16	
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 through the plan's board, committees, etc.	§ 1300.69	
Reasonable advocacy and witness fees for substantial contribution to consumers	§1348.9	Person or organization that makes a substantial contribution to adoption of regulation, order or decision on behalf of consumers is entitled to advocacy and witness fees.	§ 1010 (Consumer Participation Program)	
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.	§§1300.67.01, 1300.67.02, 1300.67.2.2 (timely access standards for non-emergency health care services)	
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.	§ 1300.74.16	
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.	§1300.67.2.1	

Specific Services Coverage				
Basic Services	§1367(i)	Unless exempted, plans must provide basic health care services as defined in §1345(b).	§§1300.67, 1300.67.005	
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	Plans must provide coverage for mammography for screening or diagnostic purposes.		
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	Plans must provide coverage for screening and diagnosis of prostate cancer.		
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	Must cover medically-necessary surgical procedures affecting the jawbone.		
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			*Garcia v. PacifiCare of California, Inc.*, 750 F.3d 1113 (9th Cir. 2014). Exclusion in employer's group health insurance plan for myoelectric prosthetic devices did not violate Knox-Keene Act. Statute only required that whatever prosthetics coverage was offered by plan, it had to include original and replacement devices.
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.	§ 1300.74.72 (Mental Health Parity)	*Harlick v. Blue Shield of California*, 686 F.3d 699 (9th Cir. 2012). Mental Health Parity Act requires that a plan within the scope of the Act provide all "medically necessary treatment" for the nine enumerated "severe medical illnesses" under the same financial terms as those applied to physical illnesses.
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	Plans must offer coverage for treatment of infertility, except in vitro fertilization. Must be provided without discrimination consistent with Section 1365.5. Employers that are religious organizations are not required to provide coverage for infertility treatment inconsistent with religious beliefs.		
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	Applies to plans that are not health maintenance organizations.		
Hospice Care	§1368.2	Plans must include coverage for hospice care at least to the same extent as Medicare provides.	§ 1300.68.2	
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, and plan must provide information upon request on whether specific drug is on the formulary. Internet web site where the formulary is posted must be provided to enrollees as well.	§ 1300.67.24	
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.	§ 1300.67.24	
Formulary Availability	§1367.20	Provide drug formulary to members of the public upon request.	§ 1300.67.24	
Posting Formulary Online	§1367.205	Plans must post formularies online, update them on a regular basis, and must include information on cost-sharing and utilization controls.		
Drugs removed from Formulary	§1367.22(a)(b)	Cannot cut coverage of prescription drug approved by health plan as long as doctor prescribes as medically necessary, even if removed from formulary. Does not apply to "off-label" use.	§ 1300.67.24	
Off-formulary Drugs	§1367.24	Have expeditious process for approving drugs that are not on the formulary.	§ 1300.67.24	*Kaiser Found. Health Plan, Inc. v. Zingale*, 99 Cal. App. 4th 1018 (2002). Plans not required to cover all medically necessary outpatient drugs, despite the Department's attempt to impose that requirement in regulation.
Step Therapy	§1367.243	Rules around step therapy requirements for prescription drugs.		

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.	§ 1300.67.24	
Prescription Denials	§1367.24(b)	Provide written notice of denial of non-formulary drug, with explanation of the reason for denial & grievance right.	§ 1300.67.24	
Off-label Prescriptions	§1367.21	Plans must cover a prescription drug that is prescribed for a purpose other than the FDA-approved purpose ("off-label" use), if certain statutory conditions are met.	§ 1300.67.24	
Process for getting drugs not on the formulary	§1367.24(a), (d)	Plans must maintain an expeditious process for enrollees to get necessary non-formulary drugs. Plans must advise enrollees of the process.	§ 1300.67.24	
Contraceptives coverage	§1367.25	Plans must cover contraceptives and provide exception for and definition of religious employers.		
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.).	§ 1300.67.24	
Experimental or investigational therapies	§1370.4	Plans must have an external, independent review process for experimental or investigational therapies. Criteria for that process.	§ 1300.70.4	*California Physicians' Serv. v. Aoki Diabetes Research Inst.*, 163 Cal. App. 4th 1506 (2008). IMR is available to subscribers who are denied coverage for assertedly experimental therapies, but they are not required to seek IMR before pursuing other available remedies.

