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INSURANCE CODE - INS

DIVISION 2. CLASSES OF INSURANCE [1880 - 12880.8] (*Division 2 enacted by Stats. 1935, Ch. 145.*)

PART 2. LIFE AND DISABILITY INSURANCE [10110 - 11549] (*Part 2 enacted by Stats. 1935, Ch. 145.*)

CHAPTER 8.5. Coverage for Federally Eligible Defined Individuals [10785 - 10786] (*Chapter 8.5 added by Stats. 2000, Ch. 810, Sec. 3.*)

10785. (a) A disability insurer that covers hospital, medical, or surgical expenses under an individual health benefit plan as defined in subdivision (a) of Section 10198.6 may not, with respect to a federally eligible defined individual desiring to enroll in individual health insurance coverage, decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion with respect to the coverage.

(b) For purposes of this section, "federally eligible defined individual" means an individual who, as of the date on which the individual seeks coverage under this section, meets all of the following conditions:

- (1) Has had 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002).
- (2) Is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have other health insurance coverage.
- (3) Was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud.
- (4) If offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.

(c) Every disability insurer that covers hospital, medical, or surgical expenses shall comply with applicable federal statutes and regulations regarding the provision of coverage to federally eligible defined individuals, including any relevant application periods.

(d) A disability insurer shall offer the following health benefit plans under this section that are designed for, made generally available to, are actively marketed to, and enroll, individuals: (1) either the two most popular products as defined in Section 300gg-41(c)(2) of Title 42 of the United States Code and Section 148.120(c)(2) of Title 45 of the Code of Federal Regulations or (2) the two most representative products as defined in Section 300gg-41(c)(3) of the United States Code and Section 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as determined by the insurer in compliance with federal law. An insurer that offers only one health benefit plan to individuals, excluding health benefit plans offered to Medi-Cal or Medicare beneficiaries, shall be deemed to be in compliance with this chapter if it offers that health benefit plan contract to federally eligible defined individuals in a manner consistent with this chapter.

(e) (1) In the case of a disability insurer that offers health benefit plans in the individual market through a network plan, the insurer may do both of the following:

- (A) Limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service area for the network plan.
- (B) Within the service area covered by the health benefit plan, deny coverage to individuals if the insurer has demonstrated to the commissioner that the insured will not have the capacity to deliver services adequately to additional individual insureds because of its obligations to existing group policyholders, group contractholders and insureds, and individual insureds, and that the insurer is applying this paragraph uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A disability insurer, upon denying health insurance coverage in any service area in accordance with subparagraph (B) of paragraph (1), may not offer health benefit plans through a network in the individual market within that service area for a period of 180 days after the coverage is denied.

(f) (1) A disability insurer may deny health insurance coverage in the individual market to a federally eligible defined individual if the insurer has demonstrated to the commissioner both of the following:

(A) The insurer does not have the financial reserves necessary to underwrite additional coverage.

(B) The insurer is applying this subdivision uniformly to all individuals in the individual market and without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A disability insurer, upon denying individual health insurance coverage in any service area in accordance with paragraph (1), may not offer that coverage in the individual market within that service area for a period of 180 days after the date the coverage is denied or until the insurer has demonstrated to the commissioner that the insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(g) The requirement pursuant to federal law to furnish a certificate of creditable coverage shall apply to health benefits plans offered by a disability insurer in the individual market in the same manner as it applies to an insurer in connection with a group health benefit plan policy or group health benefit plan contract.

(h) A disability insurer shall compensate an accident and health agent or a life and accident and health agent whose activities result in the enrollment of federally eligible defined individuals in the same manner and consistent with the renewal commission amounts as the insurer compensates accident and health agents or life and accident and health agents for other enrollees who are not federally eligible defined individuals and who are purchasing the same individual health benefit plan.

(i) Every disability insurer shall disclose as part of its COBRA or Cal-COBRA disclosure and enrollment documents, an explanation of the availability of guaranteed access to coverage under the federal Health Insurance Portability and Accountability Act of 1996, including the necessity to enroll in and exhaust COBRA or Cal-COBRA benefits in order to become a federally eligible defined individual.

(j) No disability insurer may request documentation as to whether or not a person is a federally eligible defined individual other than is permitted under applicable federal law or regulations.

(k) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.

(l) This section shall apply to policies or contracts offered, delivered, amended, or renewed on or after January 1, 2001.

(m) (1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plans previously issued pursuant to this section to federally eligible defined individuals.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to health benefit plans issued, amended, or renewed on or after that date.

(3) For purposes of this subdivision, the following definitions apply:

(A) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(B) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

(Amended by Stats. 2013, Ch. 441, Sec. 17.5. (AB 1180) Effective October 1, 2013. Operative January 1, 2014, pursuant to Sec. 26 of Ch 441.)

10786. (a) (1) On and after January 1, 2014, a health insurer providing health insurance coverage shall provide to policyholders in individual policies or certificate holders in group policies who cease to be enrolled in coverage a notice informing them that they may be eligible for reduced-cost coverage through the California Health Benefit Exchange (Exchange) established under Title 22 (commencing with Section 100500) of the Government Code or free or low-cost coverage through Medi-Cal. The notice shall include information on obtaining coverage pursuant to those programs, shall be in no less than 12-point type, and shall be developed by the department, no later than July 1, 2013, in consultation with the Department of Managed Health Care and the Exchange. The notice shall also include information that individuals eligible for the Medicare Program should examine their options carefully, as delaying Medicare enrollment may result in substantial financial implications, as well as information on how to find enrollment advice or assistance.

(2) The notice described in paragraph (1) may be incorporated into or sent simultaneously with and in the same manner as any other notices sent by the health insurer.

(b) (1) A health insurer shall annually notify a policyholder or certificate holder that if the policyholder or certificate holder ceases to be enrolled in coverage, the health insurer will provide information, including the policyholder's or certificate holder's name, address, and other contact information, such as email address, to the Exchange so that the policyholder or certificate holder may obtain other coverage. A policyholder or certificate holder may opt out of this transfer of information to the Exchange. This notice may be incorporated into or sent simultaneously with other notices sent by the health insurer.

(2) Beginning January 1, 2021, a health insurer that has notified its policyholders or certificate holders consistent with paragraph (1) shall provide to the Exchange the name, address, and other contact information of a policyholder or certificate holder who ceased to be enrolled in coverage and who did not opt out of the information transfer. The information shall be provided in a manner prescribed by the Exchange.

(3) The Exchange may use any contact method to communicate with and inform a policyholder or certificate holder who ceases to be enrolled in coverage of available coverage options.

(c) This section does not apply to a specialized health insurance policy or a health insurance policy consisting solely of coverage of excepted benefits as described in Section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21).

(Amended by Stats. 2019, Ch. 845, Sec. 3. (SB 260) Effective January 1, 2020.)