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 2. Administration [1346 - 1348.96] *(Article 2 added by Stats. 1975, Ch. 941.)*

1346. (a) The director shall administer and enforce this chapter and shall have the following powers:

(1) Recommend and propose the enactment of any legislation necessary to protect and promote the interests of the public, subscribers, enrollees, and providers of health care services in health care service plans in the State of California.

(2) Provide information to federal and state legislative committees and executive agencies concerning plans.

(3) Assist, advise, and cooperate with federal, state, and local agencies and officials to protect and promote the interests of plans, subscribers, enrollees, and the public.

(4) Study, investigate, research, and analyze matters affecting the interests of plans, subscribers, enrollees, and the public.

(5) Hold public hearings, subpoena witnesses, take testimony, compel the production of books, papers, documents, and other evidence, and call upon other state agencies for information to implement the purposes, and enforce this chapter.

(6) Conduct audits and examinations of the books and records of plans and other persons subject to this chapter, and may prescribe by rule or order, but is not limited to, the following:

(A) The form and contents of financial statements required under this chapter.

(B) The circumstances under which consolidated statements shall be filed.

(C) The circumstances under which financial statements shall be audited by independent certified public accountants or public accountants.

(7) Conduct necessary onsite medical surveys of the health delivery system of each plan.

(8) Propose, develop, conduct, and assist in educational programs for the public, subscribers, enrollees, and licensees.

(9) Promote and establish standards of ethical conduct for the administration of plans and undertake activities to encourage responsibility in the promotion and sale of plan contracts and the enrollment of subscribers or enrollees in the plans.

(10) Advise the Governor on all matters affecting the interests of plans, subscribers, enrollees, and the public.

(11) Determine that investments of a plan's assets necessary to meet the requirements of Section 1376 are acceptable. For those purposes, reinvestment in the plan and investment in any obligations set forth in Article 3 (commencing with Section 1170) of, and Article 4 (commencing with Section 1190) of, Chapter 2 of Part 2 of Division 1 of the Insurance Code shall be considered acceptable. All other assets shall be invested in a prudent manner.

(b) The powers enumerated in subdivision (a) shall not limit, diminish, or otherwise restrict the other powers of the director specifically set forth in this chapter and other laws.

(Amended by Stats. 1999, Ch. 525, Sec. 43. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1346.1. The department shall maintain a database indicating for each county, the names of the health care service plans that operate in that particular county.

(Added by Stats. 2003, Ch. 80, Sec. 1. Effective January 1, 2004.)

1346.2. The director shall, in coordination with the Insurance Commissioner, review the Internet portal developed by the United States Secretary of Health and Human Services under subdivision (a) of Section 1103 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and paragraph (5) of subdivision (c) of Section 1311 of that act, and any enhancements to that portal expected to be implemented by the secretary on or before January 1, 2015. The review shall examine whether the Internet portal provides sufficient information regarding all health benefit products offered by health care service plans and health insurers in the individual and small employer markets in California to facilitate fair and affirmative marketing of all individual and small employer products, particularly outside the California Health Benefit Exchange created under Title 22 (commencing with Section 100500) of the Government Code. If the director and the Insurance Commissioner jointly determine that the Internet portal does not adequately achieve those purposes, they shall jointly develop and maintain an electronic clearinghouse to achieve those purposes. In performing this function, the director and the Insurance Commissioner shall routinely monitor individual and small employer benefit filings with, and complaints submitted by individuals and small employers to, their respective departments, and shall use any other available means to maintain the clearinghouse.

(Added by Stats. 2010, Ch. 659, Sec. 3. (SB 900) Effective January 1, 2011.)

1346.4. (a) The Legislature finds and declares all of the following:

(1) That millions of Californians are insured under health care service plans regulated by the Knox-Keene Health Care Service Plan Act of 1975, and that more Californians each year are insuring themselves under these health plans.

