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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 9.9. Individual Access to Health Insurance [10965 - 10965.18] (*Chapter 9.9 added by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 19.*)

10965. For purposes of this chapter, the following definitions shall apply:

- (a) "Child" means a child described in Section 22775 of the Government Code and subdivisions (n) to (p), inclusive, of Section 599.500 of Title 2 of the California Code of Regulations.
- (b) "Dependent" means the spouse or registered domestic partner, child, or parent or stepparent pursuant to Section 10278.1, of an individual, subject to applicable terms of the health benefit plan.
- (c) "Exchange" means the California Health Benefit Exchange created by Section 100500 of the Government Code.
- (d) "Family" means the policyholder and dependent or dependents.
- (e) "Grandfathered health plan" has the same meaning as defined in Section 1251 of PPACA.
- (f) "Health benefit plan" means an individual or group policy of health insurance, as defined in Section 106. The term does not include a health insurance policy that provides excepted benefits, as described in Sections 2722 and 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91), subject to Section 10965.01 a health insurance policy provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2), or the program under Part 6.4 (commencing with Section 12699.50) of Division 2, or Medicare supplement coverage, to the extent consistent with PPACA or a specified disease or hospital indemnity policy, subject to Section 10965.01.
- (g) "Policy year" means the period from January 1 to December 31, inclusive.
- (h) "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.
- (i) "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, 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.
- (j) "Rating period" means the calendar year for which premium rates are in effect pursuant to subdivision (d) of Section 10965.9.
- (k) "Registered domestic partner" means a person who has established a domestic partnership as described in Section 297 of the Family Code.

(Amended by Stats. 2021, Ch. 468, Sec. 4. (AB 570) Effective January 1, 2022.)

10965.01. (a) For purposes of this chapter, "health benefit plan" does not include policies or certificates of specified disease or hospital confinement indemnity provided that the carrier offering those policies or certificates complies with the following:

- (1) The carrier files, on or before March 1 of each year, a certification with the commissioner that contains the statement and information described in paragraph (2).
- (2) The certification required in paragraph (1) shall contain the following:

(A) A statement from the carrier certifying that policies or certificates described in this section (i) are being offered and marketed as supplemental health insurance and not as a substitute for coverage that provides essential health benefits as defined by the state pursuant to Section 1302 of PPACA, and (ii) the disclosure forms as described in Section 10603 contains the following statement prominently on the first page:

"This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law."

(B) A summary description of each policy or certificate described in this section, including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender, or other factors, charged for the policies and certificates issued or delivered in this state.

(3) In the case of a policy or certificate that is described in this section and that is offered in this state on or after January 1, 2014, the carrier files with the commissioner the information and statement required in paragraph (2) at least 30 days prior to the date such a policy or certificate is issued or delivered in this state.

(4) The carrier issuing a policy or certificate of specified disease or a policy or certificate of hospital confinement indemnity requires that the person to be insured is covered by an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans.

(b) As used in this section, "policies or certificates of specified disease" and "policies or certificates of hospital confinement indemnity" mean policies or certificates of insurance sold to an insured to supplement other health insurance coverage as specified in this section.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 19. (AB 2 1x) Effective September 30, 2013.)

10965.02. For the purposes of determining eligibility for small employer coverage, a sole proprietor and the sole proprietor's spouse are not considered employees with respect to a sole proprietorship that consists only of the sole proprietor and the sole proprietor's spouse. A partner and a partner's spouse are not employees of a partnership that consists solely of partners and their spouses. Employer group health benefit plans shall not be issued, marketed, or sold to a sole proprietorship or partnership without employees directly or indirectly through any arrangement. Only individual health benefit plans shall be sold to any entity without employees.

(Added by Stats. 2018, Ch. 700, Sec. 11. (SB 1375) Effective January 1, 2019.)

10965.03. (a) For policy years beginning on or after January 1, 2024, a blanket disability insurance policy that meets the definition of student health insurance coverage as set forth in this section shall be considered individual health insurance coverage for purposes of subdivision (b) of Section 106.

