

Code: Section: [Up^](#) [Add To My Favorites](#)**HEALTH AND SAFETY CODE - HSC****DIVISION 2. LICENSING PROVISIONS [1200 - 1796.70]** (*Division 2 enacted by Stats. 1939, Ch. 60.*)**CHAPTER 2.2. Health Care Service Plans [1340 - 1399.874]** (*Chapter 2.2 added by Stats. 1975, Ch. 941.*)**ARTICLE 11.5. Individual Access to Contracts for Health Care Services [1399.801 - 1399.818]** (*Heading of Article 11.5 renumbered from Article 10.5 by Stats. 2001, Ch. 159, Sec. 126.*)[1399.801.](#) As used in this article:

(a) "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, 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, the Health Insurance Portability and Accountability Act of 1996.

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

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

(c) "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 a group health 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 this coverage.

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

(e) "New business" means a health care service plan contract issued to an eligible individual that is not the plan's in force business.

(f) "Preexisting condition provision" means a contract 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, and care of treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(Added by Stats. 2000, Ch. 810, Sec. 2. Effective January 1, 2001.)

1399.802. (a) Every health care service plan offering plan contracts to individuals shall, in addition to complying with the provisions of this chapter and the rules adopted thereunder, comply with the provisions of this article.

(b) For the purposes of determining eligibility for small employer coverage, a sole proprietor and the sole proprietor's spouse are not 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 care service 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 care service plans shall be sold to any entity without employees.

(Amended by Stats. 2018, Ch. 700, Sec. 5. (SB 1375) Effective January 1, 2019.)

1399.803. Nothing in this article 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, or (b) an association, trust, multiple employer welfare arrangement, or other organization or person presenting information regarding a health care service plan to persons who may be interested in subscribing or enrolling in the plan.

(Added by Stats. 2000, Ch. 810, Sec. 2. Effective January 1, 2001.)

1399.804. (a) Commencing January 1, 2001, a plan shall fairly and affirmatively offer, market, and sell the health care service plan contracts described in subdivision (d) of Section 1366.35 that are sold to individuals or to associations that include individuals to all federally eligible defined individuals in each service area in which the plan provides or arranges for the provision of health care services. Each plan shall make available to each federally eligible defined individual the identified health care service plan contracts which the plan offers and sells to individuals or to associations that include individuals.

(b) The plan may not reject an application from a federally eligible defined individual for a health care service plan contract under the following circumstances:

(1) The federally eligible defined individual as defined by subdivision (c) of Section 1399.801 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 plan contract, work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.

(c) No plan or solicitor shall, directly or indirectly, encourage or direct federally eligible defined individuals to refrain from filing an application for coverage with a plan 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 plan's approved service area.

(d) No plan shall, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract 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.

(e) Each plan shall comply with the requirements of Section 1374.3.

(Added by Stats. 2000, Ch. 810, Sec. 2. Effective January 1, 2001.)

1399.805. (a) (1) After the federally eligible defined individual submits a completed application form for a plan contract, the plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan contract, unless the plan has provided notice of the premium charge prior to the application being filed. In no case shall the premium charged for any health care service plan contract identified in subdivision (d) of Section 1366.35 exceed the following amounts:

(A) For health care service plan contracts 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 care service plan contracts identified in subdivision (d) of Section 1366.35 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 plan may adjust the premium based on family size, not to exceed the following amounts:

(A) For health care service 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 care service plans identified in subdivision (d) of Section 1366.35 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) After the federally eligible defined individual submits a completed application form for a plan contract, the plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan contract, unless the plan has provided notice of the premium charge prior to the application being filed. In no case shall the premium charged for any health care service plan contract identified in subdivision (d) of Section 1366.35 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. This subdivision 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 or 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 plan contract, the individual shall have the option of changing coverage to a different plan contract offered by the same health care service plan. If the individual notified the plan of the change within the first 15 days of a month, coverage under the new plan contract shall become effective no later than the first day of the following month. If an enrolled individual notified the plan of the change after the 15th day of a month, coverage under the new plan contract 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 plan contracts 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 care service plan contracts 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 Education and 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. 9. (AB 1180) Effective October 1, 2013.)

1399.806. A plan 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 plan contract 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. 2. Effective January 1, 2001.)