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.		*California Pac. Reg'l Med. Ctr. v. Global Excel Mgmt*., No. 13-cv-00549 NC, 2013 WL 2436602 (N.D. Cal. June 4, 2013). This section does not provide a private right of action; *Bell v. Blue Cross of California*, 131 Cal. App. 4th 211 (2005). This section requires plans to reimburse for reasonable amounts, rather than amounts unilaterally determined by plans; *Prospect Med. Group, Inc. v. Northridge Emergency Med. Group*, 45 Cal. 4th 497 (2009). Emergency room doctors may not balance bill patients when they are out-of-network.

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.	§ 1300.67.1	
Conversion Privilege	§1373.6	Group health plans must offer a right to convert to an individual plan if an employer terminates the group plan. Due to the Affordable Care Act, this only applies to individual grandfathered health plan contracts previously issued pursuant to this section to federally eligible defined individuals.		

Continuation for total disability	§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 total disability	§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. Conversion privilege does not apply unless certain changes are made to the Affordable Care Act.		
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. The plan must send a department-approved written notice to the enrollees.		
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.		

Eligibility to be a newly covered enrollee	§1373.96(l)	Prior coverage was terminated between December 1, 2013 and March 31, 2014, and the enrollee was receiving services from that provider for certain specified conditions.		
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.	§1300.68	
Acknowledge-ment 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.	§1300.68	
Online grievance forms and filing	§1368.015	Among other requirements, plans must maintain a Web site and allow for online grievance submission.	§1300.68	
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.	§§1300.68, 1300.67.04	
Normal timeframe for resolving a grievance	§1368.01(a)	Plans must resolve grievances within 30 days.	§1300.68	
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.	§ 1300.68.01 (Expedited Review of Grievances)	

Written response to grievance	§1368(a)(5)	The plan must respond to a grievance in writing, citing authority for the response.	§1300.68	
Untimely resolution of grievances	§1368(c)	Report grievances pending or unresolved after 30 days; director of grievances must make reports available to the public.	§1300.68	
Exhaustion of process	§1368(d)	Internal grievance procedures need not be exhausted before pursuing other remedies	§1300.68	
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.	§1300.68	
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.	§1300.68	
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.		*Zembsch v. Superior Court*, 146 Cal. App. 4th 153 (2006). Disclosure must be prominent, and noncompliance renders arbitration agreement unenforceable; *Viola v. California Dept. of Managed Health Care*, 133 Cal. App. 4th 299 (2005). Employers may negotiate a contract waiving jury trial on behalf of employees; *Pagarigan v. Superior Court*, 102 Cal. App. 4th 1121 (2002) Regulations promulgated under the Medicare Choice program do not preempt this provision; *Smith v. PacifiCare Behavioral Health of California, Inc.*, 93 Cal. App. 4th 139 (2001). The Federal Arbitration Act does not preempt this provision.
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.	§§ 1300.70.4, 1300.74.30	*Consumer Watchdog v. Dep't of Managed Health Care*, 225 Cal. App. 4th 862 (2014). DMHC must exercise discretion to determine whether grievance raising issues of medical necessity and coverage should be resolved through the independent medical review system or through the standard grievance procedure.