(b) "Student health insurance coverage" is a blanket disability policy under paragraph (2) of subdivision (a) of Section 10270.2, that covers hospital, medical, or surgical benefits, that is provided pursuant to a written agreement between an institution of higher education, as defined in the federal Higher Education Act of 1965, and a disability insurance issuer, and provided to students enrolled in that institution of higher education and their dependents, that meets all of the following conditions:

(1) Does not make coverage available other than in connection with enrollment as a student, or as a dependent of a student, in the institution of higher education.

(2) Does not condition eligibility for the insurance coverage on any health status-related factor relating to a student or a dependent of a student.

(3) Does not condition eligibility, an offer, issuance, a sale, or a renewal for the insurance coverage on any factor other than enrollment as a student or dependent of a student in the institution of higher education.

(c) (1) Except as otherwise expressly provided in this section, a blanket disability insurance policy that meets the definition of student health insurance coverage shall comply with the provisions of this code that are applicable to nongrandfathered individual health insurance, including, but not limited to, essential health benefits requirements as set forth in Section 10112.27, rating factors consistent with Section 10965.9, the annual limit on maximum out-of-pocket expenses as set forth in Section 10112.28, the prohibition against annual and lifetime limits pursuant to Section 10112.1, and all rules and regulations issued thereunder.

(2) Any reference to the insured in a blanket disability insurance policy that meets the definition of student health insurance coverage shall also refer to the individual students and dependents insured under those policies.

(3) For the purposes of applying Sections 10123.81, 10123.84, 10123.87, 10123.135, 10123.194, 10278, 10354, 10965, and 10965.3 to student health insurance coverage, any reference to the policyholder shall also refer to the individual students.

(d) A student, or dependent of a student, shall not be required to purchase a blanket disability insurance policy if they have minimum essential coverage that meets the requirements of the Minimum Essential Coverage Individual Mandate pursuant to Section 100705 of the Government Code.

(e) The following provisions apply to student health insurance coverage:

(1) Student health insurance coverage is exempt from laws requiring guaranteed availability or guaranteed renewability, as follows:

(A) Subdivision (f) of Section 10273.6 applies if the basis of student health insurance coverage is enrollment in the institution of higher education and an individual's enrollment in the institution ceases.

(B) For purposes of Sections 10965.3 and 10965.4, a disability insurance issuer that offers student health insurance coverage is not required to accept individuals who are not students or dependents of students in that coverage. Notwithstanding the requirements of subdivisions (a) and (c) of Section 10965.3 and Section 10965.4, a disability insurance issuer that offers student health insurance coverage is not required to establish open enrollment periods or coverage effective dates that are based on a calendar policy year or to offer policies on a calendar year basis.

(C) For purposes of Sections 10273.6 and 10965.7, a disability insurance issuer that offers student health insurance coverage is not required to renew or continue in force coverage for individuals who are no longer students or dependents of students. To the extent the institution of higher education opts to renew the student health insurance policy, student health insurance coverage shall be renewable with respect to all eligible students or dependents of students at the option of the student.

(2) The requirement to provide a specific level of coverage described in Sections 10112.3 and 10112.295 does not apply to student health insurance coverage. However, the benefits provided by that coverage shall provide at least 60 percent actuarial value, as calculated in accordance with Section 10112.295. The issuer shall specify in any plan materials summarizing the terms of the coverage the actuarial value and level of coverage, or the next lowest level of coverage, and how the coverage would otherwise satisfy requirements under Sections 10112.295 and 10112.296.

(3) Student health insurance coverage is not subject to the requirements of subdivision (h) of Section 10965.3. A health insurance issuer that offers student health insurance coverage may establish one or more separate risk pools for an institution of higher education if the distinction between or among groups of students or dependents of students who form the risk pool is based on a bona fide school-related classification and not based on a health factor. However, student health insurance rates shall reflect the claims experience of individuals who comprise the risk pool, and any adjustments to rates within a risk pool shall be actuarially justified.

(4) Student health insurance coverage shall not be required to comply with nongrandfathered individual health insurance rate review, but shall be subject to the nongrandfathered large group market rate review requirements pursuant to Article 4.7 (commencing with Section 10181) of Chapter 1, with the exception of paragraph (2) of subdivision (b) of Section 10181 and Section 10181.4. If the department determines that a rate is unreasonable or not justified consistent with Article 4.7 (commencing with Section 10181) of Chapter 1, the insurer shall notify the policyholder of this decision.

