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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 9.5. Individual Access to Contracts for Health Care Services [10900 - 10902.5] (*Chapter 9.5 added by Stats. 2000, Ch. 810, Sec. 5.*)

10900. As used in this chapter:

(a) "Benefit plan design" means a specific health coverage policy issued by a carrier to individuals, to trustees of associations that cover individuals. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health services that has significant incentives for the covered individuals to use the system.

(b) "Carrier" means any disability insurance company or any other entity that writes, issues, or administers health benefit plans, as defined in subdivision (a) of Section 10198.6, that cover individuals, regardless of the situs of the contract or master policyholder.

(c) "Creditable coverage" means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Champus supplement, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. 2504(e)).

(d) "Dependent" means the spouse or child of an eligible individual or other individual applying for coverage, subject to applicable terms of the health benefit plan covering the eligible person.

(e) "Federally eligible defined individual" means an individual who as of the date on which the individual seeks coverage under this part, (1) has 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 an employer-sponsored health benefit plan, Medicare, or Medi-Cal, and has no other health insurance coverage, (3) was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud, and (4) if offered continuation coverage under COBRA or Cal-COBRA, had elected and exhausted such coverage.

(f) "In force business" means an existing health benefit plan issued by a carrier to a federally eligible defined individual.

(g) "New business" means a health benefit plan issued to an eligible individual that is not the carrier's in force business.

(h) "Preexisting condition provision" means a policy provision that excludes coverage for charges and expenses incurred during a specified period following the eligible individual's effective date, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(Added by Stats. 2000, Ch. 810, Sec. 5. Effective January 1, 2001.)

10901. Every carrier offering health benefit plans to individuals shall comply with the provisions of this chapter and the rules adopted thereunder.

(Added by Stats. 2000, Ch. 810, Sec. 5. Effective January 1, 2001.)

10901.1. Nothing in this chapter shall be construed to preclude the application of this chapter to either of the following: (a) an association, trust, or other organization acting as a health care service plan as defined under Section 1345, (b) an association, trust, multiple employer welfare arrangement, or other organization or person presenting information regarding a health benefit plan to persons who may be interested in subscribing or enrolling in the plan.

(Added by Stats. 2000, Ch. 810, Sec. 5. Effective January 1, 2001.)

10901.2. (a) Commencing January 1, 2001, a carrier shall fairly and affirmatively offer, market, and sell the health benefit plan designs described in subdivision (d) of Section 10785 that are sold to individuals or to associations that include individuals to all federally eligible defined individuals in each geographic region in which the carrier provides coverage for health care services. Each carrier shall make available to each federally eligible defined individual the identified health benefit plan designs which the plan offers and sells to individuals or to associations that include individuals.

(b) A carrier may not reject an application from a federally eligible defined individual for a benefit plan design under the following circumstances:

(1) The federally eligible defined individual as defined by subdivision (e) of Section 10900 agrees to make the required premium payments.

(2) The federally eligible defined individual, and his or her dependents who are to be covered by the carrier, work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.

(c) No carrier or agent or broker shall, directly or indirectly, encourage or direct federally eligible defined individuals to refrain from filing an application for coverage with a carrier because of health status, claims experience, industry, occupation, receipt of health care, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, disability, or geographic location provided that it is within the carrier's approved service area.

(d) No carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to a solicitor for the sale of a health benefit plan design to be varied because of health status, claims experience, industry, occupation, receipt of health care, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, disability, or geographic location of the individual. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary for the reasons listed in this subdivision.

(e) If a carrier enters into a contract, agreement, or other arrangement with a third-party administrator or other entity to provide administrative, marketing, or other services related to the offering of health benefit plans to individuals in this state, the third-party administrator shall be subject to this chapter.

(Added by Stats. 2000, Ch. 810, Sec. 5. Effective January 1, 2001.)

10901.3. (a) (1) After the federally eligible defined individual submits a completed application form for a health benefit plan, the carrier shall, within 30 days, notify the individual of the individual's actual premium charges for that health benefit plan design. In no

case shall the premium charged for any health benefit plan identified in subdivision (d) of Section 10785 exceed the following amounts:

(A) For health benefit plans that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for a federally eligible defined individual who is between the ages of 60 and 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(B) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for a federally eligible defined individual who is between the ages of 60 and 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium rates.

(2) A carrier may adjust the premium based on family size, not to exceed the following amounts:

(A) For health benefit plans that offer services through a preferred provider arrangement, the average of the Major Risk Medical Insurance Program rate for families of the same size that reside in the same geographic area as the federally eligible defined individual.

(B) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to a family that is of the same size and resides in the same geographic area as the federally eligible defined individual.