Prompt Implementation of Independent Medical Review Decision	§1374.34	Health plans must promptly implement IMR decision; time periods for implementing, including reimbursements to enrollee.	§§ 1300.70.4, 1300.74.30	
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.	§§ 1300.70.4, 1300.74.30	*California Physicians' Serv. v. Aoki Diabetes Research Inst.*, 163 Cal. App. 4th 1506 (2008). IMR is available to subscribers who are denied coverage for assertedly experimental therapies, but they are not required to seek IMR before pursuing other available remedies.
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.	§ 1300.71.38	
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.	§1300.67.3 (separation of medical decisions from fiscal and administrative)	
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	A health plan that authorizes a specific type of treatment by a provider shall not rescind or modify the authorization after the provider renders the service to the enrollee in good faith. This section does not expand or alter the benefits available to the enrollee under the plan.		*U.C. Regents v. Principal Fin.*, 412 F. Supp. 2d 1037 (N.D. Cal. 2006). This provision does not relieve the plan from the obligation to pay on the grounds that the enrollee was ineligible for benefits due to his participation in criminal activity.
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.		*Ochs v. PacifiCare of California*, 115 Cal. App. 4th 782 (2004). No independent basis of liability for health care payments by service plans that have delegated their obligations to contracting entities under the Knox Keene Act.
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.	§ 1300.71	*Children's Hospital Central California v. Blue Cross of California*, 226 Cal. App. 4th 1260 (2014). Factors in the regulation's definition of "reimbursement of a claim" may provide guidance in analyzing the reasonable value of the services, but are not the exclusive measure.
Claims Review	§§1399.55-1399.57	A rejected claim must include the specific rationale for the rejection. Claims reviewers cannot be paid by number of rejected claims. 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.		*California Physicians' Serv. v. Aoki Diabetes Research Inst.*, 163 Cal. App. 4th 1506 (2008). IMR is available to subscribers who are denied coverage for assertedly experimental therapies, but they are not required to seek IMR before pursuing other available remedies.
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.		*Cal. Med. Ass'n,* Inc. *v. Aetna U.S. Healthcare of California, Inc*, 94 Cal. App. 4th 151 (2001). No obligation for health plans to pay physicians after intermediaries failed to do so, if the health plan has already paid the intermediaries.
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, 1395.5, 1395.6	Marketing, advertising, and disclosure requirements and prohibitions. Deceptive practices. Discipline of illegal marketing.	§ 1300.61.3 (Deceptive Advertising); § 1300.66 (Deceptive Plan Names)	*People v. Cole*, 44 Cal. Rptr. 3d 261 (2006). Registered dispensing opticians not exempted for statutory prohibition on doing business with licensed optometrists or opthalmologists; *Samura v. Kaiser Found. Health Plan, Inc.*, 17 Cal. App. 4th 1284 (1993). Statute only applies to deceptive "use" in advertising.
Disclosure Forms	§1363, 1363.05	Requirements for disclosure forms, uniform matrix for displaying major provisions of a plan, including cost sharing, limitations on providers, and limitations on covered services.	§1300.67.4 (disclosure forms; subscriber and group contracts); § 1300.63; § 1300.63.3	
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.		
Health Care Provider Advertising	§1395.5	Contracts with providers may not restrict a provider's advertising.		
Medi-Cal & 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	Rules around permitted definitions, limitations, exclusions, conditions, reductions or other restrictive provisions.		
Renewal or continuation of Medi-gap policies	§§1358.17, 1358.18	Required Disclosures		
Advertising and Marketing of Medi-gap policies	§§1358.19, 1358.20, 1358.21	Rules around marketing procedures		
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.	§ 1300.67.24	
Managed Risk Medical Insurance Program (MRMIP)				
Continuation of MRMIP plan	§1373.622	Continuation of a MRMIP plan after program termination. Individuals in a MRMIP plan must receive certain prescribed notifications.		
DMHC Structure and Enforcement				
Department of Managed Health Care	§1341 *et. seq.*	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.		*Hollister v. Benzl*, 71 Cal. App. 4th 582 (1999). Independent contractors are not "health care service plans" and so do not have to comply with arbitration prediclosure requirements.
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.	§1300.67.24 (Outpatient prescription drug copayments, coinsurance, deductibles, limitations and exclusions).	
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	To develop, advise on, and monitor financial solvency requirements.		
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. DMHC may develop standardized methodologies for plans to use when reporting on compliance with timeliness standards.		*Yarick v. PacifiCare of California*, 179 Cal. App. 4th 1158 (2009). Medicare Advantage preemption provision preempts Knox Keene duty to provide sufficient and timely services.
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.	§1300.67.04 (standards for language assistance programs)	
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 covered services.		
Fairness of Contracts	§1367(h)(1)	Contracts with enrollees, providers, and others must be fair, reasonable, and consistent with the Act's objectives, and must include means for dispute resolution.	§1300.67.8	
Illegal Incentives	§1348.6, 1367.62	Prohibited incentives in contracts or for women to leave hospitals post-partum..		
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.		
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 standards	§1367.03(f)(1)	Contracts must ensure compliance with regulations on timely access to care.		
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 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.	§ 1300.67.04	
Changes to provider contracts for Medi-Cal and Healthy Families	§1375.7(b)(1)(C)	Plans must give 90 days notice of material changes; provider has rights to negotiate or terminate the contract.		
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.		*Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir. 1978). ERISA preempts Knox Keene to the extent that Knox Keene seeks to regulate ERISA-covered employee benefit plans.
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, process to convert 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.	§§ 1300.52.1-1300.52.4.	
Disclosure of bonuses and incentives	§1367.10(b)	Plan disclosure statements must describe any bonus or financial incentives.		
Dispute Resolution Reports	§1367(h)(3)	Plans must annually report on provider dispute resolution procedures and outcomes.		
Compliance with timeliness of access to care standards	§§1367.03(f)(2), (h)	Plans must report on compliance with the timeliness standards. Compliance reported in OPA's report card.		
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.	§ 1300.70	*Yarick v. PacifiCare of California, 179 Cal. App. 4th 1158* (2009). Medicare Advantage preemption provisions 1) preempt statute requiring quality-of-care review systems for HMOs, and 2) preempt statute imposing duty to ensure adequate and timely care.