(5) For purposes of subdivision (c) of Section 10113.9, the notification shall be provided to a student certificate holder in addition to the policyholder.

(6) Student health insurance coverage shall be subject to the requirements of subdivisions (b) and (c) of Section 10270.3, Section 10290, paragraph (1) of subdivision (b) of Section 10291.5, and Section 10382.

(f) Each of the following shall not apply to student health insurance coverage:

(1) (A) Subdivision (d) of Section 10965.9.

(B) The rating period, instead, is the policy year for which premium rates are established for student health insurance coverage.

(C) The premium rate for student health insurance coverage shall not vary during the rating period.

(2) Sections 2236.1, 2236.3, 2236.4, 2236.5, and 2236.6 of Article 4 of Subchapter 2 of Chapter 5 of Title 10 of the California Code of Regulations.

(3) Subdivision (a) of Section 10270.3.

(4) Subdivision (a) of Section 10144.4.

(5) Subdivisions (a) to (e), inclusive, of Section 10277.

(6) Section 10278 for dependents under 26 years of age.

(7) Subdivisions (g) and (j) of Section 10965.

(8) Subdivisions (a), (c), and (e) of, paragraphs (1) to (3), inclusive, of subdivision (f) of, and subdivision (h) of, Section 10965.3.

(g) (1) The following notice shall be provided in the student health insurance enrollment materials provided to a student or a dependent of a student:

California requires residents and their dependents to obtain, and maintain, health coverage or pay a penalty, unless they qualify for an exemption. Enrolling in student health insurance offered by the college or university you are attending is one way to meet this requirement.

You may be eligible to get free or low-cost health coverage through Medi-Cal regardless of immigration status. In addition, you may be eligible for free or low-cost health coverage through Covered California. Visit Covered California at www.coveredca.com to learn about health coverage options that are available for you and your dependents, and how you might qualify to get financial assistance with the cost of coverage.

If you are under 26 years of age, you may be eligible for coverage as a dependent in a group health plan of your parent's employer or under your parents' individual market coverage. In addition, you may be eligible to buy individual health insurance directly from a health insurer or health plan, regardless of immigration status.

Please examine your options carefully to see if other options are more affordable and whether you are currently eligible to enroll in these other forms of coverage pursuant to an open or special enrollment period.

(2) The notice shall be prominently displayed in clear, conspicuous, 14-point bold type.

(3) In addition to the enrollment materials, the notice also may be provided on the internet website of the institution of higher education.

(h) (1) A "student administrative health fee" is a fee charged by the institution of higher education on a periodic basis to students of the institution of higher education to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage.

(2) Notwithstanding the requirements under Section 10112.2, a student administrative health fee is not considered a cost-sharing requirement with respect to specified recommended preventive services.

(i) A "health factor" means, in relation to an individual, any of the following health status-related factors:

(1) Health status.

(2) Medical condition, including both physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(9) Any other health status-related factor as determined by any federal regulation, rule, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(Added by Stats. 2022, Ch. 688, Sec. 2. (AB 1823) Effective January 1, 2023.)

10965.1. Except as provided in Section 10965.15, the provisions of this chapter shall only apply with respect to nongrandfathered individual health benefit plans offered by a health insurer, and shall apply in addition to other provisions of this chapter and the rules adopted thereunder.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 19. (AB 2 1x) Effective September 30, 2013.)

10965.3. (a) (1) On and after October 1, 2013, a health insurer shall fairly and affirmatively offer, market, and sell all of the insurer's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the insurer provides or arranges for the provision of health care services. A health insurer shall limit enrollment in individual health benefit plans to open enrollment periods, annual enrollment periods, and special enrollment periods as provided in subdivisions (c) and (d).

(2) A health insurer shall allow the policyholder of an individual health benefit plan to add a dependent to the policyholder's health benefit plan at the option of the policyholder, consistent with the open enrollment, annual enrollment, and special enrollment period requirements in this section.

