**[Cal. Gov. Code §§ 22850 through 22869.]**

## § 22850 of Health Benefit Plans and Contracts

(a) The board may, without compliance with any provision of law relating to competitive bidding, enter into contracts with carriers offering health benefit plans or with entities offering services relating to the administration of health benefit plans.

(b) The board may contract with carriers for health benefit plans or approve health benefit plans offered by employee organizations, provided that the carriers have operated successfully in the hospital and medical care fields prior to the contracting for or approval thereof. The plans may include hospital benefits, surgical benefits, inpatient medical benefits, outpatient benefits, obstetrical benefits, and benefits offered by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means.

(c) Notwithstanding any other provision of this part, the board may contract with health benefit plans offering unique or specialized health services.

(d) The board may administer self-funded or minimum premium health benefit plans.

(e) The board may contract for or implement employee cost containment and cost reduction incentive programs that involve the employee, the annuitant, and family members as active participants, along with the carrier and the provider, in a joint effort toward containing and reducing the cost of providing medical and hospital health care services to public employees. In developing these plans, the board, in cooperation with the Department of Human Resources, may request proposals from carriers and certified public employee representatives.

(f) Notwithstanding any other provision of this part, the board may do any of the following:

(1) Contract for, or approve, health benefit plans that charge a contracting agency and its employees and annuitants rates based on regional variations in the costs of health care services.

(2) Contract for, or approve, health benefit plans exclusively for the employees and annuitants of contracting agencies. State employees and annuitants may not enroll in these plans. The board may provide health benefit plans exclusively for employees and annuitants of contracting agencies in addition to or in lieu of other health benefit plans offered under this part pursuant to Section 22922.

(3) Implement and administer risk adjustment procedures consistent with Section 22864 that require health benefit plans to adjust premiums and authorize the system to redistribute premiums based on rules and regulations established by the board for this purpose.

(g) (1) The board shall approve any employee association health benefit plan that was approved by the board in the 1987–88 contract year or prior, provided the plan continues to meet the minimum standards prescribed by the board. The trustees of an employee association health benefit plan are responsible for providing health benefit plan administration and services to its enrollees.

(2) Notwithstanding any other provision of this part, the California Correctional Peace Officer Association Health Benefits Trust and the Peace Officers Research Association of California Insurance and Benefits Trust may offer different health benefit plan designs with varying premiums in different areas of the state. The trustees of these health benefit plan trusts shall not use geographic regions that are different from the geographic regions established by the board for the regional premiums of contracting agencies, as authorized in paragraph (1) of subdivision (f), except that these trusts may use a north or south geographic region of the state that is different from the regions established by the board.

(h) Irrespective of any other provision of law, the sponsors of a health benefit plan approved under this section may reinsure the operation of the plan with an admitted insurer authorized to write disability insurance, if the premium includes the entire prepayment fee.

## § 22850.5 of Health Benefit Plans and Contracts

(a) In performing the duties prescribed by Section 22850, the board shall negotiate with carriers providing health benefit plans to add a core health plan option to the existing portfolio of health plans or to implement other measures to achieve ongoing cost savings beginning in the 2012–13 fiscal year, or both.
(b) For purposes of this section, a “core health plan” means a plan that includes all of the following:
(1) A plan that provides coverage for essential benefits at lower premiums, for both the state and the employee, than existing benefit plan options.
(2) A plan that may include fewer benefits and higher employee cost sharing than those provided in existing health benefit plan options.
(3) A plan option that is available for participants beginning in the 2012 open enrollment period for the 2013 calendar year.

## § 22851 of Health Benefit Plans and Contracts

The board may enter into any joint purchasing arrangement with private or public entities, if the arrangement does all of the following:
(a) Benefits persons receiving health coverage under this part.
(b) Does not restrict the authority of the board or the state.
(c) Does not jeopardize the system’s tax status or its governmental plan status.

## § 22852 of Health Benefit Plans and Contracts

(a) A contract for a health benefit plan shall be for a uniform term of at least one year and may be made automatically renewable in the absence of notice of termination by either party. Every contract for

administrative services with respect to the operation of a self-funded health benefit plan administered by the board shall be on terms as the board deems necessary or desirable.
(b) The board shall determine the beginning and ending dates of a contract with the carrier of a health benefit plan and with an entity providing services in connection with the administration of a health benefit plan.
(c) Irrespective of an agreed upon termination date, the board may extend a contract for a reasonable period of time, subject to agreed upon terms and conditions.