(3) This subdivision shall become inoperative on January 1, 2014. This subdivision shall become operative on January 1, 2020.

(b) (1) On and after January 1, 2014, after the federally eligible defined individual submits a completed application form for a health benefit plan, the carrier shall, within 30 days, notify the individual of the individual's actual premium charges for that health benefit plan design. In no case shall the premium charged for any health benefit plan identified in subdivision (d) of Section 10785 exceed the following amounts:

(A) With respect to the rate charged for coverage provided in 2014, the rate charged in 2013 for that coverage multiplied by 1.09.

(B) With respect to the rate charged for coverage provided in 2015 and each subsequent year, the rate charged in the prior year multiplied by a factor of one plus the percentage change in the statewide average premium for the second lowest cost silver plan offered on the Exchange. The Exchange shall determine the percentage change in the statewide average premium for the second lowest cost silver plan by subtracting clause (i) from clause (ii) and dividing the result by clause (i).

(i) The average of the premiums charged in the year prior to the applicable year for the second lowest cost silver plan in all 19 rating regions, with the premium for each region weighted based on the region's relative share of the Exchange's total individual enrollment according to the latest data available to the Exchange.

(ii) The average of the premiums to be charged in the applicable year for the second lowest cost silver plan in all 19 rating regions, with the premium for each region weighted based on the region's relative share of the Exchange's total individual enrollment according to the latest data available to the Exchange.

(C) The Exchange shall determine the percentage change in the statewide average premium no later than 30 days after the Exchange's rates for individual coverage for the applicable year have been finalized.

(2) For purposes of this subdivision, "Exchange" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(3) This subdivision shall become operative on January 1, 2014, and shall become inoperative on January 1, 2020.

(c) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(d) During the first 30 days after the effective date of the health benefit plan, the individual shall have the option of changing coverage to a different health benefit plan design offered by the same carrier. If the individual notified the plan of the change within the first 15 days of a month, coverage under the new health benefit plan shall become effective no later than the first day of the

following month. If an enrolled individual notified the carrier of the change after the 15th day of a month, coverage under the health benefit plan shall become effective no later than the first day of the second month following notification.

(e) (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. Section 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. 18. (AB 1180) Effective October 1, 2013.)

10901.4. A carrier may not exclude any federally eligible defined individual, or his or her dependents, who would otherwise be entitled to health care services, on the basis of an actual or expected health condition of that individual or dependent. No health benefit plan may limit or exclude coverage for a specific federally eligible defined individual, or his or her dependents, by type of illness, treatment, medical condition, or accident.

(Added by Stats. 2000, Ch. 810, Sec. 5. Effective January 1, 2001.)

10901.7. (a) The commissioner may require a carrier to discontinue the offering of health benefit plans or the acceptance of applications from any individual upon a determination by the commissioner that the plan carrier does not have sufficient financial viability, organization, and administrative capacity to assure the delivery of health care services to its enrollees.

(b) The commissioner's determination shall follow an evaluation that includes a certification by the commissioner that the acceptance of an application or applications would place the carrier in a financially impaired condition.

(c) A carrier that has not offered coverage or accepted applications pursuant to this chapter shall not offer coverage or accept applications for any individual until the commissioner has determined that the carrier has ceased to be financially impaired.

(Added by Stats. 2000, Ch. 810, Sec. 5. Effective January 1, 2001.)

10901.8. All health benefit plans offered to a federally eligible defined individual shall be renewable with respect to the individual and dependents at the option of the enrolled individual except in cases of:

(a) Nonpayment of the required premiums.

(b) Fraud or misrepresentation by the enrolled individual.

(c) The carrier ceases to provide or arrange for the provision of health care services for individual health benefit plan contracts in this state, provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefit plans in this state is provided to the commissioner and to the contractholder.

(2) Individual health benefit plan contracts subject to this chapter shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a carrier that remains in force, any carrier that ceases to offer for sale new individual health benefit plan contracts shall continue to be governed by this article with respect to business conducted under this chapter.

(3) A carrier that ceases to write new individual business in this state after the effective date of this chapter shall be prohibited from offering for sale new individual health benefit plan contracts in this state for a period of three years from the date of the notice to the commissioner.

(d) When a carrier withdraws a health benefit plan design from the individual market, provided that a carrier makes available to eligible individuals all health plan benefit designs that it makes available to new individual business, and provided that premium for the new health benefit plan complies with the renewal increase requirements set forth in Section 10901.9.

(e) (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. Section 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. 19. (AB 1180) Effective October 1, 2013.)