(b) An individual health benefit plan issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.

(c) (1) With respect to individual health benefit plans offered outside of the Exchange, a health insurer shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, an annual enrollment period for the policy year beginning on January 1, 2015, from November 15, 2014, to February 15, 2015, inclusive, annual enrollment periods for policy years beginning on or after January 1, 2016, to December 31, 2018, inclusive, from November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive, and annual enrollment periods for policy years beginning on or after January 1, 2019, from October 15 of the preceding calendar year, to January 15 of the benefit year, inclusive.

(2) With respect to individual health benefit plans offered through the Exchange, a health insurer shall provide an annual enrollment period for the policy years beginning on January 1, 2016, to December 31, 2018, inclusive, from November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive, and annual enrollment periods for policy years beginning on or after January 1, 2019, from November 1 to December 15 of the preceding calendar year, inclusive.

(3) With respect to individual health benefit plans offered through the Exchange, for policy years beginning on or after January 1, 2019, a health insurer shall provide a special enrollment period for all individuals selecting an individual health benefit plan through the Exchange from October 15 to October 31 of the preceding calendar year, inclusive, and from December 16, of the preceding calendar year, to January 15 of the benefit year, inclusive. An application for a health benefit plan submitted during these two special enrollment periods shall be treated the same as an application submitted during the annual open enrollment period. The effective date of coverage for plan selections made between October 15 and October 31, inclusive, shall be January 1 of the benefit year, and for plan selections made from December 16 to January 15, inclusive, shall be no later than February 1 of the benefit year.

(4) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar year individual health plan contracts, a health insurer shall also provide a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

(d) (1) Subject to paragraph (2), commencing January 1, 2014, a health insurer shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

(A) The individual or the individual's dependent loses minimum essential coverage. For purposes of this paragraph, both of the following definitions shall apply:

(i) "Minimum essential coverage" has the same meaning as that term is defined in Section 1345.5 of the Health and Safety Code or subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

(ii) "Loss of minimum essential coverage" includes, but is not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code. "Loss of minimum essential coverage" also includes loss of that coverage for a reason that is not due to the fault of the individual.

(iii) "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to clause (ii) and Sections 10119.2 and 10384.17.

(B) The individual gains a dependent or becomes a dependent.

(C) The individual is mandated to be covered as a dependent pursuant to a valid state or federal court order.

(D) The individual has been released from incarceration.

(E) The individual's health coverage issuer substantially violated a material provision of the health coverage contract.

(F) The individual gains access to new health benefit plans as a result of a permanent move.

(G) The individual was receiving services from a contracting provider under another health benefit plan, as defined in Section 10965 of this code or Section 1399.845 of the Health and Safety Code, for one of the conditions described in subdivision (a) of Section 10133.56 of this code and that provider is no longer participating in the health benefit plan.

(H) The individual demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the department, with respect to health benefit plans offered outside the Exchange, that the individual did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because the individual was misinformed that the individual was covered under minimum essential coverage.

(I) The individual is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

(J) With respect to individual health benefit plans offered through the Exchange, in addition to the triggering events listed in this paragraph, any other events listed in Section 155.420(d) of Title 45 of the Code of Federal Regulations.

(2) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to apply for coverage from a health care service plan subject to this section. With respect to individual health benefit plans offered through the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to select a plan offered through the Exchange, unless a longer period is provided in Part 155 (commencing with Section 155.10) of Subchapter B of Subtitle A of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage required pursuant to this section shall be consistent with the dates specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations, as applicable. A dependent who is a registered domestic partner pursuant to Section 297 of the Family Code shall have the same effective date of coverage as a spouse.

(f) With respect to an individual health benefit plan offered outside the Exchange, the following provisions shall apply:

(1) After an individual submits a completed application form for a plan, the insurer shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 10965.9. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(2) With respect to an individual health benefit plan for which an individual applies during the initial open enrollment period described in paragraph (1) of subdivision (c), when the policyholder submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, to December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan for which an individual applies during the annual open enrollment period described in paragraph (1) of subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15 of the preceding calendar year, coverage shall become effective on January 1 of the benefit year. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 to December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(4) With respect to an individual health benefit plan for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the 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 under the plan shall become effective no later than the first day of the following month. When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(B) Notwithstanding subparagraph (A), in the case of a birth, adoption, or placement for adoption, the coverage shall be effective on the date of birth, adoption, or placement for adoption.

