HEALTH AND SAFETY CODE - HSC

DIVISION 2. LICENSING PROVISIONS [1200 - 1796.70] *(Division 2 enacted by Stats. 1939, Ch. 60.)*

CHAPTER 2.2. Health Care Service Plans [1340 - 1399.874] *(Chapter 2.2 added by Stats. 1975, Ch. 941.)*

ARTICLE 1. General [1340 - 1345.5] *(Article 1 added by Stats. 1975, Ch. 941.)*

1340. This chapter shall be known and may be cited as the Knox-Keene Health Care Service Plan Act of 1975.

(Added by Stats. 1975, Ch. 941.)

1341. (a) There is in state government, in the California Health and Human Services Agency, a Department of Managed Health Care that has charge of the execution of the laws of this state relating to health care service plans and the health care service plan business including, but not limited to, those laws directing the department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees.

(b) The chief officer of the Department of Managed Health Care is the Director of the Department of Managed Health Care. The director shall be appointed by the Governor and shall hold office at the pleasure of the Governor. The director shall receive an annual salary as fixed in the Government Code. Within 15 days from the time of the director's appointment, the director shall take and subscribe to the constitutional oath of office and file it in the office of the Secretary of State.

(c) The director shall be responsible for the performance of all duties, the exercise of all powers and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the department. The director has and may exercise all powers necessary or convenient for the administration and enforcement of, among other laws, the laws described in subdivision (a).

(Amended by Stats. 2011, Ch. 552, Sec. 2. (AB 922) Effective January 1, 2012.)

1341.1. The director shall have his or her principal office in the City of Sacramento, and may establish branch offices in the City and County of San Francisco, in the City of Los Angeles, and in the City of San Diego. The director shall from time to time obtain the necessary furniture, stationery, fuel, light, and other proper conveniences for the transaction of the business of the Department of Managed Health Care.

(Amended by Stats. 2000, Ch. 857, Sec. 20. Effective January 1, 2001.)

1341.2. In accordance with the laws governing the state civil service, the director shall employ and, with the approval of the Department of Finance, fix the compensation of such personnel as the director needs to discharge properly the duties imposed upon the director by law, including, but not limited to, a chief deputy, a public information officer, a chief enforcement counsel, and legal counsel to act as the attorney for the director in actions or proceedings brought by or against the director under or pursuant to any provision of any law under the director's jurisdiction, or in which the director joins or intervenes as to a matter within the director's jurisdiction, as a friend of the court or otherwise, and stenographic reporters to take and transcribe the testimony in any formal hearing or investigation before the director or before a person authorized by the director. The personnel of the Department of Managed Health Care shall perform such duties as the director assigns to them. Such employees as the director designates by rule or order shall, within 15 days after their appointments, take and subscribe to the constitutional oath of office and file it in the office of the Secretary of State.

(Amended by Stats. 2000, Ch. 857, Sec. 21. Effective January 1, 2001.)

1341.3. The director shall adopt a seal bearing the inscription: "Director, Department of Managed Health Care, State of California." The seal shall be affixed to or imprinted on all orders and certificates issued by him or her and such other instruments as he or she directs. All courts shall take judicial notice of this seal.

(Amended by Stats. 2000, Ch. 857, Sec. 22. Effective January 1, 2001.)

1341.4. (a) In order to effectively support the Department of Managed Health Care in the administration of this law, there is hereby established in the State Treasury, the Managed Care Fund. The administration of the Department of Managed Health Care shall be supported from the Managed Care Fund.

(b) In any fiscal year, the Managed Care Fund shall maintain not more than a prudent 5 percent reserve unless otherwise determined by the Department of Finance.

(Amended by Stats. 2007, Ch. 577, Sec. 6. Effective October 13, 2007.)

1341.45. (a) There is hereby created in the State Treasury the Managed Care Administrative Fines and Penalties Fund.

(b) The fines and administrative penalties collected pursuant to this chapter, on and after September 30, 2008, shall be deposited into the Managed Care Administrative Fines and Penalties Fund.

(c) The fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department, beginning September 1, 2009, and annually thereafter, as follows:

(1) The first one million dollars ($1,000,000) shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) or Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(2) Any amount over the first one million dollars ($1,000,000), including accrued interest, in the fund shall be transferred to the Health Care Services Plan Fines and Penalties Fund created pursuant to Section 15893 of the Welfare and Institutions Code.

(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.

(e) The amendments made to this section by the act adding this subdivision shall become operative on July 1, 2014.

(f) The amendments made to this section by the act adding this subdivision shall become operative on July 1, 2017.

(Amended by Stats. 2024, Ch. 40, Sec. 11. (SB 159) Effective June 29, 2024.)

1341.5. (a) The director, as a general rule, shall publish or make available for public inspection any information filed with or obtained by the department, unless the director finds that this availability or publication is contrary to law. No provision of this chapter authorizes the director or any of the director's assistants, clerks, or deputies to disclose any information withheld from public inspection except among themselves or when necessary or appropriate in a proceeding or investigation under this chapter or to other federal or state regulatory agencies. No provision of this chapter either creates or derogates from any privilege that exists at common law or otherwise when documentary or other evidence is sought under a subpoena directed to the director or any of his or her assistants, clerks, or deputies.

(b) It is unlawful for the director or any of his or her assistants, clerks, or deputies to use for personal benefit any information that is filed with or obtained by the director and that is not then generally available to the public.

(Added by Stats. 1999, Ch. 525, Sec. 27. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1341.6. (a) The Attorney General shall render to the director opinions upon all questions of law, relating to the construction or interpretation of any law under the director's jurisdiction or arising in the administration thereof, that may be submitted to the Attorney General by the director and upon the director's request shall act as the attorney for the director in actions and proceedings brought by or against the director under or pursuant to any provision of any law under the director's jurisdiction.

(b) Sections 11041, 11042, and 11043 of the Government Code do not apply to the Director of the Department of Managed Health Care.

(Amended by Stats. 2000, Ch. 857, Sec. 23. Effective January 1, 2001.)

1341.7. (a) Neither the director nor any of the director's assistants, clerks, or deputies shall be interested as a director, officer, shareholder, member other than a member of an organization formed for religious purposes, partner, agent, or employee of any person who, during the period of the official's or employee's association with the Department of Managed Health Care, was licensed or applied for a license as a health care service plan under this chapter.

(b) Nothing contained in subdivision (a) shall prohibit the holdings or purchasing of any securities by the director, an assistant, clerk, or deputy in accordance with rules which shall be adopted for the purpose of protecting the public interest and avoiding conflicts of interest.

