WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7. Basic Health Care [14000 - 14199.87] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 3.5. Third Party Liability [14124.70 - 14124.94] *(Article 3.5 added by Stats. 1976, Ch. 621.)*

14124.70. As used in this article:

(a) “Carrier” includes any insurer as defined in Section 23 of the Insurance Code, including any private company, corporation, mutual association, trust fund, reciprocal or interinsurance exchange authorized under the laws of this state to insure persons against liability for injuries caused to another, and also any insurer providing benefits under a policy of bodily injury liability insurance covering liability arising out of the ownership, maintenance or use of a motor vehicle which provides uninsured motorist endorsement or coverage, pursuant to Section 11580.2 of the Insurance Code.

(b) “Beneficiary” means any person who has received benefits or will be provided benefits under this chapter because of an injury for which another person or party may be liable. It includes such beneficiary’s guardian, conservator or other personal representative, his estate or survivors.

(c) “Reasonable value of benefits” means both of the following:

(1) Except in a case in which services were provided to a beneficiary under a managed care arrangement or contract, “reasonable value of benefits” means the Medi-Cal rate of payment, for the type of services rendered, under the schedule of maximum allowances authorized by Section 14106 or, the Medi-Cal rate of payment, for the type of services rendered, under regulations adopted pursuant to this chapter, including but not limited, to Section 14105.

(2) If services were provided to a beneficiary under a managed care arrangement or contract, “reasonable value of benefits” means the rate of payment to the provider by the plan for the services rendered to the beneficiary, except in cases where the plan pays the provider on a capitated or risk sharing basis, in which case it means the value of the services rendered to the beneficiary calculated by the plan as the usual customary and reasonable charge made to the general public by the provider for similar services.

(d) “Lien” means the director’s claim for recovery, from a beneficiary’s tort action or claim, of the reasonable value of benefits provided on behalf of the beneficiary.

(Amended by Stats. 2017, Ch. 52, Sec. 30. (SB 97) Effective July 10, 2017.)

14124.71. (a) When benefits are provided or will be provided to a beneficiary under this chapter because of an injury for which another party is liable, or for which a carrier is liable in accordance with the provisions of any policy of insurance issued pursuant to Section 11580.2 of the Insurance Code, the director shall have a right to recover from such a party or carrier the reasonable value of benefits so provided. The Attorney General, or counsel for the fiscal intermediary under the Medi-Cal program with the permission of the Attorney General, or a contractor pursuant to Section 14124.80, or a county through its civil legal adviser, may, to enforce such right, institute and prosecute legal proceedings against the third party or carrier who may be liable for the injury in an appropriate court, either in the name of the director or in the name of the injured person, his guardian, conservator, personal representative, estate, or survivors.

(b) The director may:

(1) Compromise, or settle and release any such claim in whole or in part with any such party or carrier, or

(2) Waive any such claim, in whole or in part, for the convenience of the director, or if the director determines that collection would result in undue hardship upon the person who suffered the injury, or in a wrongful death action upon the heirs of the deceased.

(c) No action taken on behalf of the director pursuant to this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the beneficiary, his guardian, conservator, personal representative, estate, dependents, or survivors against the third party who may be liable for the injury, or shall operate to deny to the beneficiary the recovery for that portion of any damages not covered hereunder.

(d) The cost of a service provided to an eligible developmentally disabled Medi-Cal beneficiary under Section 14132.44 may be recovered by the director from a liable third party or carrier.

(Amended by Stats. 2017, Ch. 52, Sec. 31. (SB 97) Effective July 10, 2017.)

14124.72. (a) If an action is brought by the director pursuant to Section 14124.71, it shall be commenced within the period prescribed in Section 338 of the Code of Civil Procedure.

(b) The death of the beneficiary does not abate any right of action established by Section 14124.71.

(c) When an action or claim is brought by persons entitled to bring such actions or assert such claims against a third party who may be liable for causing the death of a beneficiary, any settlement, judgment or award obtained is subject to the director's right to recover from that party the reasonable value of the benefits provided to the beneficiary under the Medi-Cal program, as provided in subdivision (d).