(2) That greater awareness of the rights and protections afforded by the Knox-Keene Health Care Service Plan Act of 1975 will further the act's goal of providing access to quality health care.

(3) That the public, Knox-Keene providers, and those seeking to form health care service plans under the act will benefit from having the text of the act available to them, affording a greater understanding of what the act does and making it easier for providers to comply with its provisions.

(b) The director shall annually publish this chapter and make it available for sale to the public.

(Amended by Stats. 1999, Ch. 525, Sec. 44. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1346.5. If the director determines that an entity purporting to be a health care service plan exempt from the provisions of Section 740 of the Insurance Code is not a health care service plan, the director shall inform the Department of Insurance of that finding. However, if the director determines that an entity is a health care service plan, the director shall prepare and maintain for public inspection a list of those persons or entities described in subdivision (a) of Section 740 of the Insurance Code, which are not subject to the jurisdiction of another agency of this or another state or the federal government and which the director knows to be operating in the state. There shall be no liability of any kind on the part of the state, the director, and employees of the Department of Managed Health Care for the accuracy of the list or for any comments made with respect to it. Additionally, any solicitor or solicitor firm who advertises or solicits health care service plan coverage in this state described in subdivision (a) of Section 740 of the Insurance Code, which is provided by any person or entity described in subdivision (c) of that section, and where such coverage does not meet all pertinent requirements specified in the Insurance Code, and which is not provided or completely underwritten, insured or otherwise fully covered by a health care service plan, shall advise and disclose to any purchaser, prospective purchaser, covered person or entity, all financial and operational information relative to the content and scope of the plan and, specifically, as to the lack of plan coverage.

(Amended by Stats. 2000, Ch. 857, Sec. 28. Effective January 1, 2001.)

1347.15. (a) There is hereby established in the Department of Managed Health Care the Financial Solvency Standards Board composed of 11 members. The members shall consist of the director, or the director's designee, and 10 members appointed by the director. The 10 members appointed by the director may be, but are not necessarily limited to, health care consumer advocates and individuals with training and experience in the following subject areas or fields: medical and health care economics; accountancy, with experience in integrated or affiliated health care delivery systems; excess loss insurance underwriting in the medical, hospital, and health plan business; actuarial studies in the area of health care delivery systems; management and administration in integrated or affiliated health care delivery systems; investment banking; information technology in integrated or affiliated health care delivery systems; and large group health insurance purchasing. The members appointed by the director shall be appointed for a term of three years, but may be removed or reappointed by the director before the expiration of the term.

(b) The purpose of the board is to do all of the following:

(1) Advise the director on matters of financial solvency affecting the delivery of health care services.

(2) Develop and recommend to the director financial solvency requirements and standards relating to plan operations, plan-affiliate operations and transactions, plan-provider contractual relationships, and provider-affiliate operations and transactions.

(3) Periodically monitor and report on the implementation and results of the financial solvency requirements and standards.

(c) Financial solvency requirements and standards recommended to the director by the board may, after a period of review and comment not to exceed 45 days, be noticed for adoption as regulations as proposed or modified under the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). During the director's 45-day review and comment period, the director, in consultation with the board, may postpone the adoption of the requirements and standards pending further review and comment. Nothing in this subdivision prohibits the director from adopting regulations, including emergency regulations, under the rulemaking provisions of the Administrative Procedure Act.

(d) The board shall meet at least quarterly and at the call of the chair. In order to preserve the independence of the board, the director shall not serve as chair. The members of the board may establish their own rules and procedures. All members shall serve without compensation, but shall be reimbursed from department funds for expenses actually and necessarily incurred in the performance of their duties.

(e) For purposes of this section, "board" means the Financial Solvency Standards Board.

(Amended by Stats. 2024, Ch. 116, Sec. 1. (AB 2767) Effective January 1, 2025.)