(c) Nothing in this section shall prohibit or preclude the director or any of the director's assistants, clerks, or deputies or any employee of the Department of Managed Health Care from obtaining health care services as a subscriber or an enrollee from a plan licensed under this chapter, subject to any rules that may be adopted hereunder or pursuant to proper authority.

(Amended by Stats. 2000, Ch. 857, Sec. 24. Effective January 1, 2001.)

1341.8. The director shall have the powers of a head of a department pursuant to Chapter 2 (commencing with Section 11150) of Part 1 of Division 3 of Title 2 of the Government Code. The director may make the agreements that he or she deems necessary or appropriate in exercising his or her powers.

(Added by Stats. 1999, Ch. 525, Sec. 30. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1341.9. The director and department succeed to, and are vested with, all duties, powers, purposes, responsibilities, and jurisdiction of the Commissioner of Corporations and the Department of Corporations as they relate to the Department of Corporations' Health Plan Program, health care service plans, and the health care service plan business, including those powers and duties specified in this chapter. Nothing in this section abrogates, limits, diminishes, or otherwise restricts the duties, powers, purposes, responsibilities, and jurisdictions of the Commissioner of Corporations and the Department of Corporations under the Investment Program, the Financial Services Program, and the other laws in which jurisdiction is vested in the Commissioner of Corporations and the Department of Corporations.

(Added by Stats. 1999, Ch. 525, Sec. 31. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1341.10. The department may use the unexpended balance of funds available for use in connection with the performance of the functions of the Department of Corporations to which the department succeeds pursuant to Section 1341.9.

(Added by Stats. 1999, Ch. 525, Sec. 32. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1341.11. All officers and employees of the Department of Corporations who, on the operative date of this section, are performing any duty, power, purpose, responsibility, or jurisdiction to which the department succeeds, who are serving in the state civil service, other than as temporary employees, and engaged in the performance of a function vested by the department by Section 1341.9, shall be transferred to the department. The status, positions, and rights of those persons shall not be affected by the transfer and shall be retained by those persons as officers and employees of the department, pursuant to the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code), except as to positions exempted from civil service.

(Added by Stats. 1999, Ch. 525, Sec. 33. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1341.12. The department shall have possession and control of all records, papers, offices, equipment, supplies, moneys, funds, appropriations, licenses, permits, agreements, contracts, claims, judgments, land, and other property, real or personal, connected with the administration of, or held for the benefit or use of, the Department of Corporations for the performance of the functions transferred to the department by Section 1341.9.

(Added by Stats. 1999, Ch. 525, Sec. 34. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1341.13. All officers or employees of the department employed after the operative date of this section shall be appointed by the director.

(Added by Stats. 1999, Ch. 525, Sec. 35. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1341.14. (a) Any regulation, order, or other action, adopted, prescribed, taken, or performed by the Department of Corporations or by an officer of the Department of Corporations in the administration of a program or the performance of a duty, responsibility, or authorization transferred to the department by Section 1341.9 shall remain in effect and shall be deemed to be a regulation, order, or action of the department.

(b) No suit, action, or other proceeding lawfully commenced by or against the Department of Corporations or any other officer of the state, in relation to the administration of any program or the discharge of any duty, responsibility, or authorization transferred to the department by Section 1341.9 shall abate by reason of the transfer of the program, duty, responsibility, or authorization.

(Added by Stats. 1999, Ch. 525, Sec. 36. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1342. It is the intent and purpose of the Legislature to promote the delivery and the quality of health and medical care to the people of the State of California who enroll in, or subscribe for the services rendered by, a health care service plan or specialized health care service plan by accomplishing all of the following:

(a) Ensuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional.

(b) Ensuring that subscribers and enrollees are educated and informed of the benefits and services available in order to enable a rational consumer choice in the marketplace.

(c) Prosecuting malefactors who make fraudulent solicitations or who use deceptive methods, misrepresentations, or practices which are inimical to the general purpose of enabling a rational choice for the consumer public.

(d) Helping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers.

(e) Promoting effective representation of the interests of subscribers and enrollees.

(f) Ensuring the financial stability thereof by means of proper regulatory procedures.

(g) Ensuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care.

(h) Ensuring that subscribers and enrollees have their grievances expeditiously and thoroughly reviewed by the department.

(Amended by Stats. 2002, Ch. 797, Sec. 2. Effective January 1, 2003.)

1342.2. (a) Notwithstanding any other law, a health care service plan contract that covers medical, surgical, and hospital benefits, excluding a specialized health care service plan contract, shall cover the costs for COVID-19 diagnostic and screening testing and health care services related to diagnostic and screening testing approved or granted emergency use authorization by the federal Food and Drug Administration for COVID-19, regardless of whether the services are provided by an in-network or out-of-network provider. Coverage required by this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. Services related to COVID-19 diagnostic and screening testing include, but are not limited to, hospital or health care provider office visits for the purposes of receiving testing, products related to testing, the administration of testing, and items and services furnished to an enrollee as part of testing. Services related to COVID-19 diagnostic and screening testing do not include bonus payments for the use of specialized equipment or expedited processing.

(1) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the health care service plan shall reimburse the health care provider the amount of that lost cost sharing.

(2) A health care service plan contract shall not impose prior authorization or any other utilization management requirements on COVID-19 diagnostic and screening testing.

(3) With respect to an enrollee, a health care service plan shall reimburse the provider of the testing according to either of the following:

(A) If the health plan has a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(B) If the health plan does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider, the plan may negotiate a rate with such provider.

(4) For an out-of-network provider with whom a health care service plan does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing and health care services related to testing, a plan shall reimburse the provider for all testing items or services in an amount that is reasonable, as determined in comparison to prevailing market rates for testing items or services in the geographic region where the item or service is rendered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee for services related to testing, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee.

(5) Beginning six months after the federal public health emergency expires, a health care service plan shall no longer be required to cover the cost sharing for COVID-19 diagnostic and screening testing and health care services related to testing when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

(6) Changes to a contract between a health care service plan and a provider delegating financial risk for diagnostic and screening testing related to a declared public health emergency shall be considered a material change to the parties' contract. A health care service plan shall not delegate the financial risk to a contracted provider for the cost of enrollee services provided under this section unless the parties have negotiated and agreed upon a new provision of the parties' contract pursuant to Section 1375.7.