(d) The director's claim for reimbursement of the benefits provided to the beneficiary shall be limited to the amount of the director's lien, as defined in subdivision (d) of Section 14124.70. If the action or claim is brought by the beneficiary alone and the beneficiary incurs a personal liability to pay attorney's fees and costs of litigation, the amount of the director's lien that is reimbursed shall be reduced by 25 percent, which represents the director's reasonable share of attorney's fees paid by the beneficiary, and that portion of the cost of litigation expenses determined by multiplying the actual litigation expenses by the ratio of the amount reimbursed to the director as satisfaction of the director's lien, prior to deducting reasonable attorney's fees and litigation expenses, to the full amount of the settlement, judgment, or award.

(Amended by Stats. 2017, Ch. 52, Sec. 32. (SB 97) Effective July 10, 2017.)

14124.73. (a) If either the beneficiary or the director brings an action or claim against such third party or carrier, the beneficiary or the director shall within 30 calendar days of filing the action give to the other written notice by personal service, registered mail, or other means of communication deemed appropriate by the department of the action or claim, and of the name of the court or state or local agency in which the action or claim is brought. The purpose of the notice is to provide the beneficiary and the director, as applicable, the opportunity to ensure their interests are adequately represented in an action or claim against a liable third party or carrier. Proof of such notice shall be filed in such action or claim. If an action or claim is brought by either the director or the beneficiary, the other may, at any time before trial on the facts, become a party to, or shall consolidate his action or claim with the other if brought independently.

(b) If an action or claim is brought by the director pursuant to subdivision (a) of Section 14124.71, written notice to the beneficiary, guardian, conservator, personal representative, estate or survivor given pursuant to this section shall advise him of his right to intervene in the proceeding, his right to obtain a private attorney of his choice, and the director's right to recover the amount of the director's lien, as defined in subdivision (d) of Section 14124.70.

(c) Notification of either the beneficiary or the director of an action or claim against a third party or carrier shall include, at a minimum, the following information:

(1) The date of the beneficiary's injury.

(2) The beneficiary's Medi-Cal identification number.

(3) The name and contact information of the liable third party or carrier against whom the action or claim has been filed.

(4) The name and contact information of the carrier for the party identified in paragraph (3) against which a claim has been or will be filed for the beneficiary's injury, the carrier's unique claim identifier for the claim, and the name and contact information of the party responsible for adjudicating the claim on the carrier's behalf, to the extent these are known by the party providing notice under subdivision (a) at the time such notice is provided.

(d) If any information required pursuant to paragraph (4) of subdivision (c) is not known to the party at the time notice pursuant to subdivision (a) is provided, the party providing such notice shall provide such information to the notice recipient within 15 calendar days of obtaining the information.

(Amended by Stats. 2017, Ch. 52, Sec. 33. (SB 97) Effective July 10, 2017.)

14124.74. In the event of a settlement, judgment, or award in a suit or claim against a third party or carrier:

(a) If the action or claim is prosecuted by the beneficiary alone, the court or agency shall first order paid from any settlement, judgment, or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees, when an attorney has been retained. After payment of these expenses and attorney's fees the court or agency shall, on the application of the director, allow as a first lien against the amount of the settlement, judgment, or award the amount that the director is entitled to recover as satisfaction of the director's lien, as provided in subdivision (d) of Section 14124.72, and as a second lien, the amount of any claims, pursuant to Section 14019.3, owed to a provider, as provided in Section 14124.791.

(b) If the action or claim is prosecuted both by the beneficiary and the director, the court or agency shall first order paid from any settlement, judgment, or award, the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the beneficiary. After payment of these expenses and attorney's fees, the court or agency shall first apply out of the balance of the settlement, judgment, or award an amount sufficient to reimburse the amount that the director is entitled to recover as satisfaction of the director's lien, as provided under subdivision (d) of Section 14124.72, and then an amount sufficient to reimburse a provider who has filed a lien for any claims for services rendered to the beneficiary, as provided under Section 14124.791.