## § 22853 of Health Benefit Plans and Contracts

(a) Each contract shall contain a detailed statement of benefits offered and shall include maximums, limitations, exclusions, and other definitions of benefits as the board deems necessary or desirable.
(b) Except as otherwise provided by this part, a health benefit plan or contract may not exclude any person on account of physical condition, age, race, or other status. Except as otherwise provided by this part, transfer of enrollment to a health benefit plan shall be open to all employees and annuitants in accordance with Section 22841.
(c) A health benefit plan or contract shall offer to each employee or annuitant whose enrollment in the plan is terminated other than by cancellation of enrollment, voluntary separation from employment, or dismissal from employment for cause, the option to convert to an individual health benefits policy, without regard to health status, but within the time limit approved by the board. An employee or annuitant that exercises this option shall pay the full periodic charges of the individual policy according to the terms and conditions prescribed by the carrier and approved by the board.
(d) A health benefit plan or contract shall provide grievance procedures to protect the rights of employees and annuitants.
(e) The board shall provide a sufficient number of health benefit plans that provide chiropractic services so that every employee and annuitant has a reasonable opportunity to enroll in a health benefit plan that provides chiropractic services without prior referral by a physician.

## § 22853.1 of Health Benefit Plans and Contracts

(a) A health benefit plan or contract shall provide coverage for a vaccine for acquired immune deficiency syndrome (AIDS) that is approved for marketing by the federal Food and Drug Administration and that is recommended by the United States Public Health Service.
(b) This section does not require a health benefit plan or contract to provide coverage for any clinical trials relating to an AIDS vaccine or for any AIDS vaccine that has been approved by the federal Food and Drug Administration in the form of an investigational new drug application.
(c) Nothing in this section is to be construed in any manner to limit or impede the board's power or responsibility to purchase the vaccine at the most cost-effective price.

## § 22854 of Health Benefit Plans and Contracts

(a) The board, in considering a contract with any entity that seeks to enter into a contract under this article for the provision of health care benefits or services, may consider all of the following:

(1) Whether the applicant is of reputable and responsible character. The board may consider any available information that the applicant has demonstrated a pattern and practice of violations of state or federal laws and regulations.
(2) Whether the applicant has the ability to provide, or arrange to provide for, health care benefits or services. The board may consider any of the following:
(A) Any prior history of providing, or arranging to provide for, health care services or benefits in this state, the applicant's history of substantial compliance with the requirements imposed under that license, and applicable federal laws, regulations, and requirements.
(B) Any prior history in this state or any other state, of providing, or arranging to provide for, health care services or benefits authorized to receive Medicare Program reimbursement or Medicaid Program reimbursement, the applicant's history of substantial compliance with that state's requirements, and applicable federal laws, regulations, and requirements.
(C) Any prior history of providing, or arranging to provide for, health services as a licensed health professional or an individual or entity contracting with a health care service plan or insurer, and the applicant's history of substantial compliance with state requirements, and applicable federal law, regulations, and requirements.
(b) The board may also require the entity described in subdivision (a) to furnish other information or documents for the purposes of this section.

## § 22854.5 of Health Benefit Plans and Contracts

(a) A health benefit plan or contractor, or an entity offering services relating to the administration of health benefit plans to members and annuitants, shall disclose to the board, staff, and any contractor or consultant of the system, the cost, utilization, actual claim payments, and contract allowance amounts for health care services rendered by participating hospitals to each member and annuitant.
(b) The information specified in subdivision (a) shall be deemed confidential information and protected in accordance with the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg), the final regulations issued pursuant to the act by the United States Department of Health and Human Services (45 C.F.R. Parts 160 and 164), and the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code). Information provided to the board, staff, and any contractor or consultant of the system shall not include individual member or annuitant identifying information.
(c) The information specified in subdivision (a) shall be deemed to be confidential trade secret information in accordance with subdivision (d) of Section 3426.1 of the Civil Code and Section 1060 of the Evidence Code.
(d) The board shall not disclose the information specified in subdivision (a) in either individual or aggregated form to any other health care service plan or insurer or any entity offering services relating to the administration of health benefit plans, and shall not make this information available to the public, including, but not limited to, any summaries, compilations, or rankings derived from this information. This information shall be used only to make decisions that materially affect the members and annuitants of the health benefits program established by the board.
(e) Any staff, contractor, or consultant to whom information is disclosed pursuant to subdivision (a) shall be subject to all the restrictions in this section regarding the confidentiality and nondisclosure of that information.

(f) The information specified in subdivision (a), in either individual or aggregated form, shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1) pursuant to subdivision (k) of Section 6254.
(g) Upon request from a hospital, the board shall, on an annual basis, provide the hospital a reasonable opportunity to validate the data that has been provided to the board by a health insurer, health care service plan, or entity pursuant to subdivision (a).
(h) For purposes of this section:
(1) "Actual claim payment" means the actual amount paid by the health care plan or administrator to the participating hospital for a health care service rendered to a member or annuitant, exclusive of member or annuitant cost sharing and any other payment adjustments.
(2) "Contract allowance amounts" means the negotiated rate that the participating hospital agrees to accept as payment for a health care service rendered to a member or annuitant under the provider agreement between the health plan or administrator and the participating hospital.
(3) "Cost" means the full amount billed by the participating hospital for a health care service rendered to a member or annuitant.