1347.5. (a) A health care service plan providing individual coverage in the Exchange shall cooperate with requests from the Exchange to collaborate in the development of, and participate in the implementation of, the Medi-Cal program's premium and cost-sharing payments under Sections 14102 and 14148.65 of the Welfare and Institutions Code for eligible Exchange enrollees.

(b) A health care service plan providing individual coverage in the Exchange shall not charge, bill, ask, or require an enrollee receiving benefits under Section 14102 or 14148.65 of the Welfare and Institutions Code to make any premium or cost-sharing payments for any services that are subject to premium or cost-sharing payments by the State Department of Health Care Services under Section 14102 or 14148.65 of the Welfare and Institutions Code.

(c) For purposes of this section, "Exchange" means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(Amended by Stats. 2015, Ch. 303, Sec. 249. (AB 731) Effective January 1, 2016.)

1347.8. (a) Beginning on July 1, 2023, and annually thereafter, a health care service plan providing a qualified health plan through the Exchange shall report to the director the total amount of funds maintained in a segregated account pursuant to subdivision (a) of Section 1303 of the federal Patient Protection and Affordable Care Act (Public Law 111-148). This annual report shall contain the ending balance of the account and the total dollar amount of claims paid during the reporting year.

(b) For purposes of this section:

(1) "Exchange" means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(2) "Qualified health plan" has the same meaning as defined in Section 1301 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(Added by Stats. 2022, Ch. 563, Sec. 1. (AB 2205) Effective January 1, 2023.)

1348. (a) Every health care service plan licensed to do business in this state shall establish an antifraud plan. The purpose of the antifraud plan shall be to organize and implement an antifraud strategy to identify and reduce costs to the plans, providers, subscribers, enrollees, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. The antifraud plan elements shall include, but not be limited to, all of the following: the designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations; training of plan personnel and contractors concerning the detection of health care fraud; the plan's procedure for managing incidents of suspected fraud; and the internal procedure for referring suspected fraud to the appropriate government agency.

(b) Every plan shall submit its antifraud plan to the department no later than July 1, 1999. Any changes shall be filed with the department pursuant to Section 1352. The submission shall describe the manner in which the plan is complying with subdivision (a), and the name and telephone number of the contact person to whom inquiries concerning the antifraud plan may be directed.

(c) Every health care service plan that establishes an antifraud plan pursuant to subdivision (a) shall provide to the director an annual written report describing the plan's efforts to deter, detect, and investigate fraud, and to report cases of fraud to a law enforcement agency. For those cases that are reported to law enforcement agencies by the plan, this report shall include the number of cases prosecuted to the extent known by the plan. This report may also include recommendations by the plan to improve efforts to combat health care fraud.

(d) Nothing in this section shall be construed to limit the director's authority to implement this section in accordance with Section 1344.

(e) For purposes of this section, "fraud" includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit.

(f) Nothing in this section shall be construed to limit any civil, criminal, or administrative liability under any other provision of law.

(Amended by Stats. 1999, Ch. 525, Sec. 48. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1348.5. A health care service plan shall comply with the provisions of Section 56.107 of the Civil Code to the extent required by that section. To the extent this chapter conflicts with Section 56.107 of the Civil Code, the provisions of Section 56.107 of the Civil Code shall control.

(Added by Stats. 2013, Ch. 444, Sec. 10. (SB 138) Effective January 1, 2014.)

1348.6. (a) No contract between a health care service plan and a physician, physician group, or other licensed health care practitioner shall contain any incentive plan that includes specific payment made directly, in any type or form, to a physician, physician group, or other licensed health care practitioner as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services provided with respect to a specific enrollee or groups of enrollees with similar medical conditions.

(b) Nothing in this section shall be construed to prohibit contracts that contain incentive plans that involve general payments, such as capitation payments, or shared-risk arrangements that are not tied to specific medical decisions involving specific enrollees or groups of enrollees with similar medical conditions. The payments rendered or to be rendered to physicians, physician groups, or other licensed health care practitioners under these arrangements shall be deemed confidential information in accordance with subdivision (d) of Section 1351.

