§ 1366.29. Continuing coverage for enrollees who have exhausted continuation coverage under COBRA

(a) A health care service plan shall offer an enrollee who has exhausted continuation coverage under COBRA the opportunity to continue coverage for up to 36 months from the date the enrollee's continuation coverage began, if the enrollee is entitled to less than 36 months of continuation coverage under

COBRA. The health care service plan shall offer coverage pursuant to the terms of this article, including the rate limitations contained in Section 1366.26.

(b) Notification of the coverage available under this section shall be included in the notice of the pending termination of COBRA coverage that is required to be provided to COBRA beneficiaries and that is required to be provided under Section 1366.24.

(c) For purposes of this section, "COBRA" means Section 4980B of Title 26 of the United States Code, Sections 1161 et seq. of Title 29 of the United States Code, and Section 300bb of Title 42 of the United States Code.

(d) This section shall not apply to specialized health care service plans providing noncore coverage, as defined in subdivision (g) of Section 1366.21.

(e) This section shall become operative on September 1, 2003, and shall apply to individuals who begin receiving COBRA coverage on or after January 1, 2003.

HISTORY:
Added Stats 2002 ch 794 § 4 (AB 1401), operative September 1, 2003.

ARTICLE 4.6

Coverage for Federally Eligible Defined Individuals

Section

HISTORY: Added Stats 2000 ch 810 § 1 (SB 265).

§ 1366.35. Required coverage [Inoperative; Operative date contingent]

(a) A health care service plan providing coverage for hospital, medical, or surgical benefits under an individual health care service plan contract may not, with respect to a federally eligible defined individual desiring to enroll in individual health insurance coverage, decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion with respect to the coverage.

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

(1) Has had 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002).

(2) Is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have other health insurance coverage.

(3) Was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud.

(4) If offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.

(c) Every health care service plan shall comply with applicable federal statutes and regulations regarding the provision of coverage to federally eligible defined individuals, including any relevant application periods.

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

(e)(1) In the case of a health care service plan that offers health insurance coverage in the individual market through a network plan, the plan may do both of the following:

(A) Limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service area for the network plan.

(B) Within the service area of the plan, deny coverage to individuals if the plan has demonstrated to the director that the plan will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contractholders and enrollees and individual enrollees, and that the plan is applying this paragraph uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

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

(f)(1) A health care service plan may deny health insurance coverage in the individual market to a federally eligible defined individual if the plan has demonstrated to the director both of the following:

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

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

(2) A health care service plan, upon denying individual health insurance coverage in any service area in accordance with paragraph (1), may not offer that coverage in the individual market within that service area for a period of 180 days after the date the coverage is denied or until the issuer has

demonstrated to the director that the plan has sufficient financial reserves to underwrite additional coverage, whichever is later.

(g) The requirement pursuant to federal law to furnish a certificate of creditable coverage shall apply to health insurance coverage offered by a health care service plan in the individual market in the same manner as it applies to a health care service plan in connection with a group health benefit plan.

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

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

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

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

(*l*) This section shall apply to health care service plan contracts offered, delivered, amended, or renewed on or after January 1, 2001.

(m)(1) This section shall be inoperative on January 1, 2014.

(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), this section shall become operative on the date of that repeal or amendment.

(3) For purposes of this subdivision, "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.

HISTORY:

Added Stats 2000 ch 810 § 1 (SB 265). Amended Stats 2013 ch 441 § 4 (AB 1180), effective October 1, 2013, inoperative January 1, 2014, operative date contingent.

§ 1366.50. Notice of eligibility for reduced-cost coverage through California Health Benefit Exchange or no-cost coverage through Medi-Cal

(a)(1) On and after January 1, 2014, a health care service plan providing individual or group health care coverage shall provide to enrollees or subscribers who cease to be enrolled in coverage a notice informing them that they may be eligible for reduced-cost coverage through the California Health Benefit Exchange (Exchange) established under Title 22 (commenc-

ing with Section 100500) of the Government Code or no-cost coverage through Medi-Cal. The notice shall include information on obtaining coverage pursuant to those programs, shall be in no less than 12-point type, and shall be developed by the department, no later than July 1, 2013, in consultation with the Department of Insurance and the Exchange. The notice shall also include information that individuals eligible for the Medicare Program should examine their options carefully, as delaying Medicare enrollment may result in substantial financial implications, as well as information on how to find enrollment advice or assistance.

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

(b)(1) A health care service plan providing individual or group health care coverage shall annually notify an enrollee or subscriber that if the enrollee or subscriber ceases to be enrolled in coverage, the health care service plan will provide information, including the enrollee's or subscriber's name, address, and other contact information, such as email address, to the Exchange so that the enrollee or subscriber may obtain other coverage. An enrollee or subscriber may opt out of this transfer of information to the Exchange. This notice may be incorporated into or sent simultaneously with other notices sent by the health care service plan.