## § 22855 of Health Benefit Plans and Contracts

The board shall withdraw its approval of a health benefit plan if it finds that the plan or carrier is not in compliance with the standards prescribed therefor, that the plan or carrier has not paid or will be unable to pay claims accrued or to accrue, or for other good cause as shown. The board shall provide reasonable notice of its intention to withdraw approval of a health benefit plan to any carrier, employee organization, or organization of physicians that may be directly interested, to the persons enrolled in the health benefit plan, and to other persons and organizations as the board may deem proper. The notice shall state the effective date of, and reason for, the withdrawal of board approval. The approval of a health benefit plan may not be withdrawn until after the notice and after all interested parties have been afforded reasonable opportunity for public hearing on the question. The hearings shall be conducted, insofar as practicable, pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3.

## § 22857 of Health Benefit Plans and Contracts

(a) Notwithstanding any other provision of law, the board may contract with carriers licensed and doing business in other states to provide health benefits for employees and annuitants who reside outside of this state. The contracts shall be on terms as the board deems necessary or desirable. The health benefit plans are not necessarily required to meet the minimum requirements of the board, as specified in board regulations, but shall provide appropriate safeguards for members.
(b) An out-of-state employee may enter into a group health benefit plan provided by an out-of-state health maintenance organization, group insurance policy, group service agreement, membership or subscription contract, or other similar group arrangement provided by a carrier for the purpose of providing, arranging, paying for, or reimbursing the cost of health benefits and that is in operation in the community or area where the employee's duties are usually performed. These contracts, plans, agreements, arrangements, or policies shall meet with the approval of, or meet standards approved by, the board.

## § 22859 of Health Benefit Plans and Contracts

(a) A health benefit plan or contract may not provide any of the following:
(1) An exception for other coverage where the other coverage is entitlement to Medi-Cal or medicaid benefits.
(2) An exception for Medi-Cal or medicaid benefits.
(3) A benefits reduction if the person has entitlement to Medi-Cal or medicaid benefits.
(4) An exception for enrollment because of an applicant's entitlement to Medi-Cal or medicaid benefits.
(b) Each health benefit plan shall be considered in determining the third-party liability for medical expenses incurred by a Medi-Cal or a medicaid recipient.

## § 22860 of Health Benefit Plans and Contracts

It is the policy of the Legislature that benefits provided by a health benefit plan be integrated with the benefits provided by federal or state plans for health care services for the aged in which there is federal or state financial participation. The board shall adopt rules and regulations necessary to implement this section. Notwithstanding any other provision of this part, those rules and regulations may establish exclusions and limitations with respect to benefits, different rates within health benefit plans for employees or annuitants eligible for benefits under other plans, or enrollment of those employees or annuitants in separate plans.

## § 22863 of Health Benefit Plans and Contracts

(a) The board shall make available to employees and annuitants eligible to enroll in a health benefit plan information that will enable the employees or annuitants to exercise an informed choice among the available health benefit plans. Each employee or annuitant enrolled in a health benefit plan shall be issued an appropriate document setting forth or summarizing the services or benefits to which the employee, annuitant, or family members are entitled to thereunder, the procedure for obtaining benefits, and the principal provisions of the health benefit plan.
(b) The board shall compile and provide data regarding age, sex, family composition, and geographical distribution of employees and annuitants and make continuing study of the operation of this part, including, but not limited to, surveys and reports on health benefit plans, medical and hospital benefits, the standard of care available to employees and annuitants, and the experience of health benefit plans receiving contributions under this part with respect to matters such as gross and net cost, administrative cost, and utilization of benefits.
(c) The board shall, with the advice of and in consultation with persons or organizations having special skills or experience in the provision of health care services, study methods of evaluating and improving the quality and cost of health care services provided under this part.

## § 22864 of Health Benefit Plans and Contracts

(a) Premiums charged for enrollment in a health benefit plan shall reasonably reflect the cost of the benefits provided.
(b) This part does not limit the board's authority to do any of the following:
(1) Enter into contracts with carriers providing compensation based on carrier performance.

(2) Credit premiums to an employer for expenditures that the board determines are likely to improve the health status of employees and annuitants or otherwise reduce health care costs.
(3) Adjust the premiums charged under any health benefit plan or contract to reflect regional variations in the cost of health care services and other relevant factors. Any adjustment of these premiums shall be at the sole discretion of the board and shall only apply to the premiums charged to employees and annuitants of contracting agencies. The board may require a contracting agency and its employees and annuitants to pay the premium rate established pursuant to this paragraph, which may be different than the health benefit plan or contract premium rate that would otherwise be applicable to that agency.
(4) Adjust premiums as part of programs for health promotion and disease prevention.
(5) Develop procedures for risk adjustment of premiums across plans that encourage plans to offer benefits based upon medical and administrative efficiency and quality of care rather than on the employee's or annuitant's health status or service areas with low-risk populations. Any risk adjustment program or procedure shall be at the sole discretion of the board.