1399.809. The director may require a plan to discontinue the offering of contracts or the acceptance of applications from any individual upon a determination by the director that the plan does not have sufficient financial viability, organization, and administrative capacity to assure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

(Added by Stats. 2000, Ch. 810, Sec. 2. Effective January 1, 2001.)

1399.810. All health care service plan contracts offered to a federally eligible defined individual shall be renewable with respect to the individual and dependents at the option of the contractholder except in cases of:

(a) Nonpayment of the required premiums.

(b) Fraud or misrepresentation by the contractholder.

(c) The plan ceases to provide or arrange for the provision of health care services for individual health care service 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 director and to the contractholder.

(2) Individual health care service 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 plan that remains in force, any plan that ceases to offer for sale new individual health care service plan contracts shall continue to be governed by this article with respect to business conducted under this article.

(3) A plan that ceases to write new individual business in this state after January 1, 2001, shall be prohibited from offering for sale new individual health care service plan contracts in this state for a period of three years from the date of the notice to the director.

(d) When the plan withdraws a health care service plan contract from the individual market, provided that the plan makes available to eligible individuals all plan contracts that it makes available to new individual business, and provided that the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1399.811.

(e) (1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plan contracts 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 care service plan contracts 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 Education and 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. 10. (AB 1180) Effective October 1, 2013.)

1399.811. (a) (1) Premiums for contracts offered, delivered, amended, or renewed by plans on or after January 1, 2001, shall be subject to the following requirements:

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

(i) For health care service plan contracts identified in subdivision (d) of Section 1366.35 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 the ages of 60 to 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.

(ii) For health care service plan contracts identified in subdivision (d) of Section 1366.35 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 the ages of 60 to 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.

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

(i) For health care service plan contracts identified in subdivision (d) of Section 1366.35 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 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.

(ii) For health care service plan contracts identified in subdivision (d) of Section 1366.35 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 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 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.

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

(b) (1) Premiums for contracts offered, delivered, amended, or renewed by plans on or after January 1, 2014, 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. This subdivision 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 care service plan contracts identified in subdivision (d) of Section 1366.35 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 care service plan contracts identified in subdivision (d) of Section 1366.35 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 plan 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 plan contracts 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 care service plan contracts 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 Education and 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. 11. (AB 1180) Effective October 1, 2013.)

1399.812. Plans shall apply premiums consistently with respect to all federally eligible defined individuals who apply for coverage.

(Added by Stats. 2000, Ch. 810, Sec. 2. Effective January 1, 2001.)

1399.813. In connection with the offering for sale of any plan contract to an individual, each plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of all individual contracts.

(Added by Stats. 2000, Ch. 810, Sec. 2. Effective January 1, 2001.)

1399.814. Nothing in this article shall be construed to require a health benefit plan to offer a contract to an individual if the plan does not otherwise offer contracts to individuals.

(Added by Stats. 2000, Ch. 810, Sec. 2. Effective January 1, 2001.)

1399.815. (a) At least 20 business days prior to renewing or amending a plan contract subject to this article, or at least 20 business days prior to the initial offering of a plan contract subject to this article, a plan shall file a notice of an amendment with the director in accordance with the provisions of Section 1352. The notice of an amendment shall include a statement certifying that the plan is in compliance with subdivision (a) of Section 1399.805 and with Section 1399.811. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons the plan contract does not comply with the requirements of this chapter.

(b) Prior to making any changes in the premium, the plan shall file an amendment in accordance with the provisions of Section 1352, and shall include a statement certifying the plan is in compliance with subdivision (a) of Section 1399.805 and with Section 1399.811. All other changes to a plan contract previously filed with the director pursuant to subdivision (a) shall be filed as an

amendment in accordance with the provisions of Section 1352, unless the change otherwise would require the filing of a material modification.

(c) (1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plan contracts 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 plan contracts 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 Education and 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. 12. (AB 1180) Effective October 1, 2013.)

1399.817. The director may issue regulations that are necessary to carry out the purposes of this article. Any rules and regulations adopted pursuant to this article 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 director.

(Added by Stats. 2000, Ch. 810, Sec. 2. Effective January 1, 2001.)

1399.818. This article shall apply to health care service plan contracts offered, delivered, amended, or renewed on or after January 1, 2001.

(Added by Stats. 2000, Ch. 810, Sec. 2. Effective January 1, 2001.)