Reporting on timely access standard compliance	§§1367.03, 1380-1383	DMHC may develop standardized methodologies for plans to use when reporting on compliance with timeliness standards.	§ 1300.70	
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.		*Martin v. PacifiCare of California*, 198 Cal. App 4th 1390 (2011). Plans not vicariously liable for the bad faith of providers; *PacifiCare of Cal. V. Bright Med. Assocs., Inc.*, 198 Cal. App. 4th 1451 (2011). Plan may be held jointly and severally liable with provider if both contribute to damages; *Watanabe v. California Physicians' Serv.*, 169 Cal. App. 4th 56 (2008). Plan not vicariously liable for medical provider's alleged failure to diagnose patient's brain tumor.
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	Plans must arrange for the provision of medically necessary services. Plan liable for negligence that resulted in denial, delay, or modification of a service recommended or furnished to an enrollee who suffers substantial harm. Must exhaust before suing unless substantial harm occurs before exhaustion or is imminent.		

Compliance with Patient Protection and Affordable Care Act				
Lifetime limits and annual limits	§ 1367.001, 42 U.S.C. § 300gg-11 (ACA § 1001; PHSA § 2711)	Plans must comply with applicable federal law limiting lifetime and annual limits (does not apply to Medi-Cal, Healthy Families, AIM, MRMIP, or PCIP)		
Preventive health services	§ 1367.002, 42 U.S.C. § 300gg-13 (ACA § 1001; PHSA § 2713)	Plans must comply with applicable federal law mandating coverage of preventive health services without cost-sharing		
Annual Rebate	§ 1367.003, 42 U.S.C. § 300gg-18 (ACA § 1001; PHSA § 2718)	Provides for rebate if expenses for reimbursement do not reach a certain percentage of annual premium revenue. Mirrors federal law.		
External review of cancellation, rescission, or non-renewal of coverage	§ 1368(f), 42 U.S.C. § 300gg-19 (ACA § 1001; PHSA § 2719)	Plans must comply with applicable federal law requiring independent external review of cancellation, rescission, or non-renewal of coverage		
Essential Health Benefits	§§ 1367.005, 1367.006	Nongrandfathered health care service plans shall cover certain essential health benefits.	§1300.67.005	

ACA= Patient Protection and Affordable Care Act
PHSA= Public Health Service Act

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[1] *Cal. Ass'n of Health Plans v. Zingale*, No. 00-06803, 2001 WL 1334987 (C.D. Cal. 2011) holds that all California State standards relating to benefit requirements (including cost-sharing requirements), requirements relating to the inclusion or treatment of providers, coverage determinations (including related appeals and grievance procedures) and marketing materials as they may concern health care service plans in California that participate in the Medicare + Choice program are superseded by section 1856(b)(3)(B) of the Social Security Act, as amended, 42 U.S.C. § 1395w-26(b)(3)(B).