(b) (1) A health care service plan contract that covers medical, surgical, and hospital benefits shall cover without cost sharing any item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is either of the following with respect to the individual enrollee:

(A) An evidence-based item or service that has in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.

(B) An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention, regardless of whether the immunization is recommended for routine use.

(2) The item, service, or immunization covered pursuant to paragraph (1) shall be covered no later than 15 business days after the date on which the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention makes a recommendation relating to the item, service, or immunization. A recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention is considered in effect after it has been adopted, or granted emergency use authorization, by the Director of the Centers for Disease Control and Prevention.

(3) (A) A health care service plan subject to this subdivision shall not impose any cost-sharing requirements, including a copayment, coinsurance, or deductible, for any item, service, or immunization described in paragraph (1), regardless of whether such service is delivered by an in-network or out-of-network provider.

(B) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the health care service plan shall reimburse the health care provider the amount of that lost cost sharing.

(C) With respect to an enrollee, a health care service plan shall reimburse the provider of the immunization according to either of the following:

(i) If the health plan has a negotiated rate with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(ii) If the health plan does not have a negotiated rate with such provider, the plan may negotiate a rate with such provider.

(D) A health care service plan shall not impose cost sharing for any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), including, but not limited to, provider office visits and vaccine administration, regardless of whether the service is delivered by an in-network or out-of-network provider.

(E) (i) For an out-of-network provider with whom a health care service plan does not have a negotiated rate for an item, service, or immunization described in paragraph (1), a health care service plan shall reimburse the provider for all related items or services, including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), in an amount that is reasonable, as determined in comparison to prevailing market rates for such items or services in the geographic region in which the item or service is rendered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for items, services, and immunizations described in subdivision (b), including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1).

(ii) Beginning six months after the federal public health emergency expires, a health care service plan shall no longer be required to cover the cost sharing for any item, service, or immunization described in paragraph (1) and to cover items or services that are necessary for the furnishing of the items, services, or immunizations described in paragraph (1) when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this section shall remain in effect after the federal public health emergency expires.

(4) A health care service plan subject to this subdivision shall not impose prior authorization or any other utilization management requirements on any item, service, or immunization described in paragraph (1) or to items or services that are necessary for the furnishing of the items, services, or immunizations described in subparagraph (D) of paragraph (3).

(5) Changes to a contract between a health care service plan and a provider delegating financial risk for immunization related to a declared public health emergency, shall be considered a material change to the parties’ contract. A health plan shall not delegate the financial risk to a contracted provider for the cost of enrollee services provided under this section unless the parties have negotiated and agreed upon a new provision of the parties’ contract pursuant to Section 1375.7.

(c) The director may issue guidance to health care service plans regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the

Government Code). The department shall consult with the Department of Insurance in issuing the guidance specified in this subdivision.

(d) This section, excluding subdivision (h), shall apply retroactively beginning from the Governor's declared State of Emergency related to the SARS-CoV-2 (COVID-19) pandemic on March 4, 2020. Notwithstanding Section 1390, this subdivision does not create criminal liability for transactions that occurred before January 1, 2022.

(e) For purposes of this section:

(1) "Diagnostic testing" means all of the following:

(A) Testing intended to identify current or past infection and performed when a person has signs or symptoms consistent with COVID-19, or when a person is asymptomatic but has recent known or suspected exposure to SARS-CoV-2.

(B) Testing a person with symptoms consistent with COVID-19.

(C) Testing a person as a result of contact tracing efforts.

(D) Testing a person who indicates that they were exposed to someone with a confirmed or suspected case of COVID-19.

(E) Testing a person after an individualized clinical assessment by a licensed health care provider.

(2) "Screening testing" means tests that are intended to identify people with COVID-19 who are asymptomatic and do not have known, suspected, or reported exposure to SARS-CoV-2. Screening testing helps to identify unknown cases so that measures can be taken to prevent further transmission. Screening testing includes all of the following:

(A) Workers in a workplace setting.

(B) Students, faculty, and staff in a school setting.

(C) A person before or after travel.

(D) At home for someone who does not have symptoms associated with COVID-19 and does not have a known exposure to someone with COVID-19.

(f) This section does not relieve a health care service plan from continuing to cover testing as required by federal law and guidance.

(g) The department shall hold health care service plans accountable for timely access to services required under this section and coverage requirements established under federal law, regulations, or guidelines.

(h) (1) This subdivision applies to a health care service plan contract issued, amended, or renewed on or after the operative date of this subdivision that covers medical, surgical, and hospital benefits, excluding a specialized health care service plan contract, with respect to therapeutics for COVID-19 covered under the contract, which shall include therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a licensed health care provider acting within their scope of practice and the standard of care.

(2) A health care service plan shall reimburse a provider for the therapeutics described in paragraph (1) at the specifically negotiated rate for those therapeutics, if the plan and provider have negotiated a rate. If the plan does not have a negotiated rate with a provider, the plan may negotiate a rate with the provider.

(3) For an out-of-network provider with whom a health care service plan does not have a negotiated rate for the therapeutics described in paragraph (1), a health care service plan shall reimburse the provider for the therapeutics in an amount that is reasonable, as determined in comparison to prevailing market rates for the therapeutics in the geographic region in which the therapeutic was delivered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for therapeutics described in this subdivision.

(4) A health care service plan shall cover COVID-19 therapeutics without cost sharing, regardless of whether the therapeutics are provided by an in-network or out-of-network provider, and without utilization management. If a provider would have been entitled to receive cost sharing but for this section, the health care service plan shall reimburse the provider for the amount of that lost cost sharing. A provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for therapeutics pursuant to this subdivision.

(5) Beginning six months after the federal public health emergency expires, a health care service plan shall no longer be required to cover the cost sharing for COVID-19 therapeutics delivered by an out-of-network provider, unless otherwise required by law. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

(6) This section does not apply to a Medi-Cal managed care plan that contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(Amended by Stats. 2025, Ch. 21, Sec. 6. (AB 116) Effective June 30, 2025.)

1342.3. (a) A health care service plan contract that covers medical, surgical, and hospital benefits, excluding a specialized health care service plan contract, shall cover, without cost sharing and without prior authorization or other utilization management, the costs of the following health care services to prevent or mitigate a disease when the Governor of the State of California has declared a public health emergency due to that disease:

(1) An evidence-based item, service, or immunization that is intended to prevent or mitigate a disease as recommended by the United States Preventive Services Task Force that has in effect a rating of "A" or "B" or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention.