(C) Notwithstanding subparagraph (A), in the case of marriage or becoming a registered domestic partner or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the month following the date the insurer receives the request for special enrollment.

(g) (1) A health insurer shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:

(A) Health status.

(B) Medical condition, including physical and mental illnesses.

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability, including conditions arising out of acts of domestic violence.

(H) Disability.

(I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act (Public Law 78-410).

(2) Notwithstanding subdivision (c) of Section 10291.5, a health insurer shall not require an individual applicant or the applicant's dependent to fill out a health assessment or medical questionnaire prior to enrollment under an individual health benefit plan. A health insurer shall not acquire or request information that relates to a health status-related factor from the applicant or the applicant's dependent or any other source prior to enrollment of the individual.

(h) (1) A health insurer shall consider as a single risk pool for rating purposes in the individual market the claims experience of all insureds and enrollees in all nongrandfathered individual health benefit plans offered by that insurer in this state, whether offered as health care service plan contracts or individual health insurance policies, including those insureds and enrollees who enroll in individual coverage through the Exchange and insureds and enrollees who enroll in individual coverage outside the Exchange. Student health insurance coverage, as such coverage is defined in Section 147.145(a) of Title 45 of the Code of Federal Regulations, shall not be included in a health insurer's single risk pool for individual coverage.

(2) Each calendar year, a health insurer shall establish an index rate for the individual market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment program established for the state pursuant to Section 1343 of PPACA and Exchange user fees, as described in subdivision (d) of Section 156.80 of Title 45 of the Code of Federal Regulations. The premium rate for all of the health benefit plans in the individual market within the single risk pool required under paragraph (1) shall use the applicable marketwide adjusted index rate, subject only to the adjustments permitted under paragraph (3).

(3) A health insurer may vary premium rates for a particular health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 10112.27. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(E) Administrative costs, excluding any user fees required by the Exchange.

(i) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

(j) This section shall not apply to a grandfathered health plan.

(Amended by Stats. 2021, Ch. 764, Sec. 11. (SB 326) Effective January 1, 2022.)

10965.4. (a) Notwithstanding paragraph (1) of subdivision (c) of Section 10965.3, with respect to individual health benefit plans offered outside of the Exchange, a health insurer shall provide an annual enrollment period for policy years beginning on or after January 1, 2020, from November 1 of the preceding calendar year, to January 31 of the benefit year, inclusive.

(b) Notwithstanding paragraphs (2) and (3) of subdivision (c) of Section 10965.3, with respect to individual health benefit plans offered through the Exchange, for policy years beginning on or after January 1, 2023, a health insurer shall provide an annual enrollment period from November 1 of the preceding calendar year to January 31 of the benefit year, inclusive.

(c) Notwithstanding paragraph (3) of subdivision (c) of Section 10965.3, with respect to individual health benefit plans offered outside and through the Exchange, the effective date of coverage shall be as follows:

(1) No later than January 1 of the benefit year for plan selection made from November 1 to December 31 of the preceding calendar year, inclusive.

(2) No later than February 1 of the benefit year for plan selection made from January 1 to January 31 of the benefit year, inclusive.

(Amended by Stats. 2022, Ch. 545, Sec. 6. (SB 1473) Effective September 25, 2022.)

10965.5. (a) Commencing on October 1, 2013, a health insurer or agent or broker shall not, directly or indirectly, engage in the following activities:

(1) Encourage or direct an individual to refrain from filing an application for individual coverage with an insurer because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the insurer's approved service area, of the individual.

(2) Encourage or direct an individual to seek individual coverage from another health care service plan or health insurer or the California Health Benefit Exchange because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the insurer's approved service area, of the individual.

(3) Employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

(b) Commencing on October 1, 2013, a health insurer shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a broker or agent that provides for or results in the compensation paid to a broker or agent for the sale of an individual health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the individual. This subdivision does not apply to a compensation arrangement that provides compensation to a broker or agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the individual.