10901.9. (a) Commencing January 1, 2001, premiums for health benefit plans offered, delivered, amended, or renewed by carriers shall be subject to the following requirements:

(1) The premium for new business for a federally eligible defined individual shall not exceed the following amounts:

(A) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally eligible defined individuals who are between 60 to 64 years of age, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(B) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally eligible defined individuals who are between 60 to 64 years of age, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) The premium for in force business for a federally eligible defined individual shall not exceed the following amounts:

(A) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally eligible defined individuals who are between 60 and 64 years of age, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(B) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally eligible defined individuals who are between 60 and 64 years of age, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The premium effective on January 1, 2001, shall apply to in force business at the earlier of either the time of renewal or July 1, 2001.

(3) This subdivision shall become inoperative January 1, 2014. This subdivision shall become operative on January 1, 2020.

(b) (1) Commencing January 1, 2014, premiums for health benefit plans offered, delivered, amended, or renewed by carriers shall be subject to the following requirements:

(A) With respect to the rate charged for coverage provided in 2014, the rate charged in 2013 for that coverage multiplied by 1.09.

(B) With respect to the rate charged for coverage provided in 2015 and each subsequent year, the rate charged in the prior year multiplied by a factor of one plus the percentage change in the statewide average premium for the second lowest cost silver plan offered on the Exchange. The Exchange shall determine the percentage change in the statewide average premium for the second lowest cost silver plan by subtracting clause (i) from clause (ii) and dividing the result by clause (i).

(i) The average of the premiums charged in the year prior to the applicable year for the second lowest cost silver plan in all 19 rating regions, with the premium for each region weighted based on the region's relative share of the Exchange's total individual enrollment according to the latest data available to the Exchange.

(ii) The average of the premiums to be charged in the applicable year for the second lowest cost silver plan in all 19 rating regions, with the premium for each region weighted based on the region's relative share of the Exchange's total individual enrollment according to the latest data available to the Exchange.

(C) The Exchange shall determine the percentage change in the statewide average premium no later than 30 days after the Exchange's rates for individual coverage for the applicable year have been finalized.

(2) For purposes of this subdivision, "Exchange" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(3) This subdivision shall become operative on January 1, 2014, and shall become inoperative on January 1, 2020.

(c) The premium applied to a federally eligible defined individual may not increase by more than the following amounts:

(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual.

(2) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, the increase in premiums charged to a nonfederally eligible defined individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

(3) For a contract that a carrier has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

(d) (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. Section 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 or amended 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. 20. (AB 1180) Effective October 1, 2013.)

10902. Carriers shall apply premiums consistently with respect to all federally eligible defined individuals who apply for coverage.

(Added by Stats. 2000, Ch. 810, Sec. 5. Effective January 1, 2001.)

10902.1. In connection with the offering for sale of any health benefit plan designed to an individual, each carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all individual contracts.

(Added by Stats. 2000, Ch. 810, Sec. 5. Effective January 1, 2001.)

10902.2. Nothing in this chapter shall be construed to require a health benefit plan to offer a contract to an individual if the carrier does not otherwise offer contracts to individuals.

(Added by Stats. 2000, Ch. 810, Sec. 5. Effective January 1, 2001.)

10902.3. (a) At least 20 business days prior to renewing or amending a health benefit plan contract subject to this chapter, or at least 20 business days prior to the initial offering of a health benefit plan subject to this chapter, a carrier shall file a statement with the commissioner in the same manner as required for small employers as outlined in Section 10717. The statement shall include a

statement certifying that the carrier is in compliance with subdivision (a) of Section 10901.3 and with Section 10901.9. Any action by the commissioner, as permitted under Section 10717, to disapprove, suspend, or postpone the plan's use of a carrier's health benefit plan design shall be in writing, specifying the reasons the health benefit plan does not comply with the requirements of this chapter.

(b) Prior to making any changes in the premium, the carrier shall file an amendment in the same manner as required for small employers as outlined in Section 10717, and shall include a statement certifying the carrier is in compliance with subdivision (a) of Section 10901.3 and with Section 10901.9. All other changes to a health benefit plan previously filed with the commissioner pursuant to subdivision (a) shall be filed as an amendment in the same manner as required for small employers as outlined in Section 10717.

(c) (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. Section 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. 21. (AB 1180) Effective October 1, 2013.)

10902.5. The commissioner may issue regulations that are necessary to carry out the purposes of this chapter. Any rules and regulations adopted pursuant to this chapter may be adopted as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Until December 31, 2001, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The regulations shall be enforced by the commissioner.

(Added by Stats. 2000, Ch. 810, Sec. 5. Effective January 1, 2001.)