(Added by Stats. 1996, Ch. 1014, Sec. 2. Effective January 1, 1997.)

1348.8. (a) A health care service plan that provides, operates, or contracts for telephone medical advice services to its enrollees and subscribers shall do all of the following:

(1) Ensure that the in-state or out-of-state telephone medical advice service complies with the requirements of Chapter 15 (commencing with Section 4999) of Division 2 of the Business and Professions Code.

(2) Ensure that the staff providing telephone medical advice services for the in-state or out-of-state telephone medical advice service are licensed as follows:

(A) For full service health care service plans, the staff hold a valid California license as a registered nurse or a valid license in the state within which they provide telephone medical advice services as a physician and surgeon or physician assistant, and are operating in compliance with the laws governing their respective scopes of practice.

(B) (i) For specialized health care service plans providing, operating, or contracting with a telephone medical advice service in California, the staff shall be appropriately licensed, registered, or certified as a dentist pursuant to Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code, as a dental hygienist pursuant to Article 7 (commencing with Section 1740) of Chapter 4 of Division 2 of the Business and Professions Code, as a physician and surgeon pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act, as a registered nurse pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, as a psychologist pursuant to Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code, as an optometrist pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code, as a marriage and family therapist pursuant to Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, as a licensed clinical social worker pursuant to Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code, as a professional clinical counselor pursuant to Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, or as a chiropractor pursuant to the Chiropractic Initiative Act, and operating in compliance with the laws governing their respective scopes of practice.

(ii) For specialized health care service plans providing, operating, or contracting with an out-of-state telephone medical advice service, the staff shall be health care professionals, as identified in clause (i), who are licensed, registered, or certified in the state within which they are providing the telephone medical advice services and are operating in compliance with the laws governing their respective scopes of practice. All registered nurses providing telephone medical advice services to both in-state and out-of-state business entities registered pursuant to this chapter shall be licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

(3) Ensure that every full service health care service plan provides for a physician and surgeon who is available on an on-call basis at all times the service is advertised to be available to enrollees and subscribers.

(4) Ensure that staff members handling enrollee or subscriber calls, who are not licensed, certified, or registered as required by paragraph (2), do not provide telephone medical advice. Those staff members may ask questions on behalf of a staff member who is licensed, certified, or registered as required by paragraph (2), in order to help ascertain the condition of an enrollee or subscriber so that the enrollee or subscriber can be referred to licensed staff. However, under no circumstances shall those staff members use the answers to those questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of an enrollee or subscriber or determine when an enrollee or subscriber needs to be seen by a licensed medical professional.

(5) Ensure that no staff member uses a title or designation when speaking to an enrollee or subscriber that may cause a reasonable person to believe that the staff member is a licensed, certified, or registered professional described in Section 4999.2 of the Business and Professions Code unless the staff member is a licensed, certified, or registered professional.

(6) Ensure that the in-state or out-of-state telephone medical advice service designates an agent for service of process in California and files this designation with the director.

(7) Require that the in-state or out-of-state telephone medical advice service makes and maintains records for a period of five years after the telephone medical advice services are provided, including, but not limited to, oral or written transcripts of all medical advice conversations with the health care service plan's enrollees or subscribers in California and copies of all complaints. If the records of telephone medical advice services are kept out of state, the health care service plan shall, upon the request of the director, provide the records to the director within 10 days of the request.

(8) Ensure that the telephone medical advice services are provided consistent with good professional practice.

(b) The director shall forward to the Department of Consumer Affairs, within 30 days of the end of each calendar quarter, data regarding complaints filed with the department concerning telephone medical advice services.