(c) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

(d) This section shall be enforced in the same manner as Section 790.03, including through Sections 790.05 and 790.035.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 19. (AB 2 1x) Effective September 30, 2013.)

10965.7. (a) An individual health benefit plan shall be renewable at the option of the insured except as permitted to be canceled, rescinded, or not renewed pursuant to Section 155.430(b) of Title 45 of the Code of Federal Regulations.

(b) Any insurer that ceases to offer for sale new individual health benefit plans pursuant to Section 10273.6 shall continue to be governed by this chapter with respect to business conducted under this chapter.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 19. (AB 2 1x) Effective September 30, 2013.)

10965.9. (a) With respect to individual health benefit plans issued, amended, or renewed on or after January 1, 2014, a health insurer may use only the following characteristics of an individual, and any dependent thereof, for purposes of establishing the rate of the individual health benefit plan covering the individual and the eligible dependents thereof, along with the health benefit plan selected by the individual:

(1) Age, pursuant to the age bands established by the United States Secretary of Health and Human Services and the age rating curve established by the federal Centers for Medicare and Medicaid Services pursuant to Section 2701(a)(3) of the federal Public

Health Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall be determined using the individual's age as of the date of the plan issuance or renewal, as applicable, and shall not vary by more than three to one for like individuals of different ages who are 21 years of age or older as described in federal regulations adopted pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)).

(2) (A) Geographic region. The geographic regions for purposes of rating shall be the following:

(i) Region 1 shall consist of the Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

(ii) Region 2 shall consist of the Counties of Marin, Napa, Solano, and Sonoma.

(iii) Region 3 shall consist of the Counties of El Dorado, Placer, Sacramento, and Yolo.

(iv) Region 4 shall consist of the City and County of San Francisco.

(v) Region 5 shall consist of the County of Contra Costa.

(vi) Region 6 shall consist of the County of Alameda.

(vii) Region 7 shall consist of the County of Santa Clara.

(viii) Region 8 shall consist of the County of San Mateo.

(ix) Region 9 shall consist of the Counties of Monterey, San Benito, and Santa Cruz.

(x) Region 10 shall consist of the Counties of Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.

(xi) Region 11 shall consist of the Counties of Fresno, Kings, and Madera.

(xii) Region 12 shall consist of the Counties of San Luis Obispo, Santa Barbara, and Ventura.

(xiii) Region 13 shall consist of the Counties of Imperial, Inyo, and Mono.

(xiv) Region 14 shall consist of the County of Kern.

(xv) Region 15 shall consist of the ZIP Codes in the County of Los Angeles starting with 906 to 912, inclusive, 915, 917, 918, and 935.

(xvi) Region 16 shall consist of the ZIP Codes in the County of Los Angeles other than those identified in clause (xv).

(xvii) Region 17 shall consist of the Counties of Riverside and San Bernardino.

(xviii) Region 18 shall consist of the County of Orange.

(xix) Region 19 shall consist of the County of San Diego.

(B) No later than June 1, 2017, the department, in collaboration with the Exchange and the Department of Managed Health Care, shall review the geographic rating regions specified in this paragraph and the impacts of those regions on the health care coverage market in California, and make a report to the appropriate policy committees of the Legislature.

(3) Whether the plan covers an individual or family, as described in PPACA.

(b) The rate for a health benefit plan subject to this section shall not vary by any factor not described in this section.

(c) With respect to family coverage under an individual health benefit plan, the rating variation permitted under paragraph (1) of subdivision (a) shall be applied based on the portion of the premium attributable to each family member covered under the plan. The total premium for family coverage shall be determined by summing the premiums for each individual family member. In determining the total premium for family members, premiums for no more than the three oldest family members who are under 21 years of age shall be taken into account.

(d) The rating period for rates subject to this section shall be from January 1 to December 31, inclusive.

(e) This section shall not apply to an individual health benefit plan that is a grandfathered health plan.

(f) The requirement for submitting a report imposed under subparagraph (B) of paragraph (2) of subdivision (a) is inoperative on June 1, 2021, pursuant to Section 10231.5 of the Government Code.

