WELFARE AND INSTITUTIONS CODE - WIC

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

PART 3.3. Health Care Coverage Assistance [15800 - 15895] *(Part 3.3 added by Stats. 2013, Ch. 23, Sec. 68.)*

CHAPTER 4. California Major Risk Medical Insurance Program [15870 - 15895] *(Chapter 4 added by Stats. 2014, Ch. 31, Sec. 90.)*

ARTICLE 5. Subscriber Eligibility and Enrollment [15884 - 15888.5] *(Article 5 added by Stats. 2014, Ch. 31, Sec. 90.)*

15884. (a) Each resident of the state meeting the eligibility criteria of this section and who is unable to secure adequate private health coverage is eligible to apply for major risk medical coverage through the program. For these purposes, “resident” includes a member of a federally recognized California Indian tribe.

(b) To be eligible for enrollment in the program, an applicant shall have been rejected for health care coverage by at least one private health plan. An applicant shall be deemed to have been rejected if the only private health coverage that the applicant could secure would do one of the following:

(1) Impose substantial waivers that the department determines would leave a subscriber without adequate coverage for medically necessary services.

(2) Afford limited coverage that the department determines would leave the subscriber without adequate coverage for medically necessary services.

(3) Afford coverage only at an excessive price, which the department determines is significantly above standard average individual coverage rates.

(c) Rejection for policies or certificates of specified disease or policies or certificates of hospital confinement indemnity, as described in Section 10198.61 of the Insurance Code, shall not be deemed to be rejection for the purposes of eligibility for enrollment.

(d) The department may permit dependents of eligible subscribers to enroll in major risk medical coverage through the program if the department determines the enrollment can be carried out in an actuarially and administratively sound manner.

(e) Notwithstanding the provisions of this section, the department shall prescribe a period of time during which a resident is ineligible to apply for major risk medical coverage through the program if the resident either voluntarily disenrolls from, or was terminated for nonpayment of the premium from, a private health plan after enrolling in that private health plan pursuant to either Section 10127.16 of the Insurance Code, and Section 1373.622 of the Health and Safety Code.

(Added by Stats. 2014, Ch. 31, Sec. 90. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15872.5.)

15884.5. (a) It shall constitute unfair competition for purposes of Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 of the Business and Professions Code for an insurer, an insurance agent or broker, or an administrator, as defined in Section 1759 of the Insurance Code, to refer an individual employee, or his or her dependents, to the program, or arrange for an individual employee, or his or her dependents, to apply to the program, for the purpose of separating that employee, or his or her dependents, from group health coverage provided in connection with the employees employment.

(b) It shall constitute an unfair labor practice contrary to public policy and enforceable under Section 95 of the Labor Code for any employer to refer an individual employee, or his or her dependents, to the program, or to arrange for an individual employee, or his or her dependents, to apply to the program, for the purpose of separating that employee, or his or her dependents, from group health coverage provided in connection with the employee’s employment.

(c) As used in this section, “group health coverage” includes any nonprofit hospital service plan, health care service plan, self-insured employee welfare benefit plan, or disability insurance providing medical or hospital benefits.

(Added by Stats. 2014, Ch. 31, Sec. 90. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15872.5.)

15885. The department may permit the exclusion of coverage or benefits for charges or expenses incurred by a subscriber during the first six months of enrollment in the program for any condition for which, during the six months immediately preceding enrollment in the program medical advice, diagnosis, care, or treatment was recommended or received as to the condition during that period.

However, the exclusion from coverage of this section shall be waived to the extent to which the subscriber was covered under any creditable coverage, as defined in Section 10900 of the Insurance Code, that was terminated, provided the subscriber has applied for enrollment in the program not later than 63 days following termination of the prior coverage, or within 180 days of termination of coverage if the subscriber lost his or her previous creditable coverage because the subscriber's employment ended, the availability of health coverage offered through employment or sponsored by an employer terminated, or an employer's contribution toward health coverage terminated. The exclusion from coverage of this section shall also be waived as to any condition of a subscriber previously receiving coverage under a plan of another state similar to the program established by this chapter if the subscriber was eligible for benefits under that other-state coverage for the condition. The department may establish alternative mechanisms applicable to enrollment in participating health plans. These mechanisms may include, but are not limited to, a postenrollment waiting period.

(Added by Stats. 2014, Ch. 31, Sec. 90. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15872.5.)

15885.5. If more than one participating health plan is offered, the department shall make available to applicants eligible to enroll in the program sufficient information to make an informed choice among the various types of participating health plans. Each applicant shall be issued an appropriate document setting forth or summarizing the services to which an enrollee is entitled, procedures for obtaining major risk medical coverage, a list of contracting health plans and providers, and a summary of grievance procedures.

(Amended by Stats. 2015, Ch. 303, Sec. 626. (AB 731) Effective January 1, 2016.)

15886. After the applicant notifies the department in writing of his or her choice of participating health plan, the department shall assist the applicant in enrolling as a subscriber and securing major risk medical coverage for the subscriber and any dependents.

(Added by Stats. 2014, Ch. 31, Sec. 90. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15872.5.)

15886.5. A subscriber may request a change in coverage based upon a change in the family status of any dependent, by filing an application within 30 days after the occurrence of the change in family status, or at other times and under conditions as may be prescribed by the department.

(Added by Stats. 2014, Ch. 31, Sec. 90. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15872.5.)

15887. Health coverage secured through the program shall permit a covered dependent of a subscriber to elect to continue the same coverage upon the death of the subscriber, or upon the subscriber becoming eligible for Medicare Part A and Part B.

(Added by Stats. 2014, Ch. 31, Sec. 90. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15872.5.)

15887.5. A transfer of enrollment from one participating health plan to another may be made by a subscriber at times and under conditions as may be prescribed by the department.

(Added by Stats. 2014, Ch. 31, Sec. 90. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15872.5.)

15888. If a subscriber is dissatisfied with any action or failure to act which has occurred in connection with a participating plan's coverage, the subscriber shall have the right to appeal to the department and shall be accorded an opportunity for a fair hearing. Hearings may be conducted, insofar as practicable, pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(Added by Stats. 2014, Ch. 31, Sec. 90. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15872.5.)

15888.5. Subscribers and their dependents who become eligible for Medicare Part A and Part B, excluding those on Medicare solely because of end-stage renal disease, shall not be enrolled, or continue to be enrolled, in major risk medical coverage afforded by this chapter.

(Added by Stats. 2014, Ch. 31, Sec. 90. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15872.5.)