(2) A health care service or product related to diagnostic and screening testing for the disease that is approved or granted emergency use authorization by the federal Food and Drug Administration, or is recommended by the State Department of Public Health or the federal Centers for Disease Control and Prevention.

(3) Therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for the disease.

(b) The item, service, or immunization covered pursuant to paragraph (1) of subdivision (a) shall be covered no later than 15 business days after the date on which the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention makes a recommendation relating to the item, service, or immunization.

(c) For purposes of this section, "health care service plan" includes a Medi-Cal managed care plan that contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code. The State Department of Health Care Services shall seek any federal approvals it deems necessary to implement this section. This section applies to a Medi-Cal managed care plan contract only to the extent that the State Department of Health Care Services obtains any necessary federal approvals, and federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

(Amended by Stats. 2022, Ch. 545, Sec. 2. (SB 1473) Effective September 25, 2022.)

1342.4. (a) The Department of Managed Health Care and the Department of Insurance shall maintain a joint senior level working group to ensure clarity for health care consumers about who enforces their patient rights and consistency in the regulations of these departments.

(b) The joint working group shall undertake a review and examination of the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code as they apply to the Department of Managed Health Care and the Department of Insurance to ensure consistency in consumer protection.

(c) The joint working group shall review and examine all of the following processes in each department:

(1) Grievance and consumer complaint processes, including, but not limited to, outreach, standard complaints, including coverage and medical necessity complaints, independent medical review, and information developed for consumer use.

(2) The processes used to ensure enforcement of the law, including, but not limited to, the medical survey and audit process in the Health and Safety Code and market conduct exams in the Insurance Code.

(3) The processes for regulating the timely payment of claims.

(d) The joint working group shall report its findings to the Insurance Commissioner and the Director of the Department of Managed Health Care for review and approval. The commissioner and the director shall submit the approved final report under signature to the Legislature by January 1 of every year for five years.

(Added by Stats. 2002, Ch. 793, Sec. 1. Effective January 1, 2003.)

1342.5. The director shall consult with the Insurance Commissioner prior to adopting any regulations applicable to health care service plans subject to this chapter and other entities governed by the Insurance Code for the specific purpose of ensuring, to the extent practical, that there is consistency of regulations applicable to these plans and entities by the Insurance Commissioner and the Director of the Department of Managed Health Care.

(Amended by Stats. 2007, Ch. 577, Sec. 8. Effective October 13, 2007.)

1342.6. It is the intent of the Legislature to ensure that the citizens of this state receive high-quality health care coverage in the most efficient and cost-effective manner possible. In furtherance of this intent, the Legislature finds and declares that it is in the public interest to promote various types of contracts between public or private payers of health care coverage, and institutional or professional providers of health care services. This intent has been demonstrated by the recent enactment of Chapters 328, 329, and 1594 of the Statutes of 1982, authorizing various types of contracts to be entered into between public or private payers of health care coverage, and institutional or professional providers of health care services. The Legislature further finds and declares that individual providers, whether institutional or professional, and individual purchasers, have not proven to be efficient-sized bargaining units for these contracts, and that the formation of groups and combinations of institutional and professional providers and combinations of purchasing groups for the purpose of creating efficient-sized contracting units represents a meaningful addition to the health care marketplace. The Legislature further finds and declares that negotiations between purchasers or payers of health services, and health care service plans governed by the provisions of this chapter, or through a person or entity acting for, or on behalf of, a purchaser or payer of health services, or a health care service plan, are in furtherance of the public's interest in obtaining quality health care services in the most efficient and cost-effective manner possible. It is the intent of the Legislature, therefore, that the formation of groups and combinations of providers and purchasing groups for the purpose of creating efficient-sized contracting units be recognized as the creation of a new product within the health care marketplace, and be subject, therefore, only to those antitrust prohibitions applicable to the conduct of other presumptively legitimate enterprises.

This section does not change existing antitrust law as it relates to any agreement or arrangement to exclude from any of the above-described groups or combinations, any person who is lawfully qualified to perform the services to be performed by the members of the group or combination, where the ground for the exclusion is failure to possess the same license or certification as is possessed by the members of the group or combination.

(Added by Stats. 1985, Ch. 1592, Sec. 2.)

1342.7. (a) The Legislature finds that in enacting Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72, it did not intend to limit the department's authority to regulate the provision of medically necessary prescription drug benefits by a health care service plan to the extent that the plan provides coverage for those benefits.

(b) (1) Nothing in this chapter shall preclude a plan from filing relevant information with the department pursuant to Section 1352 to seek the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits. If the department approves an exclusion to a plan's prescription drug benefits, the exclusion shall not be subject to review through the independent medical review process pursuant to Section 1374.30 on the grounds of medical necessity. The department shall retain its role in assessing whether issues are related to coverage or medical necessity pursuant to paragraph (2) of subdivision (d) of Section 1374.30.

(2) A plan seeking approval of a copayment or deductible may file an amendment pursuant to Section 1352.1. A plan seeking approval of a limitation or exclusion shall file a material modification pursuant to subdivision (b) of Section 1352.

(c) Nothing in this chapter shall prohibit a plan from charging a subscriber or enrollee a copayment or deductible for a prescription drug benefit or from setting forth by contract, a limitation or an exclusion from, coverage of prescription drug benefits, if the copayment, deductible, limitation, or exclusion is reported to, and found unobjectionable by, the director and disclosed to the subscriber or enrollee pursuant to the provisions of Section 1363.

(d) The department in developing standards for the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits, shall consider alternative benefit designs, including, but not limited to, the following:

(1) Different out-of-pocket costs for consumers, including copayments and deductibles.

(2) Different limitations, including caps on benefits.

(3) Use of exclusions from coverage of prescription drugs to treat various conditions, including the effect of the exclusions on the plan's ability to provide basic health care services, the amount of subscriber or enrollee premiums, and the amount of out-of-pocket costs for an enrollee.

(4) Different packages negotiated between purchasers and plans.

(5) Different tiered pharmacy benefits, including the use of generic prescription drugs.

(6) Current and past practices.

(e) The department shall develop a regulation outlining the standards to be used in reviewing a plan's request for approval of its proposed copayment, deductible, limitation, or exclusion on its prescription drug benefits.

(f) Nothing in subdivision (b) or (c) shall permit a plan to limit prescription drug benefits provided in a manner that is inconsistent with Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72.