(Amended by Stats. 2017, Ch. 52, Sec. 34. (SB 97) Effective July 10, 2017.)

14124.75. The court or agency shall, upon further application at any time before the judgment or award is satisfied, allow as a further lien the reasonable value of additional benefits provided arising out of the same cause of action or claim provided on behalf of the beneficiary under the Medi-Cal Program, where such benefits were provided or became payable subsequent to the original order.

(Amended by Stats. 1998, Ch. 310, Sec. 102. Effective August 19, 1998.)

14124.76. (a) No settlement, judgment, or award in any action or claim by a beneficiary to recover damages for injuries, where the director has an interest, shall be deemed final or satisfied without first giving the director notice and a reasonable opportunity to perfect and to satisfy the director's lien. Recovery of the director's lien from an injured beneficiary's action or claim is limited to that portion of a settlement, judgment, or award that represents payment for medical expenses, or medical care, provided on behalf of the beneficiary. All reasonable efforts shall be made to obtain the director's advance agreement to a determination as to what portion of a settlement, judgment, or award that represents payment for medical expenses, or medical care, provided of behalf on the beneficiary. Absent the director's advance agreement as to what portion of a settlement, judgment, or award represents payment for medical expenses, or medical care, provided on behalf of the beneficiary, the matter shall be submitted to a court for decision. Either the director or the beneficiary may seek resolution of the dispute by filing a motion, which shall be subject to regular law and motion procedures. In determining what portion of a settlement, judgment, or award represents payment for medical expenses, or medical care, provided on behalf of the beneficiary and as to what the appropriate reimbursement amount to the director should be, the court shall be guided by the United States Supreme Court decision in Arkansas Department of Health and Human Services v. Ahlborn (2006) 547 U.S. 268 and other relevant statutory and case law.

(b) If the beneficiary has filed a third-party action or claim, the court where the action or claim was filed shall have jurisdiction over a dispute between the director and the beneficiary regarding the amount of a lien asserted pursuant to this section that is based upon an allocation of damages contained in a settlement or compromise of the third-party action or claim. If no third-party action or claim has been filed, any superior court in California where venue would have been proper had a claim or action been filed shall have jurisdiction over the motion. The motion may be filed as a special motion and treated as an ordinary law and motion proceeding and subject to regular motion fees. The reimbursement determination motion shall be treated as a special proceeding of a civil nature pursuant to Part 3 (commencing with Section 1063) of the Code of Civil Procedure. When no action is pending, the person making the motion shall be required to pay a first appearance fee. When an action is pending, the person making the motion shall pay a regular law and motion fee. Notwithstanding Section 1064 of the Code of Civil Procedure, either the beneficiary or the director may appeal the final findings, decision, or order.

(c) The court shall issue its findings, decision, or order, which shall be considered the final determination of the parties' rights and obligations with respect to the director's lien, unless the settlement is contingent on an acceptable allocation of the settlement proceeds, in which case, the court's findings, decision, or order shall be considered a tentative determination. If the beneficiary does not serve notice of a rejection of the tentative determination, which shall be based solely upon a rejection of the contingent settlement, within 30 days of the notice of entry of the court's tentative determination, subject to further consideration by the court pursuant to subdivision (d), the tentative determination shall become final. Notwithstanding Section 1064 of the Code of Civil Procedure, either the beneficiary or the director may appeal the final findings, decision, or order.

(d) If the beneficiary does not accept the tentative determination, which shall be based solely upon a rejection of the contingent settlement, any party may subsequently seek further consideration of the court's findings upon application to modify the prior findings, decision, or order based on new or different facts or circumstances. The application shall include an affidavit showing what application was made before, when, and to what judge, what order or decision was made, and what new or different facts or circumstances, including a different settlement, are claimed to exist. Upon further consideration, the court may modify the allocation in the interest of fairness and for good cause.

(Amended by Stats. 2007, Ch. 188, Sec. 71. Effective August 24, 2007.)