(c) For purposes of this section, "telephone medical advice" means a telephonic communication between a patient and a health care professional in which the health care professional's primary function is to provide to the patient a telephonic response to the patient's questions regarding his or her or a family member's medical care or treatment. "Telephone medical advice" includes assessment, evaluation, or advice provided to patients or their family members.

(Amended by Stats. 2016, Ch. 799, Sec. 42. (SB 1039) Effective January 1, 2017.)

1348.9. (a) On or before July 1, 2003, the director shall adopt regulations to establish the Consumer Participation Program, which shall allow for the director to award reasonable advocacy and witness fees to a person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of a regulation or to an order or decision made by the director if the order or decision has the potential to impact a significant number of enrollees.

(b) The regulations adopted by the director shall include specifications for eligibility of participation, rates of compensation, and procedures for seeking compensation. The regulations shall require that the person or organization demonstrate a record of advocacy on behalf of health care consumers in administrative or legislative proceedings in order to determine whether the person or organization represents the interests of consumers.

(c) This section applies to all proceedings of the department, but does not apply to resolution of individual grievances, complaints, or cases.

(d) Fees awarded pursuant to this section may not exceed three hundred fifty thousand dollars ($350,000) each fiscal year.

(e) The fees awarded pursuant to this section shall be considered costs and expenses pursuant to Section 1356 and shall be paid from the assessment made under that section. The amount of the assessment shall not be increased to pay the fees awarded under this section.

(f) By March 1, 2022, and annually each March 1 thereafter, the department shall post all of the following information on its public internet website:

(1) The amount of reasonable advocacy and witness fees awarded each fiscal year.

(2) The individuals or organization to whom advocacy and witness fees were awarded pursuant to this section.

(3) The orders, decisions, and regulations pursuant to which the advocacy and witness fees were awarded.

(Amended by Stats. 2021, Ch. 741, Sec. 1. (AB 326) Effective January 1, 2022.)

1348.95. (a) Commencing March 1, 2013, and at least annually thereafter, a health care service plan, not including a health care service plan offering specialized health care service plan contracts, shall provide to the department, in a form and manner determined by the department in consultation with the Department of Insurance, the number of enrollees, by product type, as of December 31 of the prior year, that receive health care coverage under a health care service plan contract that covers individuals and small groups inside and outside of the California Health Benefit Exchange, large groups, administrative services only business lines, and any other business lines. Health care service plans shall include the enrollment data in specific product types as determined by the department, including, but not limited to, HMO, point-of-service, PPO, grandfathered, and Medi-Cal managed care. Data reported pursuant to this subdivision shall specify the covered persons that are being reported pursuant to subdivision (b).

(b) Commencing March 1, 2020, and at least annually thereafter, a health care service plan that provides coverage through a multiple employer welfare arrangement (MEWA) that is not subject to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 of the Insurance Code shall provide to the department, in a form and manner determined by the department in consultation with the Department of Insurance, the name of each MEWA and the number of covered persons in each MEWA as of December 31 of the prior year, divided by market segment and product type. Data reported pursuant to this subdivision shall be identified and separately reported under subdivision (a).

(c) The department shall publicly report the data provided by each health care service plan pursuant to this section, including, but not limited to, posting the data on the department's internet website. The department shall consult with the Department of Insurance to ensure that the data reported is comparable and consistent, does not duplicate existing reporting requirements, and utilizes existing reporting formats. The data for the previous calendar year shall be made available no later than April 15 of each calendar year.

(Amended by Stats. 2020, Ch. 370, Sec. 192. (SB 1371) Effective January 1, 2021.)

1348.96. Any data submitted by a health care service plan to the United States Secretary of Health and Human Services, or his or her designee, for purposes of the risk adjustment program described in Section 1343 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18063) shall be concurrently submitted to the department in the same format. The department shall use the information to monitor federal implementation of risk adjustment in the state and to ensure that health care service plans are in compliance with federal requirements related to risk adjustment.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 2, Sec. 1. (SB 2 1x) Effective September 30, 2013.)