(g) Nothing in this section shall be construed to require or authorize a plan that contracts with the State Department of Health Services to provide services to Medi-Cal beneficiaries or with the Managed Risk Medical Insurance Board to provide services to enrollees of the Healthy Families Program to provide coverage for prescription drugs that are not required pursuant to those programs or contracts, or to limit or exclude any prescription drugs that are required by those programs or contracts.

(h) Nothing in this section shall be construed as prohibiting or otherwise affecting a plan contract that does not cover outpatient prescription drugs except for coverage for limited classes of prescription drugs because they are integral to treatments covered as basic health care services, including, but not limited to, immunosuppressives, in order to allow for transplants of bodily organs.

(i) The department shall periodically review its regulations developed pursuant to this section.

(j) This section shall become operative on January 2, 2003, and shall only apply to contracts issued, amended, or renewed on or after that date.

(Amended by Stats. 2012, Ch. 728, Sec. 81. (SB 71) Effective January 1, 2013.)

1342.71. (a) The Legislature hereby finds and declares all of the following:

(1) The federal Patient Protection and Affordable Care Act, its implementing regulations and guidance, and related state law prohibit discrimination based on a person's expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions, including benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs.

(2) The Legislature intends to build on the existing state and federal law to ensure that health coverage benefit designs do not have an unreasonable discriminatory impact on chronically ill individuals, and to ensure affordability of outpatient prescription drugs.

(3) Assignment of all or most prescription medications that treat a specific medical condition to the highest cost tiers of a formulary may effectively discourage enrollment by chronically ill individuals, and may result in lower adherence to a prescription drug treatment regimen.

(b) A nongrandfathered health care service plan contract that is offered, amended, or renewed on or after January 1, 2017, shall comply with this section. The cost-sharing limits established by this section apply only to outpatient prescription drugs covered by the contract that constitute essential health benefits, as defined in Section 1367.005.

(c) A health care service plan contract that provides coverage for outpatient prescription drugs shall cover medically necessary prescription drugs, including nonformulary drugs determined to be medically necessary consistent with this chapter.

(d) (1) Consistent with federal law and guidance, the formulary or formularies for outpatient prescription drugs maintained by the health care service plan shall not discourage the enrollment of individuals with health conditions and shall not reduce the generosity of the benefit for enrollees with a particular condition in a manner that is not based on a clinical indication or reasonable medical management practices. Section 1342.7 and any regulations adopted pursuant to that section shall be interpreted in a manner that is consistent with this section.

(2) For combination antiretroviral drug treatments that are medically necessary for the treatment of AIDS/HIV, a health care service plan contract shall cover a single-tablet drug regimen that is as effective as a multitablet regimen unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multitablet regimen is clinically equally or more effective and more likely to result in adherence to a drug regimen.

(e) A health care service plan contract shall ensure that the placement of prescription drugs on formulary tiers is based on clinically indicated, reasonable medical management practices.

(f) (1) This section shall not be construed to require a health care service plan to impose cost sharing.

(2) This section shall not be construed to require cost sharing for prescription drugs that state or federal law otherwise requires to be provided without cost sharing.

(3) A plan's prescription drug benefit shall provide that if the pharmacy's retail price for a prescription drug is less than the applicable copayment or coinsurance amount, the enrollee shall not be required to pay more than the retail price. The payment rendered shall constitute the applicable cost sharing and shall apply to the deductible, if any, and also to the maximum out-of-pocket limit in the same manner as if the enrollee had purchased the prescription medication by paying the cost-sharing amount.

(g) In the provision of outpatient prescription drug coverage, a health care service plan may utilize formulary, prior authorization, step therapy, or other reasonable medical management practices consistent with this chapter.

(h) This section does not apply to a health care service plan contract with the State Department of Health Care Services.

(Amended (as amended by Stats. 2016, Ch. 86, Sec. 175) by Stats. 2018, Ch. 787, Sec. 1. (SB 1021) Effective January 1, 2019.)

1342.73. (a) (1) With respect to an individual or group health care service plan contract subject to Section 1367.006, the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription for a supply of up to 30 days shall not exceed two hundred fifty dollars ($250), except as provided in paragraphs (2) and (3).

(2) With respect to products with actuarial value at, or equivalent to, the bronze level, cost sharing for a covered outpatient prescription drug for an individual prescription for a supply of up to 30 days shall not exceed five hundred dollars ($500), except as provided in paragraph (3).

(3) For a health care service plan contract that is a “high deductible health plan” under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, paragraphs (1) and (2) of this subdivision shall apply only once an enrollee’s deductible has been satisfied for the year.

(4) For a nongrandfathered individual or small group health care service plan contract, the annual deductible for outpatient drugs, if any, shall not exceed twice the amount specified in paragraph (1) or (2), respectively.

(5) For purposes of paragraphs (1) and (2), “any other form of cost sharing” shall not include a deductible.

(6) A copayment or percentage coinsurance shall not exceed 50 percent of the cost to the plan, as described in Section 1300.67.24 of Title 28 of the California Code of Regulations.

(7) If there is a generic equivalent to a brand name drug, a plan shall ensure that the enrollee is subject to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary. This paragraph shall not be construed to require both the generic equivalent and the brand name drug to be on the formulary.

(b) (1) If a health care service plan contract for a nongrandfathered individual or small group product maintains a drug formulary grouped into tiers that includes a fourth tier, a health care service plan contract shall use the following definitions for each tier of the drug formulary:

(A) Tier one shall consist of most generic drugs and low-cost preferred brand name drugs.

(B) Tier two shall consist of nonpreferred generic drugs, preferred brand name drugs, and any other drugs recommended by the health care service plan’s pharmacy and therapeutics committee based on safety, efficacy, and cost.

(C) Tier three shall consist of nonpreferred brand name drugs or drugs that are recommended by the health care service plan’s pharmacy and therapeutics committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.

(D) Tier four shall consist of drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost the health plan more than six hundred dollars ($600) net of rebates for a one-month supply.

(2) In placing specific drugs on specific tiers, or choosing to place a drug on the formulary, the health care service plan shall comply with the other provisions of this section and this chapter.

(3) A health care service plan contract may maintain a drug formulary with fewer than four tiers. A health care service plan contract shall not maintain a drug formulary with more than four tiers.

(4) This section shall not be construed to limit a health care service plan from placing any drug in a lower tier.

(c) This section does not apply to a health care service plan contract with the State Department of Health Care Services.

(Amended by Stats. 2023, Ch. 820, Sec. 1. (AB 948) Effective January 1, 2024.)

1342.74. (a) (1) Notwithstanding Section 1342.71, a health care service plan shall not subject antiretroviral drugs that are medically necessary for the prevention of AIDS/HIV, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy, except as provided in paragraph (2).