14124.77. When the director has perfected a lien upon a judgment or award in favor of a beneficiary against any third party for an injury for which the beneficiary has received benefits under the Medi-Cal Program, the director shall be entitled to a writ of execution as lien claimant to enforce payment of said lien against such third party with interest and other accruing costs as in the case of other executions. In the event the amount of such judgment or award so recovered has been paid to the beneficiary, the director shall be entitled to a writ of execution against such beneficiary to the extent of the director's lien, with interest and other accruing costs as in the case of other executions.

(Added by Stats. 1976, Ch. 621.)

14124.78. Notwithstanding any other provision of law, in no event shall the director recover more than the beneficiary recovers after deducting, from the settlement judgment, or award, attorney's fees and litigation costs paid for by the beneficiary. If the director's recovery is determined under this section, the reductions in subdivision (d) of Section 14124.72 shall not apply.

(Amended by Stats. 2007, Ch. 188, Sec. 72. Effective August 24, 2007.)

14124.785. The director's recovery is limited to the amount derived from applying Section 14124.72, 14124.76, or 14124.78, whichever is less, to the total settlement, judgment, or award amount upon resolution of all actions or claims associated with the injury with regard to each and every defendant. All statutes of limitations related to the recovery of the director's lien are tolled until the director receives notification of the resolution of all actions or claims associated with the injury with regard to each and every defendant.

(Amended by Stats. 2017, Ch. 52, Sec. 35. (SB 97) Effective July 10, 2017.)

14124.79. In the event that the beneficiary, his guardian, conservator, personal representative, estate or survivors or any of them brings an action against the third person who may be liable for the injury, notice of institution of legal proceedings, notice of settlement and all other notices required by this code shall be given to the director in Sacramento except in cases where the director specifies that notice shall be given to the Attorney General. All such notices shall be given by insurance carriers, as described in Section 14124.70, having liability for the beneficiary's claim, and by the attorney retained to assert the beneficiary's claim, or by the injured party beneficiary, his guardian, conservator, personal representative, estate or survivors, if no attorney is retained.

(Amended by Stats. 2003, Ch. 230, Sec. 69. Effective August 11, 2003.)

14124.791. (a) Subject to the director's prior right of recovery, a provider who has rendered services to a beneficiary because of an injury for which a third party is liable and who has received payment under the Medi-Cal program shall be entitled to file a lien for all fees for services provided to the beneficiary against any judgment, award, or settlement obtained by the beneficiary or the director against that third party. A provider may only recover upon the lien if the provider has made a full reimbursement of any fees paid by the department for those services.

(b) If either the beneficiary or the director brings an action or claim against the third party, the party bringing the action shall, within 30 days of bringing the action, give written notice to any provider who is eligible to file a lien under subdivision (a) of the action and of the name of the court or state or local agency in which the action or claim is brought. Notice shall be given by personal service or registered mail, and proof of service shall be filed in the action or claim.

(c) The provider's claim for reimbursement for fees for services rendered to the beneficiary shall be limited to the amount of the fees less 25 percent, which represents the provider's reasonable share of attorneys' fees for prosecution of the action and of the cost of litigation expense.

(d) No claim authorized by this section shall be permitted to the extent that the claim would reduce the director's right to recover pursuant to Section 14124.78.

(Amended by Stats. 1992, Ch. 722, Sec. 108.7. Effective September 15, 1992.)

14124.792. If any provision of this article, or the application of any provision of this article to any person, firm, corporation, or other entity or to any circumstance or situation, shall be held invalid, the remaining provisions of this article shall not be affected thereby, and shall be given effect.

(Added by Stats. 2007, Ch. 188, Sec. 74. Effective August 24, 2007.)

14124.795. It is the intent of the Legislature to comply with federal law requiring that when a beneficiary has other available health coverage or insurance, the Medi-Cal program shall be the payer of last resort. Notwithstanding any other provision of law, any carrier described in Section 14124.70, including automobile, casualty, property, and malpractice insurers, shall enter into an agreement with the department to permit and assist the matching of the department's Medi-Cal eligibility file against the carrier's claim files, utilizing, if necessary, social security numbers as common identifiers for the purpose of determining whether Medi-Cal benefits were provided

to a beneficiary because of an injury for which another person is liable, or for which a carrier is liable in accordance with the provisions of any policy of insurance. The carrier shall maintain a centralized file of claimants' names, mailing addresses, and social security numbers or dates of birth. This information shall be made available to the department upon the department's reasonable request. The agreement described in this section shall include financial arrangements for reimbursing carriers for necessary costs incurred in furnishing requested information.