(Amended by Stats. 2021, Ch. 764, Sec. 12. (SB 326) Effective January 1, 2022.)

10965.11. (a) A health insurer shall not be required to offer an individual health benefit plan or accept applications for the plan pursuant to Section 10965.3 in the case of any of the following:

(1) To an individual who does not live or reside within the insurer's approved service areas.

(2) (A) Within a specific service area or portion of a service area, if the insurer reasonably anticipates and demonstrates to the satisfaction of the commissioner both of the following:

(i) It will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the individual because of its obligations to existing insureds.

(ii) It is applying this subparagraph uniformly to all individuals without regard to the claims experience of those individuals or any health status-related factor relating to those individuals.

(B) A health insurer that cannot offer an individual health benefit plan to individuals because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area pursuant to subparagraph (A) shall not offer an individual health benefit plan in that area until the later of the following dates:

(i) The 181st day after the date coverage is denied pursuant to this paragraph.

(ii) The date the insurer notifies the commissioner that it has the ability to deliver services to individuals, and certifies to the commissioner that from the date of the notice it will enroll all individuals requesting coverage in that area from the insurer.

(C) Subparagraph (B) shall not limit the insurer's ability to renew coverage already in force or relieve the insurer of the responsibility to renew that coverage as described in Section 10273.6.

(D) Coverage offered within a service area after the period specified in subparagraph (B) shall be subject to this section.

(b) (1) A health insurer may decline to offer an individual health benefit plan to an individual if the insurer demonstrates to the satisfaction of the commissioner both of the following:

(A) It does not have the financial reserves necessary to underwrite additional coverage. In determining whether this subparagraph has been satisfied, the commissioner shall consider, but not be limited to, the insurer's compliance with the requirements of this part and the rules adopted thereunder.

(B) It is applying this subdivision uniformly to all individuals without regard to the claims experience of those individuals or any health status-related factor relating to those individuals.

(2) A health insurer that denies coverage to an individual under paragraph (1) shall not offer coverage before the later of the following dates:

(A) The 181st day after the date coverage is denied pursuant to this subdivision.

(B) The date the insurer demonstrates to the satisfaction of the commissioner that the insurer has sufficient financial reserves necessary to underwrite additional coverage.

(3) Paragraph (2) shall not limit the insurer's ability to renew coverage already in force or relieve the insurer of the responsibility to renew that coverage as described in Section 10273.6. Coverage offered within a service area after the period specified in paragraph (2) shall be subject to this section.

(c) This chapter shall not be construed to limit the commissioner's authority to develop and implement a plan of rehabilitation for a health insurer whose financial viability or organizational and administrative capacity has become impaired, to the extent permitted by PPACA.

(d) This section shall not apply to an individual health benefit plan that is a grandfathered plan.

(Amended by Stats. 2014, Ch. 71, Sec. 105. (SB 1304) Effective January 1, 2015.)

10965.13. (a) A health insurer that receives an application for an individual health benefit plan outside the Exchange during the initial open enrollment period, an annual enrollment period, or a special enrollment period described in Section 10965.3 shall inform the applicant that he or she may be eligible for lower cost coverage through the Exchange and shall inform the applicant of the applicable enrollment period provided through the Exchange described in Section 10965.3.

(b) On or before October 1, 2013, and annually every October 1 thereafter, a health insurer shall issue a notice to a policyholder enrolled in an individual health benefit plan offered outside the Exchange. The notice shall inform the policyholder that he or she may be eligible for lower cost coverage through the Exchange and shall inform the policyholder of the applicable open enrollment period and special enrollment periods provided through the Exchange described in Section 10965.3.

(c) This section shall not apply where the individual health benefit plan described in subdivision (a) or (b) is a grandfathered health plan.

(Amended by Stats. 2017, Ch. 468, Sec. 8. (AB 156) Effective January 1, 2018.)