(2) If the United States Food and Drug Administration has approved one or more therapeutic equivalents of a drug, device, or product for the prevention of AIDS/HIV, this section does not require a health care service plan to cover all of the therapeutically equivalent versions without prior authorization or step therapy, if at least one therapeutically equivalent version is covered without prior authorization or step therapy.

(b) Notwithstanding any other law, a health care service plan shall not prohibit, or permit a delegated pharmacy benefit manager to prohibit, a pharmacy provider from dispensing preexposure prophylaxis or postexposure prophylaxis.

(c) A health care service plan shall cover preexposure prophylaxis and postexposure prophylaxis that has been furnished by a pharmacist, as authorized in Sections 4052.02 and 4052.03 of the Business and Professions Code, including the pharmacist's services and related testing ordered by the pharmacist. A health care service plan shall pay or reimburse, consistent with the requirements of this chapter, for the service performed by a pharmacist at an in-network pharmacy or a pharmacist at an out-of-network pharmacy if the health care service plan has an out-of-network pharmacy benefit.

(d) This section does not require a health care service plan to cover preexposure prophylaxis or postexposure prophylaxis by a pharmacist at an out-of-network pharmacy, unless the health care service plan has an out-of-network pharmacy benefit.

(e) This section shall not apply to Medi-Cal managed care plans contracting with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14590) of Part 3 of Division 9 of the Welfare and Institutions Code, to the extent that the services described in this section are excluded from coverage under the contract between the Medi-Cal managed care plans and the State Department of Health Care Services.

(Amended by Stats. 2024, Ch. 1, Sec. 2. (SB 339) Effective February 6, 2024.)

1342.75. (a) Notwithstanding any other law, a group or individual health care service plan offering an outpatient prescription drug benefit shall provide coverage for at least one medication approved by the United States Food and Drug Administration in each of the following categories without prior authorization, step therapy, or utilization review:

(1) Medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist.

(2) Medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product.

(3) A long-acting buprenorphine product.

(4) A long-acting injectable naltrexone product.

(b) This section does not prohibit a health care service plan from selecting an AB-rated generic equivalent, biosimilar, as defined in Section 262(i)(2) of Title 42 of the United States Code, or interchangeable biological product, as defined in Section 262(i)(3) of Title 42 of the United States Code, to meet the requirements of subdivision (a).

(Added by Stats. 2024, Ch. 633, Sec. 1. (AB 1842) Effective January 1, 2025.)

1342.8. The State Department of Health Services and the department shall coordinate, to the extent feasible, audits or surveys of physician offices required by this chapter and by the managed care program under the Medi-Cal Act (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code) and for any physician office auditing required by this chapter.

(Added by Stats. 1998, Ch. 647, Sec. 2. Effective January 1, 1999.)

1343. (a) This chapter shall apply to health care service plans and specialized health care service plan contracts as defined in subdivisions (f) and (o) of Section 1345.

(b) The director may by the adoption of rules or the issuance of orders deemed necessary and appropriate, either unconditionally or upon specified terms and conditions or for specified periods, exempt from this chapter any class of persons or plan contracts if the director finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under this chapter, and that the regulation of the persons or plan contracts is not essential to the purposes of this chapter.

(c) The director, upon request of the Director of Health Care Services, shall exempt from this chapter any county-operated pilot program contracting with the State Department of Health Care Services pursuant to Article 7 (commencing with Section 14490) of Chapter 8 of Part 3 of Division 9 of the Welfare and Institutions Code. The director may exempt noncounty-operated pilot programs upon request of the Director of Health Care Services. Those exemptions may be subject to conditions the Director of Health Care Services deems appropriate.

(d) Upon the request of the Director of Health Care Services, the director may exempt from this chapter any mental health plan contractor or any capitated rate contract under Chapter 8.9 (commencing with Section 14700) of Part 3 of Division 9 of the Welfare and Institutions Code. Those exemptions may be subject to conditions the Director of Health Care Services deems appropriate.

(e) This chapter shall not apply to:

(1) A person organized and operating pursuant to a certificate issued by the Insurance Commissioner unless the entity is directly providing the health care service through those entity-owned or contracting health facilities and providers, in which case this chapter shall apply to the insurer's plan and to the insurer.

(2) A plan directly operated by a bona fide public or private institution of higher learning that directly provides health care services only to its students, faculty, staff, administration, and their respective dependents, except that a plan described in this paragraph shall be subject to Section 1367.33.

(3) A person who does all of the following:

(A) Promises to provide care for life or for more than one year in return for a transfer of consideration from, or on behalf of, a person 60 years of age or older.

(B) Has obtained a written license pursuant to Chapter 2 (commencing with Section 1250) or Chapter 3.2 (commencing with Section 1569).

(C) Has obtained a certificate of authority from the State Department of Social Services.

(4) The Major Risk Medical Insurance Board when engaging in activities under Chapter 8 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code, and Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code.

(5) The California Small Group Reinsurance Fund.

(Amended by Stats. 2022, Ch. 630, Sec. 12. (SB 523) Effective January 1, 2023.)

1343.1. This chapter shall not apply to any program developed under the authority of Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(Amended by Stats. 2011, Ch. 367, Sec. 2. (AB 574) Effective January 1, 2012.)

1343.3. (a) The director, no later than May 1, 2021, may authorize one pilot program in southern California whereby providers approved by the department may undertake risk-bearing arrangements with a voluntary employees' beneficiary association, as defined in Section 501(c)(9) of Title 26 of the United States Code or in Section 1349.2, notwithstanding paragraph (3) of subdivision (a) of Section 1349.2, with enrollment of greater than 100,000 lives, beginning no earlier than January 1, 2022, to December 31, 2027, inclusive, if all of the following criteria are met:

(1) The purpose of the pilot program is to demonstrate the control of costs for health care services and the improvement of health outcomes and quality of service when compared against a sole fee-for-service provider reimbursement model.

(2) The voluntary employees' beneficiary association has entered into a contract with one or more health care providers under which each provider agrees to accept risk-based or global risk payment from the voluntary employees' beneficiary association.

(3) Each risk-bearing provider is registered as a risk-bearing organization pursuant to Section 1375.4 and applicable department regulations if the provider accepts professional capitation and is delegated the responsibility for the processing and payment of claims.

(4) Each global risk-bearing provider holds or will obtain in conjunction with the pilot program application a limited or restricted license pursuant to Section 1349 or 1351, or Section 1300.49 of Title 28 of the California Code of Regulations.

