

§ 1399.818. Date of applicability of article

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

HISTORY:

Added Stats 2000 ch 810 § 2 (SB 265), effective January 1, 2001.

ARTICLE 11.7

Child Access to Health Care Coverage (Inoperative; Operative date contingent)

Section

- 1399.825. Definitions (Inoperative; Operative date contingent).
- 1399.826. Child coverage; Preexisting condition; Issuance or offering of individual coverage may not be conditioned; When coverage becomes effective; Establishment of rules for eligibility; Construction (Inoperative; Operative date contingent).
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- 1399.834. Renewal of contracts; Plan ceasing to offer individual coverage (Inoperative; Operative date contingent).
- 1399.835. Issuance of guidance to health plans regarding compliance with article (Inoperative; Operative date contingent).
- 1399.836. Operation of article (Inoperative; Operative date contingent).

HISTORY: Added Stats 2010 ch 656 § 3, effective January 1, 2011. The heading of Article 11.7 which formerly read “Individual Access to Health Care Coverage,” amended to read as above by Stats 2013-2014 1st Ex Sess ch 2 § 15 (SBX1 2), effective September 30, 2013. Amended Stats 2013-2014 1st Ex Sess ch 2 § 17 (SBX1 2), effective September 30, 2013, inoperative January 1, 2014, operative date contingent (inoperative date added, contingent operative date added).

§ 1399.825. Definitions (Inoperative; Operative date contingent)

As used in this article:

(a) “Child” means any individual under 19 years of age.

(b) “Individual grandfathered plan coverage” means health care coverage in which an individual was enrolled on March 23, 2010, consistent with Section 1251 of PPACA and any rules or regulations adopted pursuant to that law.

(c) “Initial open enrollment period” means the open enrollment period beginning on January 1, 2011, and ending 60 days thereafter.

(d) “Late enrollee” means a child without coverage who did not enroll in a health care service plan contract during an open enrollment period because of any of the following:

(1) The child lost dependent coverage due to termination or change in employment status of the child or the person through whom the child was covered; cessation of an employer’s contribution toward an employee or dependent’s coverage; death of the person through whom the child was covered as a dependent; legal separation; divorce; loss of coverage under the Healthy Families Program, the Access for Infants and Mothers Program, or the Medi-Cal program; or adoption of the child.

(2) The child became a resident of California during a month that was not the child’s birth month.

(3) The child is born as a resident of California and did not enroll in the month of birth.

(4) The child is mandated to be covered pursuant to a valid state or federal court order.

(e) “Open enrollment period” means the annual open enrollment period, subsequent to the initial open enrollment period, applicable to each individual child that is the month of the child’s birth date.

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

(g) “Preexisting condition exclusion” means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment of the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

(h) “Responsible party for a child” means an adult having custody of the child or with responsibility for the financial needs of the child, including the responsibility to provide health care coverage.

(i) “Standard risk rate” means the lowest rate that can be offered for a child with the same benefit plan, effective date, age, geographic region, and family status.

HISTORY:

Added Stats 2010 ch 656 § 3 (AB 2244), effective January 1, 2011. Amended Stats 2013-2014 1st Ex Sess ch 2 § 17 (SBX1 2), effective

September 30, 2013, inoperative January 1, 2014, operative date contingent (inoperative date added, contingent operative date added).

§ 1399.826. Child coverage; Preexisting condition; Issuance or offering of individual coverage may not be conditioned; When coverage becomes effective; Establishment of rules for eligibility; Construction (Inoperative; Operative date contingent)

(a)(1) During each open enrollment period, every health care service plan offering plan contracts in the individual market, other than individual grandfathered plan coverage, shall offer to the responsible party for a child coverage for the child that does not exclude or limit coverage due to any preexisting condition of the child.

(b) A health care service plan offering coverage in the individual market shall not reject an application for a health care service plan contract from a child or filed on behalf of a child by the responsible party during an open enrollment period or from a late enrollee during a period no longer than 63 days from the qualifying event listed in subdivision (d) of Section 1399.825.

(c) Except to the extent permitted by federal law, rules, regulations, or guidance issued by the relevant federal agency, a health care service plan shall not condition the issuance or offering of individual coverage on any of the following factors:

- (1) Health status.
- (2) Medical condition, including 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 department.

This subdivision shall not apply to a contract providing individual grandfathered plan coverage.

(d) When a responsible party for a child 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 contract shall become effective no later than the first day of the following month. When that 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.

(e) A health care service plan offering coverage in the individual market shall not reject the request of a responsible party for a child to include that child as a dependent on an existing health care service plan contract that includes dependent coverage during an open enrollment period.

(f) Nothing in this article shall be construed to prohibit a health care service plan offering coverage in the individual market from establishing rules for

eligibility for coverage and offering coverage pursuant to those rules for children and individuals based on factors otherwise authorized under federal and state law for health plan contracts in addition to those offered on a guaranteed issue basis during an open enrollment period to children or late enrollees pursuant to this article. However, a health care service plan, other than a plan providing individual grandfathered plan coverage, shall not impose a preexisting condition provision on coverage, including dependent coverage, offered to a child.

(g) Nothing in this article shall be construed to require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan's existing service area.

(h) Nothing in this article shall be construed to prevent a health care service plan from offering coverage to a family member of an enrollee in grandfathered health plan coverage consistent with Section 1251 of PPACA.

HISTORY:

Added Stats 2010 ch 656 § 3 (AB 2244), effective January 1, 2011. Amended Stats 2013-2014 1st Ex Sess ch 2 § 17 (SBX1 2), effective

September 30, 2013, inoperative January 1, 2014, operative date contingent (inoperative date added, contingent operative date added).

§ 1399.827. Applicability of article (Inoperative; Operative date contingent)

This article shall not apply to health care service plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement contracts, Medi-Cal contracts with the State Department of Health Care Services, plan contracts offered under the Healthy Families Program, long-term care coverage, or specialized health care service plan contracts.

HISTORY:

Added Stats 2010 ch 656 § 3 (AB 2244), effective January 1, 2011. Amended Stats 2013-2014 1st Ex Sess ch 2 § 17 (SBX1 2), effective

September 30, 2013, inoperative January 1, 2014, operative date contingent (inoperative date added, contingent operative date added).

§ 1399.828. Availability of plan's health care service plan contracts to late enrollees; Prohibited activities; Compensation to solicitor prohibited (Inoperative; Operative date contingent)

(a) Upon the effective date of this article, a health care service plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are offered and sold to a child or the responsible party for a child in each service area in which the plan provides or arranges for the provision of health care services during any open enrollment period, to late enrollees, and during any other period in which state or federal law, rules, regulations, or guidance expressly provide that a health care service plan shall not condition offer or acceptance of coverage on any preexisting condition.

(b) No health care service plan or solicitor shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct a child or responsible party for a child to refrain from filing an application for coverage with a plan because of the health status, claims experience, industry, occupation, or geographic location,

provided that the location is within the plan's approved service area, of the child.

(2) Encourage or direct a child or responsible party for a child to seek coverage from another plan because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the plan's approved service area, of the child.

(c) A health care service plan shall not, 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 the health status, claims experience, industry, occupation, or geographic location of the child. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor 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 child.

HISTORY:

Added Stats 2010 ch 656 § 3 (AB 2244), effective January 1, 2011. Amended Stats 2013-2014 1st Ex Sess ch 2 § 17 (SBX1 2), effective

September 30, 2013, inoperative January 1, 2014, operative date contingent (inoperative date added, contingent operative date added).