10965.15. (a) On or before October 1, 2013, and annually every October 1 thereafter, a health insurer shall issue the following notice to all policyholders enrolled in an individual health benefit plan that is a grandfathered health plan:

New improved health insurance options are available in California. You currently have health insurance that is not required to follow many of the new laws. For example, your policy may not provide preventive health services without you having to pay any cost sharing (copayments or coinsurance). Also your current policy may be allowed to increase your rates based on your health status while new policies cannot. You have the option to remain in your current policy or switch to a new policy. Under the new rules, a health insurance company cannot deny your application based on any health conditions you may have. For more information about your options, please contact Covered California at _____, your policy representative or insurance agent, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.

(b) Commencing October 1, 2013, a health insurer shall include the notice described in subdivision (a) in any renewal material of the individual grandfathered health plan and in any application for dependent coverage under the individual grandfathered health plan.

(c) A health insurer shall not advertise or market an individual health benefit plan that is a grandfathered health plan for purposes of enrolling a dependent of a policyholder into the plan for policy years on or after January 1, 2014. Nothing in this subdivision shall be construed to prohibit an individual enrolled in an individual grandfathered health plan from adding a dependent to that plan to the extent permitted by PPACA.

(Amended by Stats. 2014, Ch. 31, Sec. 34. (SB 857) Effective June 20, 2014.)

10965.16. Except as otherwise provided in this chapter, this chapter shall be implemented to the extent that it meets or exceeds the requirements set forth in PPACA.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 19. (AB 2 1x) Effective September 30, 2013.)

10965.17. (a) The commissioner may, no later than December 31, 2014, adopt emergency regulations implementing this chapter. The commissioner may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(b) The initial adoption of emergency regulations implementing this chapter and the one readoption of emergency regulation authorized by this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than one year, by which time final regulations may be adopted. The commissioner shall consult with the Director of the Department of Managed Health Care prior to adopting any regulations pursuant to this subdivision for the specific purpose of ensuring, to the extent practical, that there is consistency of regulations applicable to entities regulated by the commissioner and those regulated by the Department of Managed Health Care.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 19. (AB 2 1x) Effective September 30, 2013.)

10965.18. (a) For purposes of this chapter, a bridge plan product shall mean an individual health benefit plan that is offered by a health insurer licensed under this part that contracts with the Exchange pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(b) On and after September 30, 2013, if a health insurance policy has not been filed with the commissioner, a health insurer that contracts with the Exchange to offer a qualified bridge plan product pursuant to Section 100504.5 of the Government Code shall file the policy form with the commissioner pursuant to Section 10290.

(c) (1) Notwithstanding subdivision (a) of Section 10965.3, a health insurer selling a bridge plan product shall not be required to fairly and affirmatively offer, market, and sell the health insurer's bridge plan product except to individuals eligible for the bridge plan product pursuant to the State Department of Health Care Services and the Medi-Cal managed care plan's contract entered into

pursuant to Section 14005.70 of the Welfare and Institutions Code, provided the health care service plan meets the requirements of subdivision (b) of Section 14005.70 of the Welfare and Institutions Code.

(2) Notwithstanding subdivision (c) of Section 10965.3, a health insurer selling a bridge plan product shall provide an initial open enrollment period of six months, and an annual enrollment period and a special enrollment period consistent with the annual enrollment and special enrollment periods of the Exchange.

(d) A health insurer that contracts with the Exchange to offer a qualified bridge plan product pursuant to Section 100504.5 of the Government Code shall maintain a medical loss ratio of 85 percent for the bridge plan product. A health insurer shall utilize, to the extent possible, the same methodology for calculating the medical loss ratio for the bridge plan product that is used for calculating the health insurer's medical loss ratio pursuant to Section 10112.25 and shall report its medical loss ratio for the bridge plan product to the department as provided in Section 10112.25.

(e) This section shall become inoperative on the October 1 that is five years after the date that federal approval of the bridge plan option occurs, and, as of the second January 1 thereafter, is repealed, unless a later enacted statute that is enacted before that date deletes or extends the dates on which it becomes inoperative and is repealed.

(Added by renumbering Section 10961 by Stats. 2014, Ch. 442, Sec. 8. (SB 1465) Effective September 18, 2014. Conditionally inoperative, on date prescribed by its own provisions. Repealed, by its own provisions, on second January 1 after inoperative date.)