(5) Each risk-bearing provider continues to comply with applicable financial solvency standards and audit requirements under this chapter, including, but not limited to, financial reporting on a quarterly basis, during the term of the pilot program.

(6) The voluntary employees' beneficiary association shall be responsible for providing all of the following:

(A) Basic health care services.

(B) Prescription drug benefits.

(C) Continuity of care.

(D) Standards for network adequacy and timely access to care, including, but not limited to, access to specialty care.

(E) Language assistance programs.

(F) A process for filing and resolving consumer grievances and appeals, including, but not limited to, independent medical review.

(G) Prohibitions against deceptive marketing.

(H) Member documents that include a description of the benefit coverage, any applicable copays, how to access services, and how to submit a grievance.

(I) Mechanisms for resolving provider disputes, including an appeals process.

(7) The contract between the voluntary employees' beneficiary association and each health care provider shall include all of the following:

(A) Provisions dividing financial responsibility between the parties and defining which party is financially responsible for services rendered, including arrangements for member care should a global or risk-bearing provider become insolvent.

(B) A delegation agreement.

(C) Requirements regarding utilization review or utilization management.

(D) Provisions stating the risk-based organization, limited licensee, or restricted licensee, as applicable, has the organizational and administrative capacity to provide services to covered employees, and that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management, including the disclosure of the percentage of risk assumed in relation to its total risk-based business.

(E) Requirements regarding the submission of claims by providers and the timely processing of provider claims, including a guarantee that the voluntary employees' beneficiary association will indemnify any outstanding unpaid provider claim in the event of the insolvency of a participating provider to the pilot program.

(F) Require the health care provider to comply with the voluntary employees' beneficiary association's requirements for all of the following:

(i) Continuity of care.

(ii) Language assistance.

(iii) Consumer grievances and appeals, including, but not limited to, independent medical review.

(8) The term of each contract between the voluntary employees' beneficiary association and a health care provider does not exceed the period of the pilot program.

(9) To participate in the pilot program, each voluntary employees' beneficiary association shall submit to the department an application consistent with paragraph (2) of subdivision (h).

(10) Each health care provider that has entered into a contract with the voluntary employees' beneficiary association is a party to the pilot program application submitted to the department. The application shall include a copy of each contract between the voluntary employees' beneficiary association and a participating health care provider.

(11) (A) The voluntary employees' beneficiary association and each health care provider participating in the pilot program agree to collect and report to the department, in each year of the pilot program, in a manner and frequency determined by the department, information regarding the comparative cost savings when compared to fee-for-service payment, performance measurements for clinical patient outcomes, and enrollee satisfaction. The department may require additional information be reported. Any additional reporting requirements shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(B) The department may authorize a public or private agency to receive the information specified in this paragraph and monitor the pilot program under the data standard currently used by the Integrated Healthcare Association's "Align. Measure. Perform." (AMP) program and the California Regional Health Care Cost & Quality Atlas.

(b) This section does not exempt a health care provider that contracts with a voluntary employees' beneficiary association as part of a pilot program authorized by subdivision (a) from the financial solvency requirements of Section 1375.4 and related department regulations, Section 1349 or 1351, or Section 1300.49 of Title 28 of the California Code of Regulations, as applicable, or any other provision of this chapter required by the department as part of the pilot program.

(c) Notwithstanding paragraph (3) of subdivision (a), this section does not exempt a voluntary employees' beneficiary association participating in a program authorized by subdivision (a) of Section 1349.2 from the requirement to reimburse providers on a fee-for-service basis.

(d) The participating voluntary employees' beneficiary association shall appoint an ombudsperson to monitor and respond to any complaint lodged by a participating enrollee in the pilot program. If the enrollee is not satisfied with the result, the ombudsperson shall refer the enrollee to the department's grievance and appeal process as established pursuant to Section 1368. Determinations made by the department pursuant to the grievance and appeal process shall be binding upon the voluntary employee's beneficiary association.

(e) The participating voluntary employees' beneficiary association shall report on a quarterly basis to the department any complaint lodged by a participating enrollee in the pilot program, along with a description of the response and resolution.

(f) The global and risk-bearing providers participating in a pilot program authorized by subdivision (a) shall be approved by the department. The department shall retain the right to disapprove any pilot program application for any reason consistent with this chapter, including, but not limited to, failure to demonstrate to the department's satisfaction adequate enrollee protection and compliance with all criteria and requirements in this section.

(g) The department, after the termination of the pilot program, and before January 1, 2029, shall submit a report to the Legislature regarding the costs and clinical patient outcomes of the pilot program compared to fee-for-service payment models, including data on enrollee satisfaction, consumer and provider grievances, appeals, and independent medical reviews. The department may authorize a public or private agency in subparagraph (B) of paragraph (11) of subdivision (a) to prepare the report on behalf of the department. This report shall be submitted in compliance with Section 9795 of the Government Code.

(h) The pilot program participants shall reimburse the department for reasonable regulatory costs of up to five hundred thousand dollars ($500,000) for all of the following:

(1) Commissioning the report described in subdivision (g).

(2) Developing an application process for the pilot program described in this section.

(3) Monitoring compliance with this section.

(i) This section shall remain in effect only until January 1, 2030, and as of that date is repealed.

(Amended by Stats. 2024, Ch. 818, Sec. 1. (AB 2063) Effective January 1, 2025. Repealed as of January 1, 2030, by its own provisions.)

1343.5. In any proceeding under this chapter, the burden of proving an exemption or an exception from a definition is upon the person claiming it.

(Added by Stats. 1978, Ch. 778.)

1344. (a) The director may from time to time adopt, amend, and rescind any rules, forms, and orders that are necessary to carry out the provisions of this chapter, including rules governing applications and reports, and defining any terms, whether or not used in this chapter, insofar as the definitions are not inconsistent with the provisions of this chapter. For the purpose of rules and forms, the director may classify persons and matters within the director's jurisdiction, and may prescribe different requirements for different classes. The director may waive any requirement of any rule or form in situations where in the director's discretion that requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to this chapter. The director may adopt rules consistent with federal regulations and statutes to regulate health care coverage supplementing Medicare.

(b) The director may, by regulation, modify the wording of any notice required by this chapter for purposes of clarity, readability, and accuracy, except that a modification shall not change the substantive meaning of the notice.

(c) The director may honor requests from interested parties for interpretive opinions.

