§ 1364.5. Filing of procedures to protect confidentiality; Statement for enrollees and subscribers; Notice of availability

(a) On or before July 1, 2001, every health care service plan shall file with the director a copy of their policies and procedures to protect the security of patient medical information to ensure compliance with the Confidentiality of Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code). Any amendment to the policies and procedures shall be filed in accordance with Section 1352.

(b) On and after July 1, 2001, every health care service plan shall, upon request, provide to enrollees and subscribers a written statement that describes how the contracting organization or health care service plan maintains the confidentiality of medical information obtained by and in the possession of the contracting organization or the health care service plan.

(c) The statement required by subdivision (b) shall be in at least 12-point type and meet the following requirements:

(1) The statement shall describe how the contracting organization or health care service plan protects the confidentiality of medical information pursuant to this article and inform patients or enrollees and subscribers that any disclosure of medical information beyond the provisions of the law is prohibited.

(2) The statement shall describe the types of medical information that may be collected and the type of sources that may be used to collect the information, the purposes for which the contracting organization or plan will obtain medical information from other health care providers.

(3) The statement shall describe the circumstances under which medical

information may be disclosed without prior authorization, pursuant to Section 56.10 of the Civil Code.

(4) The statement shall describe how patients or enrollees and subscribers may obtain access to medical information created by and in the possession of the contracting organization or health care service plan, including copies of medical information.

(d) On and after July 1, 2001, every health care service plan shall include in its evidence of coverage or disclosure form the following notice, in 12-point type: A STATEMENT DESCRIBING (NAME OR PLAN OR "OUR") POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

HISTORY:
Added Stats 1999 ch 526 § 10 (SB 19). Amended Stats 2000 ch 1067 § 7 (SB 2094), effective January 1, 2001.

§ 1365. Cancellation and non-renewal of enrollment or subscription

(a) An enrollment or a subscription shall not be canceled or not renewed except for the following reasons:

(1)(A) Except as otherwise specified in subparagraph (C), for nonpayment of the required premiums by the individual, employer, or contractholder if the individual, employer, or contractholder has been duly notified and billed for the charge and at least a 30-day grace period has elapsed since the date of notification or, if longer, the period of time required for notice and any other requirements pursuant to Section 2703, 2712, or 2742 of the federal Public Health Service Act (42 U.S.C. Secs. 300gg-2, 300gg-12, and 300gg-42) and any subsequent rules or regulations has elapsed.

(B) Pursuant to subparagraph (A), a health care service plan shall continue to provide coverage as required by the individual's, employer's, or contractholder's health care service plan contract during the 30-day period described in subparagraph (A).

(C)(i) For nonpayment of the required premiums by an individual who receives advance payments of the premium tax credit authorized by Section 100800 of the Government Code, or both, if the individual has been duly notified and billed for the charge and a grace period of three consecutive months has elapsed since the last day of paid coverage.

(ii) During the first month of the three-month grace period described in clause (i), a health care service plan shall continue to do both of the following:

(I) Collect advance payments of the federal premium tax credit or state advanced premium assistance subsidy, or both, on behalf of the enrollee.

(II) Provide coverage as required by the individual's health care service plan contract.

(iii) If the individual exhausts the three-month grace period described in clause (i) without paying all outstanding premiums due, the health care service plan shall return both of the following:

(I) Advance payments of the premium tax credit paid on behalf of the individual for the second and third months of the three-month

grace period described in clause (i), pursuant to Section 156.270(e)(2) of Title 45 of the Code of Federal Regulations.

(II) The advanced premium assistance subsidy paid on behalf of the individual for the second and third months of the three-month grace period described in clause (i), pursuant to subdivision (a) of Section 100805 of the Government Code.

(iv) A health care service plan shall comply with all federal and state laws and regulations relating to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advance payments of the federal premium tax credit or state advanced premium assistance subsidy. For a health care service plan contract issued, amended, or renewed on or after January 1, 2020, all requirements applicable to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advance payments of premium tax credit authorized by Section 36B of the Internal Revenue Code shall apply to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advanced premium assistance subsidy authorized by Section 100800 of the Government Code.

(2) The plan demonstrates fraud or an intentional misrepresentation of material fact under the terms of the health care service plan contract by the individual contractholder or employer.

(3) In the case of an individual health care service plan contract, the individual subscriber no longer resides, lives, or works in the plan's service area, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(4) In the case of a group health care service plan contract, violation of a material contract provision relating to employer contribution or group participation rates by the contractholder or employer.

(5) If the plan ceases to provide or arrange for the provision of health benefits for new health care service plan contracts in the individual or group market, or all markets, in this state, provided, however, that the following conditions are satisfied:

(A) Notice of the decision to cease new or existing health benefit plans in the state is provided to the director, the individual or group contractholder or employer, and the enrollees covered under those contracts, at least 180 days prior to discontinuation of those contracts.

(B) Health benefit plans shall not be canceled for 180 days after the date of the notice required under subparagraph (A) and, for that business of a plan that remains in force, any plan that ceases to offer for sale new health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(C) Except as authorized under subdivision (b) of Section 1357.09 and Section 1357.10, a plan that ceases to write new health benefit plans in the individual or group market, or all markets, in this state shall be prohibited from offering for sale health benefit plans in that market or markets in this state for a period of five years from the date of the discontinuation of the last coverage not so renewed.