(Added by Stats. 2003, Ch. 230, Sec. 70. Effective August 11, 2003.)

14124.81. (a) The department shall administer the provisions of Sections 14124.82 to 14124.86, inclusive, pertaining to the State Department of Health Care Services' administration of the personal injury and workers' compensation recovery programs.

(b) An attorney or the beneficiary, guardian, personal representative, estate, or survivors of any of those, who are mandated under Section 14124.79 to report Medi-Cal involvement are excluded from any further remuneration benefits under Sections 14124.82 to 14124.86, inclusive.

(Repealed and added by Stats. 2017, Ch. 52, Sec. 38. (SB 97) Effective July 10, 2017.)

14124.82. (a) The department, in its reasonable discretion, may execute one or more at-risk performance contracts to identify, quantify, or recover, or any combination thereof, Medi-Cal payments from responsible third parties and carriers that may be subject to a claim for reimbursement.

(b) Priority, by the terms of the contract or contracts, shall be given to the identification and recovery of claims nearing the statute of limitation, prior adjudicated claims, and prior existing injury claims. However, all claims that are older, in whole or part, than 12 months, at the time of discovery and notification by the contractor to the department, shall be subject to contractual lien recovery unless departmental personnel have previously identified these claims and have filed appropriate liens, notices, or other payment demands. A claim arises and the 12-month period begins when the department or its fiscal agent has first made payment for medical services related to the personal or workers' compensation action on behalf of a given recipient. The department may waive any time requirement, if it concludes that it will not otherwise discover the claim and be able to effect recovery.

(c) To implement this section, the department may contract with public or private entities. Contracts or amendments entered into under this section may be on an exclusive or nonexclusive basis, and on a noncompetitive bid basis. The contracts and amendments shall be exempt from all of the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.

(3) Review or approval of contracts by the Department of General Services.

(Amended by Stats. 2017, Ch. 52, Sec. 39. (SB 97) Effective July 10, 2017.)

14124.83. The agreement shall include, but is not limited to, the following provisions:

(a) The agreement shall stipulate when the contractor may identify, quantify, or recover amounts owing by third parties that may be subject to a claim for reimbursement.

(b) Payment to the contractor shall be based upon a no cost percentage of recovery formula, which shall not exceed 25 percent of the gross recovery upon the claim. It is the intent of the Legislature that "no cost" include all considerations for court costs, legal fees, and the universe of the case processing activity, not including, however, departmental processing.

(c) Payment for amounts determined to be owed to the state by third parties and carriers shall be made directly to the state.

(d) A bond in the amount required by the state for collection agencies shall be sufficient.

(e) Contractor's files shall be subject to audit, pursuant to the contract, but shall remain the property of the contractor. At the request of the department, the contractor shall provide copies of any claims related to a particular recovery.

(f) The contractor shall report periodically to the department concerning its progress in the discovery of cases and the recovery of amounts subject to claim, and shall provide other information as the department may require, and at a reasonable frequency, to adequately monitor the progress of the contractor.

(Amended by Stats. 2017, Ch. 52, Sec. 40. (SB 97) Effective July 10, 2017.)

14124.84. The department shall provide the contractor with such information as is reasonably necessary for the contractor to perform its obligations under the contract, including accounting data and other information the contractor may request.

(Added by Stats. 1981, Ch. 102, Sec. 122. Effective June 28, 1981.)

14124.86. The contractor shall retain its rights to compensation upon recovery for completed duties under the contract with respect to any claims or liens processed in whole or in part prior to the termination date of the agreement.

(Repealed and added by Stats. 2017, Ch. 52, Sec. 43. (SB 97) Effective July 10, 2017.)