(d) No provision of this chapter imposing any liability applies to any act done or omitted in good faith in conformity with any rule, form, order, or written interpretive opinion of the director, or any opinion of the Attorney General, notwithstanding that the rule, form, order, or written interpretive opinion may later be amended or rescinded or be determined by judicial or other authority to be invalid for any reason.

(Amended by Stats. 2009, Ch. 298, Sec. 3. (AB 1540) Effective January 1, 2010.)

1345. As used in this chapter:

(a) “Advertisement” means any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or similar communications media, published in connection with the offer or sale of plan contracts.

(b) “Basic health care services” means all of the following:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. “Basic health care services” includes ambulance and ambulance transport services provided through the “911” emergency response system.

(7) Hospice care pursuant to Section 1368.2.

(c) “Enrollee” means a person who is enrolled in a plan and who is a recipient of services from the plan.

(d) “Evidence of coverage” means any certificate, agreement, contract, brochure, or letter of entitlement issued to a subscriber or enrollee setting forth the coverage to which the subscriber or enrollee is entitled.

(e) “Group contract” means a contract that by its terms limits the eligibility of subscribers and enrollees to a specified group. Reference to a “group” does not include a Medi-Cal managed care contract between a health care service plan and the State Department of Health Care Services to provide benefits to beneficiaries of the Medi-Cal program.

(f) “Health care service plan” or “specialized health care service plan” means either of the following:

(1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(g) “License” means, and “licensed” refers to, a license as a plan pursuant to Section 1353.

(h) “Out-of-area coverage,” for purposes of paragraph (6) of subdivision (b), means coverage while an enrollee is anywhere outside the service area of the plan, and shall also include coverage for urgently needed services to prevent serious deterioration of an enrollee’s health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to the plan’s service area.

(i) “Provider” means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(j) “Person” means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the state.

(k) “Service area” means a geographical area designated by the plan within which a plan shall provide health care services.

(l) “Solicitation” means any presentation or advertising conducted by, or on behalf of, a plan, where information regarding the plan, or services offered and charges therefor, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan.

(m) “Solicitor” means any person who engages in the acts defined in subdivision (l).

(n) “Solicitor firm” means any person, other than a plan, who through one or more solicitors engages in the acts defined in subdivision (l).

(o) “Specialized health care service plan contract” means a contract for health care services in a single specialized area of health care, including dental care, for subscribers or enrollees, or which pays for or which reimburses any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(p) “Subscriber” means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

(q) Unless the context indicates otherwise, “plan” refers to health care service plans and specialized health care service plans.

(r) “Plan contract” means a contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health care services, including basic health care services, are furnished; and unless the context otherwise indicates it includes specialized health care service plan contracts; and unless the context otherwise indicates it includes group contracts.

(s) All references in this chapter to financial statements, assets, liabilities, and other accounting items mean those financial statements and accounting items prepared or determined in accordance with generally accepted accounting principles, and fairly presenting the matters they purport to present, subject to any specific requirement imposed by this chapter or by the director.

(Amended by Stats. 2024, Ch. 492, Sec. 2. (SB 1511) Effective January 1, 2025.)

1345.5. (a) “Minimum essential coverage” means any of the following:

(1) Coverage under any of the following government-sponsored programs:

(A) The Medicare program under Part A or Part C of Title XVIII of the federal Social Security Act.

(B) Full scope coverage under the Medi-Cal program, including the Medi-Cal Access Program and Medi-Cal for Pregnant Women, and other full scope health coverage programs administered and determined to be minimum essential coverage by the State Department of Health Care Services.

(C) The Medicaid program under Title XIX of the federal Social Security Act.

(D) The CHIP program under Title XXI of the federal Social Security Act or under a qualified CHIP look-alike program, as defined in Section 2107(g) of the federal Social Security Act.

(E) Medical coverage under Chapter 55 of Title 10 of the United States Code, including coverage under the TRICARE program.

(F) A health care program under Chapter 17 or Chapter 18 of Title 38 of the United States Code.

(G) A health plan under Section 2504(e) of Title 22 of the United States Code, relating to Peace Corps volunteers.

(H) The Nonappropriated Fund health benefits program of the Department of Defense, established under Section 349 of the National Defense Authorization Act for Fiscal Year 1995.

(I) Refugee Medical Assistance, supported by the Administration for Children and Families, which is authorized under Section 412(e)(7)(A) of The Immigration and Nationality Act.

(J) A successor program to one of the above programs, as determined by the department or, pursuant to subparagraph (B), by the State Department of Health Care Services.

(2) The University of California Student Health Insurance Plan and the University of California Voluntary Dependent Plan.

(3) Coverage under an eligible employer-sponsored plan, including grandfathered plans and policies. “Eligible employer-sponsored plan” means a group health plan offered in connection with employment to an employee or related individuals, including a governmental plan within the meaning of Section 2791(d)(8) of the federal Public Health Service Act (42 U.S.C. Sec. 201 et seq.) or any other plan, group health care service plan contract, or group health insurance policy offered in the small or large group market within the state.

(4) Coverage under an individual health care service plan contract or individual health insurance policy, including grandfathered contracts and policies, or student health coverage that substantially meets all the requirements of Title I of the Affordable Care Act pertaining to nongrandfathered, individual health insurance coverage.

(5) Any other health benefits coverage similar in form and substance to the benefits described in this subdivision that is determined by the department to constitute minimum essential coverage pursuant to this section.

(b) “Minimum essential coverage” does not include health coverage as follows:

(1) Coverage of the following excepted benefits:

(A) Coverage only for accident or disability income insurance, or a combination of the two.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for onsite medical clinics.

(H) Other similar health coverage, under which benefits for medical care are secondary or incidental to other health benefits.

(2) Coverage of the following excepted benefits, if offered separately:

(A) Limited scope dental or vision benefits, or benefits limited to any other single specialized area of health care.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Other similar, limited benefits.

(3) Coverage of the following excepted benefits if offered as independent, noncoordinated benefits.

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) Coverage of the following excepted benefits if offered as a separate contract for health care coverage:

(A) Medicare supplemental health insurance, as defined under Section 1395ss(g)(1) of Title 42 of the United States Code.

(B) Coverage supplemental to the coverage provided under Chapter 55 (commencing with Section 1071) of Title 10 of the United States Code.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, or the State Department of Health Care Services, may implement, interpret, or make specific this section by means of guidance or instructions, without taking regulatory action.

(Added by Stats. 2019, Ch. 38, Sec. 14. (SB 78) Effective June 27, 2019.)