(2) Beginning January 1, 2021, a health care service plan providing individual or group health care coverage that has notified its enrollees or subscribers consistent with paragraph (1) shall provide to the Exchange the name, address, and other contact information of an enrollee or subscriber who ceased to be enrolled in coverage and who did not opt out of the information transfer. The information shall be provided in a manner prescribed by the Exchange.

(3) The Exchange may use any contact method to communicate with and inform an enrollee or subscriber who ceases to be enrolled in coverage of available coverage options.

(c) This section does not apply to a specialized health care service plan contract or a Medicare supplemental plan contract.

HISTORY:

Added Stats 2012 ch 851 § 3 (AB 792), effective January 1, 2013. Amended Stats 2019 ch 845 § 2 (SB 260), effective January 1, 2020.

ARTICLE 5

Standards

Section

Section
1367.006. Nongrandfathered individual and group health care service plans that cover essential health benefits; Limit on annual out-of-pocket expenses for covered essential health benefits.
1367.0061. Accrual balance toward annual deductible and annual out-of-pocket maximum; Notice to enrollee; Availability of information.
1367.0065. [Section repealed 2016.]
1367.007. Limitation on deductible for small employer health care service plan.
1367.008. Levels of coverage for nongrandfathered individual market; Determination of actuarial value for nongrandfathered individual health care service plans; Catastrophic plan.
1367.0085. Actuarial value for nongrandfathered bronze level high deductible health plan.
1367.009. Levels of coverage for nongrandfathered small group market; Determination of actuarial value for nongrandfathered small employer health care service plans.
1367.01. Written policies and procedures for review and approval, modification, delay or denial of services; Medical director to ensure compliance; Compliance review.
1367.010. Minimum value of sixty percent for large group health care service plan contract.
1367.012. Renewal of small employer health care service plan contract; Notice; Exemptions; Amendments for compliance.
1367.015. Decisions to deny requests by providers for authorization or claim reimbursement for mental health services.
1367.016. Premium payments from third-party entities; Reimbursement; Dispute resolution.
1367.02. Filing relating to any economic profiling policies or procedures; Availability to public; "Economic profiling".
1367.03. Timely access requirements.
1367.031. Information regarding standards for timely access to health care services.
1367.035. Standards for timely access to health care services; Required inclusion of network adequacy data.
1367.04. Language assistance in obtaining health care services; Adoption of regulations and standards; Considerations; Reports; Public input; Contracts.
1367.041. Required non-English insurance documents.
1367.042. Information made available by health care service plan.
1367.043. Cultural competency training.
1367.045. Void and unenforceable contract provision.
1367.05. Contract with dental college.
1367.06. Service plan to cover outpatient prescription drug benefits to provide coverage for inhaler spacers, nebulizers, and peak flow meters when medically necessary for treatment of pediatric asthma.
1367.07. Report by health care service plan on cultural appropriateness in specified contexts.
1367.08. Compensation disclosure.
1367.09. Return to skilled nursing.
1367.1. Application to transitionally licensed plans.
1367.2. Coverage for alcoholism; Notice of coverage.
1367.3. Coverage plan for comprehensive preventive care of children.
1367.34. Coverage for adverse childhood experiences screenings.
1367.34. Coverage for home test kits by health care service plans.
1367.35. Comprehensive preventive care of children of specified ages.
1367.36. Costs of required immunization of children.
1367.4. Effect of blindness on coverage.
1367.41. Pharmacy and therapeutics committee.
1367.42. Enrollee access to prescription drug benefits at in-network retail pharmacy; Effect on cost-sharing.
1367.43. Prorated cost for partial fill of prescription.
1367.45. Coverage for approved AIDS vaccine; Cost effective price.
1367.46. Coverage for HIV testing required.
1367.47. Maximum amount health care service plan may require enrollee to pay at point of sale for covered prescription drug.
1367.49. Information to be furnished to consumers or purchasers concerning cost range of procedure or full course of treatment, or quality of services performed by provider or supplier; Review of methodology and data; Online posting; Definitions.
1367.5. Health service plan contract restrictions.
1367.50. Disclosure of claims data to qualified entity.
1367.51. Coverage of equipment and supplies for treatment of diabetes; Prescription items; Outpatient self-management and training.
1367.54. California Prenatal Screening Program.

Section

Section

Section
1374.195. Covered dental services; Contracts; Charge for services; Evidence of coverage and disclosure form; Required statement.
1374.196. Establishment and maintenance of application programming interfaces.
1374.197. Verification of health care provider credentialing application by health care service plan or disability insurer.

HISTORY: Added Stats 1975 ch 941 § 2, operative July 1, 1976.