14124.89. (a) (1) This section applies to all of the following entities:

(A) Health insurer, or any health care entity licensed through the Department of Insurance.

(B) Self-insured plan.

(C) Group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974.

(D) Service benefit plan.

(E) Managed care organization, including a health care service plan as defined in subdivision (f) of Section 1345 of the Health and Safety Code, licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(F) Pharmacy benefit manager.

(G) Third-party administrator.

(H) Union trust.

(I) Other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(2) The entities listed in paragraph (1) shall, upon request of the department for any records, or any information contained in records pertaining to an individual or group health insurance policy or plan issued by such insurer or plan against, or pertaining to the medical or dental benefits paid by or claims made against such insurer or plan under a policy or plan, make the requested records or information available upon a certification by the department that the individual is an applicant for or recipient of services under this chapter or is a person who is legally responsible for such an applicant or recipient.

(b) The entities listed in paragraph (1) of subdivision (a) shall enter into a cooperative agreement with the department setting forth mutually agreeable procedures for the provision of appropriate information, not inconsistent with any law pertaining to the confidentiality and privacy of medical records, at no cost to the department, within 90 days of the department's request.

(c) The information required to be made available pursuant to this section shall be limited to information necessary to determine whether health benefits have been or should have been claimed and paid pursuant to a health insurance policy or plan with respect to items of medical care and services received by a particular individual for which Medi-Cal coverage would otherwise be available.

(d) Not later than the date upon which the procedures agreed to pursuant to subdivision (b) become effective, the director shall establish guidelines to assure that information relating to an individual certified to be an applicant for or recipient of medical assistance, furnished to any insurer or plan pursuant to this section, is used only for the purpose of identifying the records or information requested in such manner so as not to violate the confidentiality of an applicant or recipient.

(Amended by Stats. 2021, Ch. 143, Sec. 381. (AB 133) Effective July 27, 2021.)

14124.90. (a) (1) It is the intent of the Legislature to comply with federal law requiring that when a beneficiary has third-party health coverage or insurance, the State Department of Health Care Services shall be the payer of last resort.

(2) In order to assess overlapping or duplicate health coverage and adjudicate claims, all of the following entities shall maintain a centralized file of the eligibility and coverage information for each subscriber, policyholder, enrollee, or insured:

(A) Health insurer or any health care entity licensed through the Department of Insurance.

(B) Self-insured plan.

(C) Group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974.

(D) Service benefit plan.

(E) Managed care organization, including a health care service plan as defined in subdivision (f) of Section 1345 of the Health and Safety Code, licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(F) Pharmacy benefit manager.

(G) Third-party administrator.

(H) Union trust.

(I) Other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(b) (1) The eligibility and coverage information shall include, at a minimum, all of the following information about a subscriber, policyholder, enrollee, or insured:

(A) Full name.

(B) Address.

(C) Date of birth.

(D) Social security number.

(E) Policy number.

(F) Group identification number.

(G) Policy or plan type.

(H) Types of covered services under the policy or plan.

(I) Effective dates of coverage.

(J) Policy or plan termination date.

(2) For any other persons covered under the policy or plan, if any, the eligibility and coverage information shall include, at a minimum, all of the following information:

(A) Full name.

(B) Social security number.

(C) Date of birth.

(D) Place of birth.

(E) Parents' names, if applicable.

(c) The information described in subdivision (b) shall be provided to the State Department of Health Care Services at least once a month, in a format provided by the department. The information shall also be provided to the department's agents and contracted Medi-Cal managed care plans, upon reasonable request, to perform cost avoidance on behalf of the department.

(d) An entity listed in subdivision (a) shall provide to the department access to real-time, electronic eligibility verification, at no cost, and in a form and manner specified by the department, as is necessary to conduct its coordination of benefits responsibilities pursuant to this section.

(e) Notwithstanding Section 20134 of the Government Code, the Board of Administration of the California Public Employees' Retirement System and affiliated systems or contract agencies shall permit data matches with the state department to identify Medi-Cal beneficiaries with third-party health coverage or insurance. A recipient's Medi-Cal identification card shall, where information is available, contain information advising providers of health care services of any third-party health coverage for the recipient. Providers shall seek reimbursement from available third-party health coverage before billing the Medi-Cal program.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of policy letter, information notice, or other similar instruction, without taking any further regulatory action.