## § 22865 of Health Benefit Plans and Contracts

Not later than 30 days prior to the approval of benefits and premium readjustments authorized under Section 22864, the board shall provide an initial estimate of proposed changes and costs in writing to the Joint Legislative Budget Committee, the chairpersons of the committees and subcommittees in each house of the Legislature that consider the Public Employees' Retirement System's budget and activities, the Controller, the Trustees of the California State University, the Department of Human Resources, the Director of Finance, and the Legislative Analyst.

## § 22866 of Health Benefit Plans and Contracts

(a) The board shall report to the Legislature and the Director of Finance on or before November 1, 2016, and annually thereafter, regarding the health benefits program. The report shall include, but not be limited to the following:
(1) General overview of the health benefits program, including, but not limited to, the following:
(A) Description of health plans and benefits provided, including essential and nonessential benefits as required by state and federal law, member expected out-of-pocket expenses, and actuarial value by metal tier as defined by the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).
(B) Geographic coverage.
(C) Historic enrollment information by basic and Medicare plans, by state and contract agencies, by active and retired membership, and by subscriber and dependent tier.
(D) Historic expenditures by basic and Medicare plans, by state and contract agencies, by active and retired membership, and by subscriber and dependent tier.
(2) Reconciliation of premium increases or decreases from the prior plan year, and the reasons for those changes.
(A) Description of benefit design and benefit changes, including prescription drug coverage, by plan. The description shall detail whether benefit changes were required by statutory mandate, federal law, or an exercise of the board's discretion, the costs or savings of the benefit change, and the impact of how the changes fit into a broader strategy.

(B) Discussion of risk.
(C) Description of medical trend changes in aggregate service categories for each plan. The aggregate service categories used shall include the standard categories of information collected by the board, consisting of the following: inpatient, emergency room, ambulatory surgery, office, ambulatory radiology, ambulatory lab, mental health and substance abuse, other professional, prescriptions, and all other service categories.
(D) Reconciliation of past year premiums against actual enrollments, revenues, and accounts receivables.
(3) Overall member health as reflected by data on chronic conditions.
(4) The impact of federal subsidies or contributions to the health care of members, including Medicare Part A, Part B, Part C, or Part D, low-income subsidies, or other federal program.
(5) The cost of benefits beyond Medicare contained in the board's Medicare supplemental plans.
(6) A description of plan quality performance and member satisfaction, including, but not limited to, the following:
(A) The Healthcare Effectiveness Data and Information Set, referred to as HEDIS.
(B) The Medicare star rating for Medicare supplemental plans.
(C) The degree of satisfaction of members and annuitants with the health benefit plans and with the quality of the care provided, to the extent the board surveys participants.
(D) The level of accessibility to preferred providers for rural members who do not have access to health maintenance organizations.
(E) Other applicable quality measurements collected by the board as part of the board's health plan contracts.
(7) A description of risk assessment and risk mitigation policy related to the board's self-funded and flex-funded plan offerings, including, but not limited to the following:
(A) Reserve levels and their adequacy to mitigate plan risk.
(B) The expected change in reserve levels and the factors leading to this change.
(C) Policies to reduce excess reserves or rebuild inadequate reserves.
(D) Decisions to lower premiums with excess reserves.
(E) The use of reinsurance and other alternatives to maintaining reserves.
(8) Description and reconciliation of administrative expenditures, including, but not limited to, the following:
(A) Organization and staffing levels, including salaries, wages, and benefits.
(B) Operating expenses and equipment expenditure items, including, but not limited to, internal and external consulting and intradepartmental transfers.
(C) Funding sources.
(D) Investment strategies, historic investment performance, and expected investment returns of the Public Employees' Contingency Reserve Fund and the Public Employees' Health Care Fund.
(9) Changes in strategic direction and major policy initiatives.
(b) A report submitted pursuant to subdivision (a) shall be provided in compliance with Section 9795.

## § 22867 of Health Benefit Plans and Contracts

The provisions of this article do not supersede, modify, or in any manner alter or impair the effect of any provision of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or any provision of the Insurance Code. This article shall be interpreted and applied in a manner consistent with those provisions of the Business and Professions Code and the Insurance Code.

## § 22869 of Health Benefit Plans and Contracts

Information disseminated by the board pursuant to Section 22863, and compliance with regulations of the board adopted pursuant to subdivision (a) of Section 22846 and Sections 22800 and 22831, shall be deemed to satisfy the requirements of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.