(6) If the plan withdraws a health benefit plan from the market, provided that all of the following conditions are satisfied:

(A) The plan notifies all affected subscribers, contractholders, employers, and enrollees and the director at least 90 days prior to the discontinuation of the plan.

(B) The plan makes available to the individual or group contractholder or employer all health benefit plans that it makes available to new individual or group business, respectively.

(C) In exercising the option to discontinue a health benefit plan under this paragraph and in offering the option of coverage under subparagraph (B), the plan acts uniformly without regard to the claims experience of the individual or contractholder or employer, or any health status-related factor relating to enrollees or potential enrollees.

(D) For small employer health care service plan contracts offered under Article 3.1 (commencing with Section 1357), the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1357.12. This subparagraph shall not apply after December 31, 2013.

(7) In the case of a group health benefit plan, if an individual or employer ceases to be a member of a guaranteed association, as defined in subdivision (n) of Section 1357, but only if that coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any enrollee.

(b)(1) An enrollee or subscriber who alleges that an enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed may request a review by the director pursuant to Section 1368.

(2) If the director determines that a proper complaint exists, the director shall notify the plan and the enrollee or subscriber who requested the review.

(3) If, after review, the director determines that the cancellation, rescission, or failure to renew is contrary to existing law, the director shall order the plan to reinstate the enrollee or subscriber. Within 15 days after receipt of that order, the health care service plan shall request a hearing or reinstate the enrollee or subscriber.

(4) If an enrollee or subscriber requests a review of the health care service plan's determination to cancel or rescind or failure to renew the enrollee's or subscriber's health care service plan contract pursuant to this section, the health care service plan shall continue to provide coverage to the enrollee or subscriber under the terms of the contract until a final determination of the enrollee's or subscriber's request for review has been made by the director. This paragraph shall not apply if the health care service plan cancels or does not renew the enrollee's or subscriber's health care service plan contract for nonpayment of premiums pursuant to paragraph (1) of subdivision (a).

(5) A reinstatement pursuant to this subdivision shall be retroactive to the time of cancellation, rescission, or failure to renew and the plan shall be liable for the expenses incurred by the subscriber or enrollee for covered health care services from the date of cancellation, rescission, or nonrenewal to and including the date of reinstatement. The health care service plan shall reimburse the enrollee or subscriber for any expenses incurred pursuant to this paragraph within 30 days of receipt of the completed claim.

(c) This section shall not abrogate any preexisting contracts entered into prior to the effective date of this chapter between a subscriber or enrollee and

a health care service plan or a specialized health care service plan, including, but not limited to, the financial liability of the plan, except that each plan shall, if directed to do so by the director, exercise its authority, if any, under those preexisting contracts to conform them to existing law.

(d) As used in this section, "health benefit plan" means any individual or group insurance policy or health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include accident only, credit, or disability income coverage, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, long-term care insurance, dental or vision coverage, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation law 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.

(e) On or before July 1, 2011, the director may issue guidance to health care service plans regarding compliance with this section and that guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Any guidance issued pursuant to this subdivision shall only be effective through December 31, 2013, or until the director adopts and effects regulations pursuant to the Administrative Procedure Act, whichever occurs first.

HISTORY:

Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1999 ch 525 § 91 (AB 78), operative July 1, 2000; Stats 2010 ch 658 § 4 (AB 2470), effective January 1, 2011; Stats 2011 ch 296 § 140 (AB 1023), effective January 1, 2012; Stats 2019 ch 38 § 15 (SB 78), effective June 27, 2019.

§ 1365.5. Modification of or refusal to enter contract on discriminatory basis

(a) No health care service plan or specialized health care service plan shall refuse to enter into any contract or shall cancel or decline to renew or reinstate any contract because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise.

(b) The terms of any contract shall not be modified, and the benefits or coverage of any contract shall not be subject to any limitations, exceptions, exclusions, reductions, copayments, coinsurance, deductibles, reservations, or premium, price, or charge differentials, or other modifications because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, potential contracting party, or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise; except that premium, price, or charge differentials because of the age of any individual when based on objective, valid, and up-to-date statistical and actuarial data are not prohibited.

(c) It shall be deemed a violation of subdivision (a) for any health care service plan to utilize marital status, living arrangements, occupation, sex, beneficiary designation, ZIP Codes or other territorial classification, or any combination thereof for the purpose of establishing sexual orientation. Noth-

ing in this section shall be construed to alter in any manner the existing law prohibiting health care service plans from conducting tests for the presence of human immunodeficiency virus or evidence thereof.

(d) This section shall not be construed to limit the authority of the director to adopt or enforce regulations prohibiting discrimination because of sex, marital status, or sexual orientation.

(e) "Sex" as used in this section shall have the same meaning as "gender," as defined in Section 422.56 of the Penal Code.

(f) The changes made to this section by the act adding this subdivision shall only apply to contracts issued, amended, or renewed on or after January 1, 2011.

HISTORY:

Added Stats 1990 ch 1402 § 1 (AB 1721). Amended Stats 1999 ch 525 § 92 (AB 78), operative July 1, 2000; Stats 2005 ch 421 § 1 (AB 1586), effective January 1, 2006; Stats 2009 ch 365 § 1 (AB 119), effective January 1, 2010.