(Repealed and added by Stats. 2021, Ch. 143, Sec. 383. (AB 133) Effective July 27, 2021.)

14124.91. The State Department of Health Services shall, whenever it is cost-effective, pay the premium for third-party health coverage for beneficiaries under this chapter. The State Department of Health Services shall, when a beneficiary's third-party health coverage would lapse due to loss of employment or change in health status, lack of sufficient income or financial resources, or any other reason, continue the health coverage by paying the costs of continuation of group coverage pursuant to federal law or converting from a group to an individual plan, whenever it is cost-effective. Notwithstanding any other provision of a contract or of law, the time period for the department to exercise either of these options shall be 60 days from the date of lapse of the policy.

(Amended by Stats. 1992, Ch. 722, Sec. 109. Effective September 15, 1992. Note: The amendment by Stats. 2003, Ch. 673, did not take effect because Ch. 673 was rejected as referendum Proposition 72 at the November 2, 2004, election.)

14124.92. (a) The department may pay administrative expenses and make incentive payments to any county, state, or federal agency, or a contracting agent of the department for identifying and reporting third-party health care coverage held or offered to beneficiaries under this chapter.

(b) Unless the third-party health care coverage identified is excluded under subdivision (d) from the incentive payment plan, an agency or contractor may be entitled to an incentive payment if the agency or contractor does all of the following:

(1) Identifies a case of which the department was not previously aware.

(2) Provides to the department adequate and necessary information relevant to the third-party health care coverage in order to make a claim for benefits or reimbursement for services rendered that would otherwise be paid by Medi-Cal.

(3) Reports to the department the identified third-party health care coverage within 30 days of the date of discovery on a form approved by the department.

(c) In no event shall any one incentive for each case identified exceed one month of savings received by the department for benefits paid by the third-party health care coverage.

(d) Third-party health care coverage that does not qualify for the incentive payment plan under this section shall be identified by the department based on policy limitations and cost-effectiveness. The types of coverage that do not qualify under this section include those that to which any of the following apply:

(1) Not specifically intended to provide third-party health care coverage, such as coverage that provides life or car insurance benefits, periodic benefits for disability or hospitalization, or income protection.

(2) Coverage is limited to a specific diagnosis, unless the beneficiary has been diagnosed with a condition or disease specified in the coverage.

(3) Coverage is limited to a specific circumstance, such as accidental injury or dismemberment.

(4) Coverage is limited to one specific category of service.

(e) For the purposes of this section, "third-party health care coverage" means health care service plans, benefits, insurance policies, and funds, including those described in Section 14124.90.

(Added by Stats. 1992, Ch. 722, Sec. 110. Effective September 15, 1992.)

14124.94. (a) When the rights of a Medi-Cal beneficiary to health care benefits from an insurer have been assigned to the department, an insurer shall not impose any requirement on the department that is different from any requirement applicable to an agent or any assignee of the covered beneficiary.

(b) The department, in the administration of the Medi-Cal program, may garnish the wages, salary, or other employment income of, and withhold amounts from state tax refunds from, any person to whom both of the following apply:

(1) The person is required by a court or administrative order to provide coverage of the costs of health services to a child who is eligible for medical assistance under the Medi-Cal program.

(2) The person has received payment from a third party for the costs of the health services for the child, but he or she has not used the payments to reimburse, as appropriate, either the other parent or the person having custody of the child, or the provider of the health services, to the extent necessary to reimburse the department for expenditures for those costs under the Medi-Cal program. All claims for current or past due child support shall take priority over claims made by the department for the costs of Medi-Cal services.

(c) For purposes of this section, "insurer" includes every health insurer, self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, including health

care service plans as defined in subdivision (f) of Section 1345 of the Health and Safety Code, licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(Amended by Stats. 2007, Ch. 188, Sec. 77. Effective August 24, 2007.)